

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Neighborhoods Rehab & Skilled Nursing by Tigerplac		STREET ADDRESS, CITY, STATE, ZIP CODE  3003 Falling Leaf Court Columbia, MO 65201	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327</b></p> <p>Based on interview and record review, staff failed to maintain a professional standard of care when staff failed to document follow-up when a medication unavailable, document physician notification when the medication unavailable, and document any adverse effects from lack of medication administration for one (Resident #36) out of five sampled residents. The facility census was 91.</p> <p>1. Review of the facility's Medication Error policy, dated 2024, showed:</p> <p>-The facility shall ensure medications will be administered according to the physician orders and in accordance with accepted standards and principles which apply to professionals providing services;</p> <p>-Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following: Resident's condition, drug category, or frequency of error (if an error occurring repeatedly such as an omission of a resident's medication several times);</p> <p>-The facility will consider factors indicating errors in medication administration, including, medication administered not in accordance with the prescriber's order to include medication omission;</p> <p>-If a medication error occurs, the nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible, monitor and document the resident's condition, document actions taken in the medical record, and once the resident is stable, the nurse reports the incident to appropriate supervision and completes and occurrence report.</p> <p>Review of the facility's Medication Reordering policy, dated 2024, showed:</p> <p>-The facility will utilize a systemic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident;</p> <p>-Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner;</p> <p>-Each time a nurse is administering medications an observes six or less doses left of one kind, that nurse will reorder the medication, time permitting.</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
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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>Review of the facility's Documentation in the Medical Record policy, dated 2024, showed each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.</p> <p>Review of the facility's Notification of Changes policy, dated 2024, showed the facility must consult with the resident's physician when there is a change requiring such notification.</p> <p>2. Review of Resident #36's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/19/24, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively impaired;</li> <li>-No behaviors or rejection of care;</li> <li>-Received antipsychotic medication in the lookback period;</li> <li>-Diagnosis of Schizophrenia, Bipolar depression, anxiety and depression.</li> </ul> <p>Review of the resident's Physician Order Sheet (POS), dated August 2024 through November 2024, showed:</p> <ul style="list-style-type: none"> <li>-On 2/20/24 an order for Aristada (antipsychotic medication used to treat Schizophrenia) intramuscular, prefilled syringe, 662 milligram (mg) per 2.4 milliliters (ml). Inject 2.4 ml intramuscular every four weeks on Friday morning and discontinued 10/28/24;</li> <li>-On 10/28/24 an order for Aristada intramuscular prefilled syringe, 662 mg per 2.4 ml. Inject 2.4 ml intramuscular every four weeks on Friday morning.</li> </ul> <p>Review of the resident's medical record, dated August 2024, showed the MAR did not contain documentation the Aristada was administered.</p> <p>Review of the resident's Medication Administration Record (MAR), dated September 2024, showed staff documented see progress notes on 09/06/24. Review showed the MAR did not contain documentation staff administered the resident Aristada as directed.</p> <p>Review of the resident's progress notes, dated 09/06/24, showed staff documented the medication Aristada on order from the pharmacy. Review showed the progress notes did not contain documentation staff notified the physician the medication not available, did not contain documentation staff monitored for adverse effects or follow up with pharmacy.</p> <p>Review of the resident's MAR, dated October 2024, showed staff documented see progress notes on 10/04/24. Review showed the MAR did not contain documentation staff administered the resident Aristada as directed.</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>Review of the resident's progress notes, dated October 2024, showed staff document the medication not available and waiting for delivery from the hospital on 10/04/24. On 10/24/24 staff documented resident was given Aristada in the left buttock and tolerated well. A note found in the nurses station after the medication was given, said resident received the medication on 10/19/24. Staff called the nurse practitioner, notified the family and the Director of Nursing (DON). Staff to monitor vital signs every four hours for three days. Dates changed per nurse practitioner so resident did not receive the injection on the first. The progress notes did not contain documentation staff contacted the pharmacy or attempts to ensure the medication was given/obtained timely as ordered by the physician.</p> <p>Review of the resident's MAR, dated November 2024, showed staff documented see progress notes on 11/01/24. Review showed the MAR did not contain documentation staff administered the resident Aristada as directed.</p> <p>Review of the resident's progress notes, dated November 2024, showed the progress notes did not contain documentation staff notified the physician the resident did not recieved the medication, the medication was not available, did not contain documentation staff monitored for adverse effects or follow up with pharmacy.</p> <p>Review of a photocopied Aristada medication label provided by the medical records staff on 11/13/24, showed the following handwritten on it:</p> <ul style="list-style-type: none"> <li>-Given 08/16/24;</li> <li>-Due 09/13/24;</li> <li>-Reorder from outside hospital;</li> <li>-Called the outside hospital to follow up on 09/27/24, they will expedite the shot to the facility, please give it;</li> <li>-Tracking number and notation stating at post office and been there since 10/08/24.</li> <li>-The document showed a typed sentence that showed its been hanging in the office window since given on 08/16/24.</li> </ul> <p>During a phone interview on 11/14/24 at 11:04 A.M., the pharmacy staff said the medication was filled and shipped to the facility on [DATE], 09/30/24, and 10/22/24.</p> <p>During an interview on 11/14/24 at 2:46 P.M., Licensed Practical Nurse (LPN) G said there has been issues getting the medication. The medication had been shipped and required a signature for the facility to receive. He/She said there was not anyone who signed for the medication so the medication went back to the post office. When it was not picked up, it went back to the outside hospital. He/She said the notes should indicate adverse effects, physician notification and process taken to get the medication. He/She thought the documentation was there.</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 11/15/24 at 9:32 A.M., the DON said the resident's Aristada comes from an outside hospital in Kansas City and was delivered. He/She said no staff signed for the medication because staff have never had to do that before, and the medication was sent back to the post office. The family was called to see if they could pick up the medication from the post office but has been a process. It was ordered from the outside hospital again, was delivered and administered, then came in again a week later and given again. At that time the physician was notified and the resident was placed on monitoring in October. The nurse was educated on documentation and a medication error investigation was completed. Staff are expected to get a hold order when medications are not available, document adverse effects and document any follow up and notify the physician for further guidance. The DON said the facility has reached out to the outside hospital to assistance getting the medication timely and working with the family to pick up the medication so it may be administered timely.</p> <p>During an interview on 11/15/24 at 11:00 A.M., the Administrator said the the resident is out of a medication, the nurse should notify the physician and ask for other options in the meantime. He/She said negative behaviors or outcome for lack of medication, should be recorded in the nurse notes. The Administrator said he/she was aware of the issue and feels the staff should have received a hold order and has addressed it with the staff.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424</b></p> <p>Based on observation, interviews, and record review, facility staff failed to store medications in a safe and effective manner in three medication rooms and one medication cart. The facility census was 91.</p> <p>1. Review of the facility's Medication Storage policy, undated, showed it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturers recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation moisture control, and security.</p> <p>2. Observation on 11/12/24 at 4:08 P.M., the Booneslick hall medication room contained:</p> <p>-One 10 inch medical tubing with the expiration date of 04/17/23;</p> <p>-One three milliliter (ml) needleless syringe with an expiration date of 07/31/22.</p> <p>3. Observation on 11/12/24 at 4:10 P.M., showed the Smithton Village hall medication room contained one topical antiseptic bottle with an expiration date of October 2024.</p> <p>4. Observation on 11/14/24 at 2:00 P.M., showed the [NAME] and [NAME] hall medication room contained one Safety Lok Vacuntainer (a blood collection syringe) needle with an expiration date of 08/31/24.</p> <p>5. Observation on 11/14/24 at 2:15 P.M., showed the [NAME] and [NAME] medication cart contained 25 Nitroglycerin 0.4 mg tablets with an expiration date of June 2024 and 25 Nitroglycerin 0.4 mg tablets with an expiration date of October 2024.</p> <p>During an interview on 11/14/24 at 2:12 P.M., Certified Medication Technician (CMT) A said there is no written process for checking medication carts for expired medication. He/She said staff are supposed to go through them weekly, evening shift usually takes all the cards out of the cart and checks for loose pills.</p> <p>During an interview on 11/15/24 at 8:45 A.M., LPN C said CMT's do a weekly medication cart audit and nurses audit for medications that need to be removed from the cart or refilled. He/She was not sure how this was documented.</p> <p>6. During an interview on 11/14/24 at 2:15 P.M., Licensed Practical Nurse (LPN) B said there are no destruction logs for non narcotic medications. Medications are destroyed in drug buster or placed in the main medication room for management to destroy. Nurses and CMT's are responsible for checking medication rooms and carts.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/15/24 at 10:03 A.M., the Director of Nursing said the pharmacy comes and reviews the medication cart and storage rooms for expired medications. The medication technicians go through the carts ever Wednesday and are to check for expired medications then. Expired medications should be destroyed.</p> <p>During an interview on 11/15/24 at 11:02 A.M., the Administrator said there should not be any expired medications in the cart or storage rooms. The CMT's should be going through the cart daily and will go through them weekly. Nurses will go through the medication storage rooms, and the pharmacy also comes in and reviews the medication storage.</p> <p>50361</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40424</p> <p>Based on interviews, and record review the facility staff failed to ensure the resident's call lights were answered in a timely manner. The facility's census was 91.</p> <p>1. Review of the facility's Call lights: Accessibility and Timely Response policy, undated, showed all staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.</p> <p>2. Review of room [ROOM NUMBER], Bed 2's the electronic call light report showed:</p> <p>-On 11/06/24 at 9:47 A.M., room [ROOM NUMBER], Bed 2 alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/06/24 at 10:43 A.M., room [ROOM NUMBER], Bed 2 alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/06/24 at 1:01 P.M., room [ROOM NUMBER], Bed 2 alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/06/24 at 6:42 P.M., room [ROOM NUMBER] Bed 2 alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/06/24 at 8:41 P.M., room [ROOM NUMBER], Bed 2 alerted staff six times, response received at 9:21 P.M., after 40 minutes;</p> <p>-On 11/07/24 at 9:20 A.M., room [ROOM NUMBER], Bed 2 alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/07/24 at 10:13 A.M., room [ROOM NUMBER], Bed 2 alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/07/24 at 12:50 P.M., room [ROOM NUMBER], Bed 2 alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/07/24 at 8:32 P.M., room [ROOM NUMBER], Bed 2 alerted staff seven times, response received at 9:07 PM, after 35 minutes;</p> <p>-On 11/08/24 at 9:26 A.M , room [ROOM NUMBER], Bed 2 alerted staff nine times before it automatically shut off after 45 minutes.;</p> <p>-On 11/08/24 at 11:08 A.M., room [ROOM NUMBER], Bed 2 alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/08/24 at 8:11 P.M., room [ROOM NUMBER], Bed 2 alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 11/08/24 at 6:30 P.M., room [ROOM NUMBER] Bed, 2 alerted staff nine times before it automatically shut off after 45 minutes.</p> <p>-On 11/09/24 at 6:28 P.M., room [ROOM NUMBER] Bed, 2 alerted staff nine times before it automatically shut off after 45 minutes.</p> <p>-On 11/10/24 at 9:11 A.M., room [ROOM NUMBER] Bed, 2 alerted staff eight times, response received at 9:47 A.M., after 36 minutes;</p> <p>-On 11/11/24 at 1:52 A.M., room [ROOM NUMBER] Bed, 2 alerted staff seven times, response received at 2:22 A.M., after 30 minutes;</p> <p>-On 11/11/24 at 6:42 P.M., room [ROOM NUMBER] Bed, 2 alerted staff nine times before it automatically shut off after 45 minutes.</p> <p>-On 11/12/24 at 6:37 P.M., room [ROOM NUMBER] Bed, 2 alerted staff seven times, response received at 7:09 P.M., after 32 minutes.</p> <p>5. Review of room [ROOM NUMBER]'s electronic call light report showed:</p> <p>-On 11/06/24 at 8:56 A.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/06/24 at 11:04 A.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/06/24 at 3:43 P.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/06/24 at 6:08 P.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/07/24 at 5:43 P.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/08/24 at 12:47 P.M., room [ROOM NUMBER] alerted staff six times, response received at 1:16 P.M., after 37 minutes;</p> <p>-On 11/08/24 at 2:46 P.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/09/24 at 1:00 P.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/09/24 3:42 P.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 11/09/24 at 4:44 P.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/09/24 at 5:44 P.M., room [ROOM NUMBER] alerted staff nine times, response received at 6:26 P.M., after 42 minutes;</p> <p>-On 11/10/24 at 11:46 A.M., room [ROOM NUMBER] alerted staff nine times before it automatically shut off after 45 minutes;</p> <p>-On 11/10/24 at 4:12 P.M., room [ROOM NUMBER] alerted staff seven times, response received at 4:47 P.M., after 35 minutes;</p> <p>-On 11/11/24 at 3:16 A.M, room [ROOM NUMBER] alerted staff eight times, response received at 3:54 A.M., after 38 minutes.</p> <p>6. During an interview on 11/12/24 at 10:52 A.M., Resident #17 said call lights are often not answered due to short staff, he/she had to yell and finally had staff show up.</p> <p>During an interview on 11/12/24 at 11:04 A.M., Resident #71 said call lights take more than 30 minutes at times especially at night, you just have to wait.</p> <p>During an interview on 11/13/24 at 1:36 P.M., Resident #17 said last weekend his/her call light did not work for the entire weekend. He/she said the facility did not know why the call light did not work. He/she said the staff did not provide an alternate way for him/her to let staff know that he/she needed assistance. They said he/she had to scream to get help. He/she said that he/she was concerned that resident well-being was at risk. He/she said an accident could happen at any time and the staff might not know to help. All Resident Council members who attended the meeting voiced agreement with his/her statement.</p> <p>During an interview on 11/14/24 at 2:18 P.M., Certified Nurse Aid (CNA) H said he/she receives a page when a call light is requested. The pagers go off nine times and then they time out if it is not answered.</p> <p>During an interview on 11/14/24 at 2:23 P.M., CNA D said pagers beep until the call is answered and call lights should only take a few minutes.</p> <p>During an interview on 11/14/24 at 3:29 P.M., CNA I said our pagers keep going off until the call is answered. Call lights should take no longer the five minutes, but is hard to get to them if there is not two aids on shift.</p> <p>During an interview on 11/14/24 at 3:35 P.M., Licensed Practical Nurse (LPN) J said he/she has never seen a pager go off so long it shuts off. He/She when acting as charge nurse there is a screen they pull up to see if lights are late, but sometimes it doesn't work.</p> <p>During an interview on 11/15/24 at 9:28 A.M. the Assistant Director of Nursing said call lights should be done in 30 minutes, if staff don't reset the light it may show unfinished.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Neighborhoods Rehab & Skilled Nursing by Tigerplac		STREET ADDRESS, CITY, STATE, ZIP CODE  3003 Falling Leaf Court Columbia, MO 65201	
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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/15/24 at 9:52 A.M., the Director of Nursing said call lights should take no more than 5 minutes but could take up to 30 minutes. He/She said the pagers do not reset on their own.</p> <p>During an interview on 11/15/24 at 11:09 A.M., the Administrator said call lights should be done within a reasonable amount of time, but could take 20 minutes during busy times. He/She said if it shows announced nine times the call light was never answered. Residents should not have to request multiple times if left unanswered.</p> <p>MO00244931</p>		