STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265878	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Rock Healthcare	712 Copper Rock Drive Rogersville, MO 65742

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents dependent on staff to for grooming and personal hygiene received baths/showers in a timely fashion for two dependent resident's (Resident #1 and #2). The facility census was 79. Review of the facility's policy titled, Bath, Shower/Tub, revised February 2018, showed the following: -Purpose to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin; -Document date and time the shower/tub bath was performed; -Document the name and title of the individual(s) who assisted the resident with the shower/tub bath, all assessment data obtained during the shower/tub bath, how the resident tolerated the shower/tub bath, if the resident refused the shower/tub bath, the reason(s) why and the intervention taken, and the signature and title of the person recording the data; -Notify the supervisor if the resident refuses the shower/tub bath; -Notify the physician of any skin areas that may need to be treated; -Report other information in accordance with facility policy and professional standards of practice. Review of the facility's Weekly Shower List Sheet showed anyone who refuses shower, staff to come back and try again. Staff to have the nurse try if the resident still refuses. Have the resident sign the shower sheet, or if they can't sign have the nurse sign the shower sheet and make a nurse's note. 1. Review of Resident #1's face sheet (admission data) showed the following information: -readmission date of 08/02/24; (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included cerebral infarction (a condition where blood flow to the brain is blocked, leading to brain tissue damage), osteoarthritis (a condition where the cartilage (tissue that protects and supports joints and other structures in the body) in joints gradually wears away, leading to pain, stiffness, and reduced movement) and unspecified pain. Review of the resident's significant change assessment Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/28/25, showed the following information: -Cognitively intact; -No assessment of shower/bathing noted; -Resident frequently incontinent of bowel and bladder. Review of the resident's care plan, initiated 08/14/24, showed the following information: -Resident had activities of daily living (ADL) self-care performance deficit related to diagnosis of stroke with right sided weakness; -Dependent on staff for all ADL's except eating; -Incontinent with bowel and bladder and staff to assist with hygiene; -The resident had potential for impairment to skin integrity related to immobility and incontinence; -Keep skin clean and dry. (Staff did not care plan related to preferred shower frequency or any shower/bath preferences. The staff did not care plan regarding any pattern of resident refusal to bathe.) Review of the facility's Weekly Shower List sheet showed the resident was scheduled for a shower/tub bath on Mondays and Thursdays. Review of the resident's March 2025 Shower Sheets showed the following: -On 03/02/25, the resident received a shower; -On 03/09/25, the resident refused a shower; -On 03/10/25, the resident refused a shower; -On 03/19/25, the resident received a shower (17 days after prior shower and 9 days after last offered shower); -On 03/24/25, the resident received a shower. Review of the resident's March 2025 progress notes showed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff did not document showers offered or completed any other days in March; -Staff did not document regarding the resident missing and/or going 17 days without a shower. 2. Review of Resident #2's face sheet showed the following information: -admission date of 12/12/24; -Diagnoses included cerebral infarction, irregular heartbeat, and paralysis of the left non-dominant side. Review of the resident's admission assessment MDS, dated [DATE], showed the following information: - Cognitively intact; -Dependent with showering/bathing; -Frequently incontinent of bowel and bladder. Review of the resident's care plan, initiated 12/18/24, showed the following information: -Keep skin clean and dry; -Dependent on staff for all ADL's and mobility; - The care plan does not indicate that the resident frequently refuses showers and/or resident specific requests regarding shower days and/or times. (Staff did not care plan related to preferred shower frequency or any shower/bath preferences. The staff did not care plan regarding any pattern of resident refusal to bathe.) Review of the facility's current Weekly Shower List Sheet showed the resident was scheduled for a shower/tub bath on Mondays and Thursdays. Review of the resident's March 2025 Shower Sheets showed the following: -The resident received a shower on 03/05/25; -The resident received a shower on 03/10/25 (seven days after the prior shower); -The resident received a shower on 03/23/25 (13 days after the prior shower); -The resident received a shower on 03/27/25. Review of the resident's March 2025 progress notes showed the following: -Staff did not document showers offered or completed any other days in March; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff did not document regarding the resident missing shower days and/or going 13 days without a shower. During an interview on 04/02/25, at 12:38 P.M., the resident and his/her spouse said the resident's last shower was Thursday, 03/26/25 and that residents were having to fight for showers. The resident's spouse said the resident had gone as long as 12 days without a shower. When the spouse had requested that the resident be given a shower, the staff ask him/her to do it his/herself. 3. During an interview on 04/03/25, at 11:58 A.M.,Certified Nursing Assistant (CNA) D said the following: -There were designated shower aides every day; -If a resident refused a shower that should be documented on the resident's shower sheet. During an interview on 04/03/25, at 12:24 P.M., CNA E said the following: -He/she was not aware of any recent shower refusals; -He/she would assume that it would be appropriate to notify the charge nurse for any frequent refusals and/or write it in on the resident's shower sheets; -It would not be appropriate for a resident to go several days without a shower. During an interview on 04/03/25, at 12:05 P.M., Licensed Practical Nurse (LPN) A said the following: - Resident showers were scheduled weekly and the facility did have a shower aide, but shower aide coverage was slim; -Sometimes, residents do not get one shower per week. -The Administrator makes the shower schedule. -The nurses receive a copy of showers given from the showers aide and the form includes new wounds. -If a resident continually refuses to take a shower, the family should be notified. - Nurses are not told if a resident refuses a shower or even who receives a shower. During an interview on 04/03/25, at 3:00 P.M., Registered Nurse (RN) B said the following: -He/she had not looked at the shower schedule. -The facility had one shower aide for 100, 200, and 300 halls and one for 400 and 500 halls. -Hospice provides showers/bathing for some residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents should receive a shower two times per week. -Residents have a right to refuse showers. Residents are encouraged to take at least one shower per week. -He/she had not received any shower sheets showing residents are refusing showers. During an interview on 04/04/25, at 10:15 A.M., the Director of Nursing (DON) said the following: -The facility had shower aides Monday through Friday and if there was extra staff on the weekend, they did showers on the weekend. -There was one shower aide for the 100, 200, and 300 halls and one shower aide for the 400 and 500 halls. -Some residents are care planned to have showers one time per week per the resident's preference. -Residents were provided two showers per week unless they refuse. If a resident refused a shower, staff have a form to document the refusal on. -He/she would expect staff to complete the refusal form and notify the charge nurse to encourage showers. -It was not appropriate for residents to go greater than 10 days without receiving a shower, unless the resident refuses. In that case staff would document the refusal During an interview on 04/04/25, at 10:38 A.M., the Administrator said the following: -She would expect staff to offer residents showers two times per week. -Some residents only want a shower one time per week and some residents refuse showers. -She stated that there were only two weeks since December of 2024 that he/she was aware of that staff was not available to give showers to residents two times per week. That has not been the case recently. -If residents refused a shower, staff was expected to fill out the refusal sheet. -The Administrator was not aware of any residents going over 10 days without a shower. -If a resident refused a shower for the third time, he/she would expect staff to offer at least a sink bath. He/she said no resident was missing a shower because it was not offered. Staff should document refusals on the shower sheet. - In the past, staff offered residents to tell what one day of the week works best for them if they want a shower a specific day of the week. MO00251182, MO00251915, MO00251921

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide care per professional standards related to pressure ulcers (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) when the facility staff failed to obtain physician's orders for treatment and interventions of wounds and failed to update the care plan regarding skin breakdown intervention changes for one resident (Resident #3) out of seven sampled residents. The facility census was 79. Review of the facility's policy titled, Pressure Injury Risk Assessment, revised March 2020, showed the following: -Identify all risk factors and then determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify; -The risk assessment should be conducted as soon as possible after admission, but no later than eight hours after admission is completed; -Once the assessment is conducted a risk factor are identified and characterized, a resident centered care plan can be created to address the risks for pressure injuries; -If a skin alteration is noted, initiate a pressure or non pressure form related to the type of alteration; -Establish interventions for the skin alteration; -Document the type of skin alteration, time and date of discovery, treatment, initiation of pressure reduction devices, and notifications to the physician and family. -Notify the supervisor, physician, and family. Review of the facility's policy titled, Wound Care, revised October 2010, showed staff to document the type of care given, the date and time, name and title of person performing care, change in status, and assessment data such as wound bed color, size, and drainage. 1. Review of the Resident #3's face sheet (brief look at resident information) showed the following information: -admission date of 03/31/25; -Diagnoses included osteonecrosis (a condition where bone tissue dies due to lack of blood supply), hypertension (a condition where blood pressure in the artery wall is too high), chronic obstructive pulmonary disease (COPD - a lung disease causing restricted airflow and breathing problems), and rheumatoid arthritis with rheumatoid factor (a disease that causes inflammation in the joints, leading to pain, swelling, and stiffness). Review of the resident's baseline care plan, dated 03/31/25, showed the following information: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Current skin integrity issues identified as left buttock 2 x 2 centimeter (cm) open lesion; right buttock approximate 4 x 4 cm open lesion; 3 x 2 cm open lesion to sacrum (a bone located in the lower back and upper part of the pelvic bone). -The resident had right hip arthroplasty (joint replacement surgery) for necrotic (death of living tissue) hip. Wound vac (a medical device that uses negative pressure to help wounds heal) intact at -125. Weight bearing as tolerated right lower extremity. -On Lovenox (a medication that helps prevent blood clots) for deep vein thrombosis (DVT - a condition where a blood clot forms in a deep vein) non-occlusive (does not completely block blood flow). -admitted for physical therapy, occupational therapy, and resolution of DVT. (Staff did not care plan related to care of or treatment for the denitrified wounds.) Review of the resident's Facility to Facility Discharge Information, document from the discharging hospital, dated 03/31/25, showed the following information: -To contact the physician for increased pain; -To follow wound/incision care instructions as recommended by the physician. (The form did not include any specific care or treatment instructions for the identified wounds.) Review of the resident's admission skin assessment, dated 03/31/25, showed the following: -Present on admission, a stage 2 (partial-thickness skin loss with exposed dermis) pressure ulcer/injury on left medial gluteus (buttocks), 2 cm in length, 2 cm width, and zero depth; -Present on admission, a stage 2 pressure ulcer/injury on right gluteus, 4 cm in length, 4 cm width, and zero depth. Light exudate (drainage) amount, with peri wound (skin around the wound) edges flush with wound bed or as a sloping edge; -Present on admission, a stage 2 pressure ulcer/injury on lateral coccyx (bone at the bottom of the spine), 3 cm in length, 2 cm width, zero depth, epithelial (a type of tissue in the body that forms a protective barrier on the outside of organs and lines internal cavities and passageways) 10%, granulation (a type of tissue that forms during the healing process of wounds, appearing as a pink or red, moist, and bumpy tissue) 20%. Peri wound edge appears flush with wound bed or as a sloping edge. (Staff did not document regarding wound treatments/orders, or regarding the resident's surgical incision.) Review of the resident's March 2025 Progress Notes showed the following: -On 03/31/25, at 9:47 P.M., resident was chair-fast and very limited. Resident made occasional slight changes in body or extremity position, but unable to make frequent or significant changes independently. Potential problem with friction and shear. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 03/31/25, at 9:48 P.M., a new stage 2 pressure ulcer/injury on the resident's left gluteal fold, laterally and medial. Measurements showed 2 cm in length, 2 cm in width, and zero depth. A second stage 2 pressure ulcer/injury was noted on the right gluteus, medial, with a length of 4 cm, width 4 cm, zero depth, and light exudate. A stage 2 pressure ulcer/injury was also noted on the lateral coccyx. It was 3 cm in length, 2 cm width, zero depth, 10% epithelial, and 20% granulation. All three wounds were present on admission, but staff was unsure how long the wounds were present. Additional documentation showed skin issue education provided to the resident, which included changing or shifting positions frequently and turning every two hours. Notification of skin issue included the dietitian, family, and provider. The RN also documented the resident had a right hip surgical incision with a wound vac. Review of the resident's March 2025 Physician Order Sheet (POS) showed the following: -No wound vac orders; -No wound treatment ordered for the buttock wounds. Review showed the facility did not provide a March 2025 Treatment Administration Record (TAR) for the resident. Review of the resident's April 2025 POS showed the following: -An order, dated 04/01/25, for house barrier cream as needed; -No wound vac orders; -No wound treatment orders for buttock wounds on 04/01/25 or 04/02/25. Review of the resident's April 2025 Progress Notes showed the following: -On 04/01/25, at 11:24 A.M., an RN noted a skin issue on the left gluteal fold had been evaluated. Described as a lateral, medial, stage 2 pressure ulcer/injury with partial thickness skin loss with exposed dermis. The wound was present on admission. It was unknown how long the wound had been present. Skin issue number two was described as a stage 2 pressure ulcer/injury, with partial thickness skin loss with exposed dermis. The wound was present on admission. It was unknown how long the wound was present. Wound number three was evaluated and documented as a stage 2 pressure ulcer/injury on the lateral coccyx with partial thickness skin loss and exposed dermis. The wound was present on admission, and it was unknown how long the wound had been present. No measurements were documented as part of the assessment. All wounds were staged in-house by nursing and no measurements were documented as part of the skin assessment; -On 04/01/25, at 4:39 P.M., a RN noted wound vac to surgical site. (Staff did not document any care and/or treatment of the wounds.) Review of the resident's April 2025 TAR showed staff did not document wound care treatments completed or ordered on 4/01/25 or 4/02/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's April 2025 progress notes showed staff did not document any care and/or treatment for the wounds for 04/01/25 and 04/02/25. Observation on 04/03/25, at 9:57 A.M., showed the resident was behind closed doors using the restroom. The resident reported to the staff member present that he/she had wounds to his/her bottom. The staff member questioned the resident about how long the wounds had been there, and that he/she would report it. During an interview on 04/03/25, at 9:57 A.M., the resident said the following: -He/she had wounds to his/her buttocks since admission to the facility. He/she had told multiple staff members, and no one had done anything about it; -A nurse did assess the wounds on admission, but did not initiate treatment; -The staff were aware that he/she also had a surgical incision to the right hip with a wound vacuum in place. -The wounds hurt. During an interview on 04/03/25, at 10:01 A.M., Licensed Practical Nurse (LPN) C said the following: -He/she was aware the resident had a wound vac in place to his/her right hip; -He/she had not been made aware of any wounds to the residents buttocks; -He/she looked in the resident's electronic medical record (EMR) and said he/she could not find any documentation or treatment orders related to the residents reported buttocks wounds and/or the wound vac. Observation on 04/03/25, at 10:10 A.M., showed LPN enter the resident's room and asked to assess the residents' wounds. The resident agreed. The resident told the LPN that he/she believed he/she was going to an orthopedic appointment on the following Monday for removal of the wound vac. The resident reported to the LPN that the wounds to his/her buttocks had been there when he/she admitted to the facility and that they were painful. Two wounds were seen, one on each buttock. Both wounds had partial thickness skin loss, and no dressings and/or cream in place. Both wounds were approximately dime sized and the wound on the right buttock was seen to have 50% slough tissue (dead tissue that presents as yellow or white, stringy, moist and often adherent tissue found in wound beds). The wound on the left buttock appeared to be 100% granulation tissue. Both wounds had purple peri-wounds. Review of the resident's April 2025 POS showed an order, dated 04/03/25, for zinc oxide (cream) 10%, apply to two inner buttock areas topically every day and evening shift until healed. During an interview on 04/03/25, at 11:58 A.M., Certified Nursing Assistant (CNA) D said the following: -Any new skin concern should be reported to the charge nurse immediately; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The aides have a documenting task in the resident's EMR and it asks about skin integrity; -The resident came in with blisters on his/her bottom; -The nurses were supposed to do a full body assessment when a resident admitted , but he/she personally documented it as well; -He/she had never seen a treatment on the resident's wounds. During an interview on 04/03/25, at 12:24 P.M., CNA E said the following: -He/she was aware that the resident has a wound vac to the right hip; -He/she was aware that the resident has wounds to his/her buttocks; -He/she had not seen any treatment on the buttocks wounds. During an interview on 04/03/25, at 12:05 P.M., LPN A said the following: -Skin assessments were completed by the nursing staff at least weekly; -The skin assessment due dates pop up on the Medication Administration Record (MAR) to alert the nursing staff; -The facility had a wound care doctor that was employed outside of the facility, and he/she completed rounds with the nursing staff; -He/she has been instructed by the Director of Nursing (DON) to do a dressing change on new wounds and relay the information to other staff until the wound doctor is available to evaluate the wound. During an interview on 04/03/25, at 3:00 P.M., Registered Nurse (RN) B said the following: -Contracted wound care staff came to the facility one time per week; -Skin assessments were completed weekly by the charge nurse and documented in the assessment section within the resident's electronic health record; -Wound orders should be on the resident's Treatment Administration Record (TAR); -If a resident did not have wound care orders, but needed them, staff would contact the primary care physician to obtain orders; -If a new wound was observed, he/she would place a dressing over it and notify the physician; -The facility had two physicians that see and treat residents at least one time per week; -The facility had limited physician standing orders for wounds; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure an effective and accurate pain management program was in place when staff failed to ensure pain patches were on-hand for administration, when staff documented administration of pain patches that were not administered, and when staff failed to accurately document monitoring of the pain patch placement for one resident (Resident #1) out of 7 sampled residents. The facility census was 79. Review of the facility's policy titled, Documentation of Medication Administration Policy, revised April 2007, showed the following: -Administration of medication must be documented immediately after (never before) it is given; -Documentation must include at a minimum: name, strength of drug, dose, method of administration, date and time of administration, reason(s) why a medication was withheld, not administered, or refused, signature and title of person administering the medication, and resident response to the medication, if applicable. Review of the facility's policy titled, Medication and Treatment Orders, revised July 2016, showed drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available. Review of the facility's policy titled, Administering Medications, revised April 2019, showed the following: -The Director of Nursing (DON) supervise and directed all personnel who administer medications and/or have related functions; -Medications are administered in accordance with prescriber orders, including any required time frame; -If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record (MAR) space for that drug and dose; -As required or indicated for a medication, the individual administering the medication records in the residents medical record the following; date and time the medication was administered, dosage, route of administration, injection site if applicable, complaints or symptoms associated, results achieved and when those results were observed, and the signature and title of the person administering the drug. 4. Review of the Resident #1's face sheet (brief resident profile sheet) showed the following information: -readmission date of 08/02/24; (continued on next page)

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	265878	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Rock Healthcare	712 Copper Rock Drive Rogersville, MO 65742

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included cerebral infarction (a condition where blood flow to the brain is blocked, leading to brain tissue damage), osteoarthritis (a condition where the cartilage (tissue that protects and supports joints and other structures in the body) in joints gradually wears away, leading to pain, stiffness, and reduced movement) and unspecified pain. Review of the resident's significant change assessment Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/28/25, showed the resident was cognitively intact and had been on a scheduled pain medication regimen. Review of the resident's care plan, initiated 08/14/24, showed the following: -The resident had pain related to a diagnosis of osteoarthritis (a degenerative joint disease where cartilage breaks down, causing pain, stiffness, and reduced movement); -Staff was to anticipate the resident's need for pain relief and respond immediately to any complaint of pain; -Staff was to monitor, record, report to nurse any signs and symptoms of non-verbal pain, changes in breathing, vocalizations such as moaning or yelling out, mood or behavior changes, and changes to eyes, face, and body related to pain; -Staff was to monitor, record, report to nurse resident complaints of pain or requests for pain treatment; -Staff was to notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain. Review of the resident's Physician Order Sheet (POS) showed an order, dated 12/21/24, for fentanyl (a potent synthetic opioid drug approved by the Food and Drug Administration (FDA) for use as an analgesic (pain relief) and anesthetic) transdermal patch 72-hour 25 micrograms per hour (mcg/hr), apply one patch transdermally (route of administration where medication is delivered via a patch through the skin) every 72 hours for pain. The order was discontinued on 03/07/25. Review of the resident's February 2025 Controlled Drug Receipt Record/Disposition Form showed the following: -On 02/22/25, one Fentanyl 25 mcg/hr patch was removed at 7:01 P.M., and four patches remained available; -On 02/25/25, one Fentanyl 25 mcg/hr patch was removed at 5:00 P.M., and three patches remained available; - On 02/28/25, one Fentanyl 25 mcg/hr patch was removed at 6:00 P.M., and two patches remained available. Review of the resident's March 2025 Medication Administration Record (MAR) and March 2025 Progress notes, dated 03/01/25, showed the day, evening, and night shift staff documented the fentanyl 25 mcg/hr patch was observed on the resident's left upper back. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's March 2025 Controlled Drug Receipt Record/Disposition Form showed on 03/02/25, at 5:08 P.M., staff applied a fentanyl patch 25 mcg/hr to the resident's left chest. Review of the resident's March 2025 MAR and March 2025 progress notes showed on 03/02/25, the day, evening, and night shift documented the fentanyl patch was observed on the residents left upper back. (Staff did not document related the the patch noted to be on the resident's chest.) Review of the resident's March 2025 Controlled Drug Receipt Record/Disposition Form showed on 03/03/25, one Fentanyl 25 mcg/hr patch was removed from the count, and a new patch was applied to the resident at 5:30 P.M., and one patch remained available. Review of the resident's March 2025 MAR and progress notes showed on 03/03/25, the day, evening and night shift staff documented the Fentanyl patch was observed on the resident's left upper back. (Staff did not document related the the patch noted to be on the resident's chest.) Review of the resident's March 2025 Drug Destruction Log showed on 03/03/25 the newly applied fentanyl 25 mcg patch was destroyed and verified by two staff signatures. Review of the resident's March 2025 MAR and March 2025 Progress Notes showed the following: -On 3/04/25, the day, evening and night shift staff documented the fentanyl patch was observed on the resident's left chest; -On 3/05/25, the day, evening and night shift staff documented the fentanyl patch was observed on the resident's left chest; -On 3/06/25, the day, evening and night shift staff documented the fentanyl patch was observed on the resident's left chest; -On 3/06/25, at 5:38 P.M., staff applied a new fentanyl patch 25 mcg/hr to the resident's left chest. Review of the resident's POS showed the previous fentanyl order was discontinued on 03/07/25, and a new order, dated 3/07/25, showed the same instructions of fentanyl transdermal patch 72-hour 25 mcg/hr, apply one patch transdermally every 72 hours for pain. Review of the resident's March 2025 Progress Notes showed an order note dated 03/07/25, at 10:30 P.M., for a drug protocol alert/warning for fentanyl transdermal patch 72-hour 25 mcg/hr, controlled drug, apply one patch transdermally every 72 hours for pain with drug-to-drug interaction triggered for Zofran (a medication that prevents nausea and vomiting) oral tablet 4 mg, hydrocodone-acetaminophen (a opioid mediation used to treat pain) oral tablet 5-325 mg, and sertraline (an antidepressant) HCL oral tablet 25 mg. Review of the resident's medical record showed staff did not document follow-up related to alert/warning. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's March 2025 MAR and March 2025 Progress Notes showed on 03/07/25, the day, evening and night shift staff documented the fentanyl patch was observed on the resident's left chest. Review of the resident's March 2025 Controlled Drug Receipt Record/Disposition Form showed on 03/08/25, one fentanyl 25 mcg/hr patch was removed from the count and applied to the resident at 8:50 A.M., and zero patches remained available. Review of the resident's March 2025 MAR and March 2025 Progress Notes showed the following: -On 03/08/25, at 9:02 A.M., staff applied fentanyl patch 25 mcg/hr to right chest; -On 03/08/25, the day, evening, and night shift staff documented the fentanyl patch was observed on the resident's right upper chest. Review of the facility's Emergency Kit Usage Report showed one fentanyl 25 mcg/hr patch removed for the resident on 03/09/25, at 4:31 P. M. Review of the resident's March 2025 Progress Notes showed the following: -Administration note on 03/09/25, at 4:41 P.M., showed Registered Nurse (RN) F applied new patch on 03/09/25 related to previous patch applied on 3/08/25, falling off and due to the plastic not being removed. Physician notified. Old patch was wasted in sharps container with Certified Medication Tech (CMT) H; -Administration note on 03/09/25, at 6:22 P. M., showed RN F reapplied new patch to left upper chest. Review of the resident's March 2025 MAR and March 2025 Progress Notes showed the following: -On 03/09/25, the day, evening, and night shift staff documented the fentanyl patch was observed on the resident's right upper chest; -On 03/10/25, the day, evening, and night shift staff documented the fentanyl patch was observed on the resident's right upper chest; -On 03/11/25, at 4:41 P.M., staff applied a fentanyl patch 25 mcg/hr to the resident's right chest. (The resident was not due for administration until 03/12/25.) Review of the resident's Controlled Drug Receipt Record/Disposition form showed the resident did not have a current supply of fentanyl patches to remove for administration. Review of the facility's Emergency E-kit use log, dated 03/11/25, showed staff did not withdraw a fentanyl patch for the resident. Review of the resident's medical record showed no order of fentanyl patches had been received for the resident since the the patch applied on 03/08/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's March 2025 MAR and March 2025 Progress Notes showed the following: -On 03/11/25, the day, evening, and night shift staff documented the fentanyl patch was observed on the resident's right upper chest; -On 03/12/25, the day, evening and night shift staff documented the fentanyl patch was observed on the resident's right upper chest; -On 03/13/25, the day, evening and night shift staff documented the fentanyl patch was observed on the resident's right upper chest; -On 03/14/25, at 7:43 A.M., RN B documented administration of 25 mcg/hr fentanyl patch to resident's right chest. Review of the resident's Controlled Drug Receipt Record/Disposition form showed the resident did not have a current supply of Fentanyl patches to remove for administration on 03/14/25. Review of the Emergency E-kit use log, dated 03/14/25, did not indicate staff removed a fentanyl patch for the resident. Review of the resident's medical record showed no order of fentanyl patches had been received for the resident since the the patch applied on 03/08/25. Review of the resident's progress note, showed a late entry entered on 04/02/25 or 03/14/25, that stated the fentanyl 25 mcg/hr medication was not administered as previously documented, as the resident had no patches for administration. Review of the resident's March 2025 MAR and March 2025 progress notes showed the following: -On 03/14/25, the day, evening, and night shift staff documented the fentanyl patch was observed on the resident's right upper chest; -On 03/15/25, the day, evening and night shift staff documented the fentanyl patch was observed on the resident's right upper chest; -On 03/16/25, the day, evening and night shift staff documented the fentanyl patch was observed on the resident's right upper chest; - On 03/17/25, at 8:00 A.M., staff applied fentanyl patch 25 mcg/hr to left chest. Review of the resident's Controlled Drug Receipt Record/Disposition form showed the resident did not have a current supply of fentanyl patches to remove for administration on 03/17/25. Review of the Emergency E-kit use log, dated 03/17/25, showed staff did not indicate a fentanyl patch withdrawal for the resident. Review of the resident's medical record showed no order of fentanyl patches had been received for the resident since the the patch applied on 03/08/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note, showed a late entry entered on 04/02/25 for 03/17/25, noting the fentanyl 25 mcg/hr medication was not administered as previously documented, as the resident had no patches for administration. Review of the resident's March 2025 MAR and progress notes showed the following: -On 03/17/25, the day, evening, and night shift staff documented the fentanyl patch was observed on the resident's left upper chest; -On 03/18/25, the day and evening shift staff documented the fentanyl patch was observed on the resident's left upper chest; - On 03/18/25, the night shift staff documented the fentanyl patch was observed on the resident's right upper chest; - On 03/19/25, the day, evening, and night shift staff documented the fentanyl patch was observed on the resident's right upper chest. Review of the resident's March 2025 Progress Notes showed an administration note on 03/19/25, at 2:13 P. M., entered by Licensed Practical Nurse (LPN) A, noted LPN observed the fentanyl patch from 03/09/25 remained on the resident's chest. No new patches on hand and waiting for further direction on removal. Review of the resident's Controlled Drug Receipt Record/ Disposition form showed the resident received 5 fentanyl patches from the pharmacy on 03/19/25. During an interview on 04/03/25, at 12:05 P.M., LPN A said the following: -On 03/19/25, he/she observed a fentanyl patch on the resident that was dated 03/09/25. He/she informed the house supervisor nurse and was instructed to leave the patch in place until the Director of Nursing (DON) was aware of it; -There were no fentanyl patches available for the resident at the time. He/she left the fentanyl patch on until a new order was received, and more patches arrived at the facility; -He/she notified the DON of the outdated patch several times and was repeatedly told that he/she was aware of the situation, but no direction was provided by the DON; -The new fentanyl order was the exact same order as the discontinued order. The new order was placed to restart the fentanyl patches, as there had been a gap in administration; -Fentanyl patches should be removed and destroyed with another nurse or medication technician in the locked medication room; -Narcotic counts are to be completed every shift. During an interview on 04/03/25, at 3:00 P.M., RN B said the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00251182, MO00251919