STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265788	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCOTLAND COUNTY CARE CENTER	434 E SIGLER AVENUE MEMPHIS, MO 63555

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff assessed and sought treatment for [REDACTED].# 15) in a review of 12 sampled residents, who sustained a fractured right tibia (a large bone located in the lower front portion of the leg) and right fibula (the smaller of the two bones of the lower leg) at the ankle. The facility census was 42. Review of the facility policy Accidents and Incidents-Investigating and Reporting dated 7/17 showed the following: -All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator; -The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident; The following data, as applicable, shall be included on the Report of Incident/Accident form: The date and time the accident/incident took place; The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); The circumstances surrounding the accident/incident; Where the accident/incident took place; the name(s) of witnesses and their accounts of the accident/incident; the injured person's account of the accident/incident; the time the injured person's attending physician was notified, as well as the time the physician responded and his/her instructions; The date/time the injured person's family was notified and by whom; The condition of the injured person, including their vital signs; the disposition of the injured(i.e., transferred to; hospital, put to bed, sent home, returned to work, etc.); Any corrective action taken, follow-up information, other pertinent data as necessary or required and the signature and title of the person completing the report; This facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device; The nurse supervisor/charge nurse and or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing services within 24 hours of the incident/accident; The director of nursing shall ensure the administrator receives a copy of the Report of Incident/Accident form for each occurrence; Incident/Accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. 1. Review of Resident #15's care plan dated 1/7/20 showed the following: -The resident was frequently confused and oriented to name only. Staff should anticipate the resident's needs, assist with finding his/her room, and assist with making decisions as needed; -The resident required assistance with Activities of Daily Living (ADLs), fall prevention and pain control. He/She did not ambulate, his/her legs were contracted, had history of falling out of bed and sometimes hit and yelled at staff during cares. Staff should provide mechanical lift transfers, assistance with all ADLs and offer the resident to lie down during the day. He/She used a wheelchair when out of bed and could propel self in the wheelchair. Staff should observe for facial grimacing, protective body movements and verbal complaints of pain and report to charge nurse. Goal was free of injuries from falls, maintain participation in ADLs and pain managed without complications. Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 1/16/20 showed the following: -[DIAGNOSES REDACTED]. Review of the resident's nurses' notes dated 3/10/20 showed the following: -At 9:30 A.M. staff documented Certified Nurse Assistant (CNA) staff reported the resident complained of right foot/ankle pain. On [DATE] a CNA accidentally ran the resident's wheelchair into the door frame. The resident's right ankle/foot was [MEDICAL CONDITION] and very painful to touch. He/She yelled out in pain when staff lifted his/her leg; -At 9:45 A.M. staff documented the physician ordered an x-ray of the foot/ankle; -At 10:15 A.M. staff documented the x-ray was completed; -At 2:45 P.M. staff documented the physician called the facility, did not want staff to wrap the resident's leg at this time in case it was wrapped too tightly. Staff reviewed pain medication currently ordered and scheduled with physician request for pain medication to be crushed for administration as resident sometimes refused medications. Review of the resident's x-ray of the right foot/ankle report dated 3/10/20 showed a non-displaced hairline [MEDICAL CONDITION] tibia (a large bone located in the lower front portion of the leg) and right fibula (the smaller of the two bones of the lower leg) at the ankle. Review of the resident's Physician Order Sheet dated 3/10/20 showed the following: -Physical therapy evaluation for possible brace on right foot/ankle; -[MEDICATION NAME]/[MEDICATION NAME] (pain medication) 37.5 milligrams/325 milligrams two tablets four times daily. Review of the resident's care plan updated 3/10/20 showed the resident had a [MEDICAL CONDITION] foot and staff should take care with the right foot due to fracture. Observation on 3/10/20 at 11:51 A.M. the resident sat in a reclining wheelchair with foot pedals. The resident said his/her knee hurt and tried to move his/her legs without success. Observation on 3/11/20 at 1:45 P.M. showed the following: -CNA H and CNA F lifted the resident with a mechanical lift out of the wheelchair. The resident said oh my foot, my foot, my lands look at my leg. The resident's right foot dangled from the end of the mechanical lift pad; -CNA H and CNA F lowered the resident into bed and provided incontinence care, turning the resident side to side. The resident's right foot touched the bed with each turn. Staff did not support the foot as the resident was repositioned. The resident said watch my foot, it hurts me; -The resident's right ankle and foot were bruised. During interview on 3/11/20 at 7:25 A.M. and 1:45 P.M. CNA F said the following: -On [DATE] he/she pushed the resident in the wheelchair down the hallway toward his/her room. The hallway floor was wet and had cones lined up on the floor. As he/she pushed the resident in the wheelchair and approached the fire doors in the hallway, the resident grabbed the wheelchair wheels and turned the wheelchair toward the fire door; -The resident's right foot rammed into the door frame. The resident immediately screamed out in pain. He/She informed the charge nurse LPN E. -The incident happened between 2:00 P.M. and 4:00 P.M. on [DATE]. No other nurse was notified except LPN E of the resident's foot injury; -The resident's right knee was bent all the time, was contracted and did not straighten. His/Her right foot sometimes crossed behind the left leg; -The resident's right ankle was moved with each turn in the bed and with mechanical lift transfers. No staff direction was given regarding immobilizing the resident's right ankle. During interview on 3/12/20 at 8:45 A.M. CNA H said the following: -He/She worked day shift on [DATE]; -He/She did not see CNA F push the resident down the hall and did not see the resident's foot hit the door frame; -CNA F told him/her about the incident and he/she heard CNA F inform LPN E of the incident; -During report the day shift CNA staff informed the night shift CNA staff the resident's right foot was hurt; -He/She worked day shift on 3/10/20. The night shift CNA staff said during report the resident's foot hurt all night. During interview on 3/12/20 at 8:30 A.M. LPN E said the following: -He/She was the day shift (6:00 A .M. to 6:00 P.M.) charge nurse on [DATE] and did not remember CNA F tell him/her anything about the resident's hurt foot. He/She did not inform the next shift about the injury or the resident's complaint of foot pain; -On 3/10/20 he/she passed medications and learned from the Director of Nursing the resident's foot was fractured. CNA staff should be careful during movement and transfers with the resident's foot. During interview on 3/12/20 at 10:15 A.M. LPN G said the following: -On [DATE] he/she was the night shift (6:00 P.M. to 6:00 A.M.) charge nurse; -Staff gave the resident a shower that evening at approximately 9:00 P.M. As staff transferred the resident to bed with the mechanical lift the resident yelled and grabbed his/her leg; -Staff reported to him/her the resident's complaint of pain; -He/She assessed the resident's right leg and found no deformity or bruising; -The night shift CNA staff said they heard the resident ran his/her foot into the door frame on the day shift and hurt his/her right foot; -He/She did not document the resident's complaint of pain in the nurses' notes or notify the physician or responsible party of the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265788	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCOTLAND COUNTY CARE CENTER	434 E SIGLER AVENUE MEMPHIS, MO 63555

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) complaint of right ankle pain. He/She passed the resident's complaint of right ankle pain to the next shift in report the following morning; -He/she should have charted the resident's right ankle assessment and complaint of right ankle pain and should have notified the Director of Nursing of any complaint of injury or change in resident's status. During interview on 3/11/20 at 2:10 P.M. and 3/12/20 at 5:40 P.M. the Director of Nursing said the following: -He/she did not know the day shift CNA staff informed the night shift CNA staff of the resident's injured foot and did not know the night shift staff were aware the resident's foot rammed into the door frame. -He/She learned of the resident's injured right foot on 3/10/20; -He/She assessed the resident's right foot, called the physician and obtained an order for [REDACTED]. right foot and of the resident hitting the door frame while in the wheelchair; -Staff should document every resident assessment and change in status in the resident's nurses' notes; -Staff should not delay treatment from the time of the incident until the following day; -No investigation was completed regarding the cause of the injury until the next day.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services consistent with acceptable standards of practice to prevent and treat urinary tract infections [MEDICAL CONDITION] for one resident (Resident #12), with an indwelling urinary catheter (tube inserted into the bladder to drain urine), in a review of 12 sampled residents. Staff failed to provide appropriate catheter care during early morning cares and failed to keep the catheter bag, tubing and dignity bag off the floor. The facility reported one resident with an indwelling catheter. The facility census was 42. Review of the facility policy, Catheter Care, Urinary dated 9/14 showed: Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident; 2. Assemble the equipment and supplies as needed; Use standard precautions when handling or manipulating the drainage system; Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag; Do not clean the peri-urethral area with antiseptics to prevent catheter-associated UTIs while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate; Be sure the catheter tubing and drainage bag are kept off the floor; For a female resident: Use a washcloth with warm water and soap to cleanse the labia. Use one area of the washcloth for each downward, cleansing stroke. Change the position of the washcloth with each downward stroke. Next, change the position of the washcloth and cleanse around the urethral meatus. Do not allow the washcloth to drag on the resident's skin or bed linen. With a clean washcloth, rinse with warm water using the above technique; For a male resident: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular [MEDICAL CONDITION] from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return the foreskin to normal position. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. Review of the Nurse Assistant in a Long Term Care Facility, 2001 revision, showed the following: -The bladder is considered sterile, the catheter, drainage tubing and bag are a sterile system; -Drainage tubing/bags must not touch the floor; -The drainage bag should always be below the level of the bladder; -If moved above, urine could flow back into the bladder. 1. Review of Resident #12's face sheet showed [DIAGNOSES REDACTED]. Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 1/9/20 showed the following: -Severely impaired cognition; -Required limited assistance of one staff member with bed mobility, transfers, dressing toileting and personal hygiene; -Required an indwelling urinary catheter. Review of the resident's Physician Order Sheet (POS) showed the following: -On 2/10/20 cleanse urinary catheter insertion site with soap and water, rinse and pat dry every shift; -On 2/12/20 obtain a urinalysis (UA) (a diagnostic lab procedure used to determine urinary changes and infection) related to mental status changes. Review of the resident's UA results dated 2/12/20 showed the following: -Appearance: Hazy (normal: clear); -Urine blood: 1+ (normal: negative); -[MEDICATION NAME] (indicative of infection): positive (normal: negative); -Leukocytes: 3+ (normal: negative); -White Blood Cells (WBCs) (fight infection): 11-25 High Power Field (HPF) (area visible under the maximum magnification power) (normal: 0-5 HPF); -Red Blood Cells (RBCs): 3-5 HPF (normal: none); -Urine culture indicated: yes (determines appropriate antibiotic treatment). Review of the resident's POS dated 2/13/20 [MEDICATION NAME](antibiotic medication) 500 milligrams twice daily for seven days, [DIAGNOSES REDACTED]. He/She required a urinary indwelling catheter due to [MEDICAL CONDITION] and [MEDICAL CONDITION]. The resident was unable to urinate without a catheter. He/She required assistance with urinary catheter care due to restricted mobility and decreased cognitive function. The urinary catheter could cause irritation and needed care each shift and as needed. Staff should observe for decreased urinary output, increased confusion or foul odor. Staff should provide urinary catheter care and cleanse the resident's catheter insertion site with soap and water and pat dry every shift. Staff should keep the urine collection bag below the level of the bladder, make sure the urine collection bag did not drag, get twisted or kinked, and should not tug or pull on the catheter. Observation on 3/10/20 at 11:43 A.M. showed the resident sat in a recliner chair with his/her urinary catheter bag in a dignity bag lying on the floor beside the recliner chair. The urinary catheter tubing contained dark, yellow, cloudy urine. Observation on 3/10/20 from 12:20 P.M. through 12:47 P.M. showed the resident sat at the dining room with his/her urinary catheter bag hanging under the wheelchair and the catheter tubing lay on the floor. Observation on 3/11/20 at 7:15 A.M. showed the following: -The resident lay in bed (the urinary drainage bag hung from the bed frame) in his/her room, and CNA C stood with gloved hands and prepared to perform morning cares; -He/She applied the resident's pants, socks and shoes, de-gloved, washed hands and re-donned gloves; -He/she picked up several packaged alcohol pads and exposed the resident's front perineal area; -He/She opened a package, pulled the alcohol wipe out and wiped around the catheter insertion site with bright, red blood noted. He/She repeated this five times with separate alcohol wipes; -He/She covered the resident's perineal area, assisted the resident to sit on the side of the bed and stand to his/her walker. The resident ambulated to the bathroom where the resident performed morning cares with staff assist. The resident then ambulated to his/her wheelchair where he/she sat and CNA C placed the urinary drainage bag in a cloth dignity bag and hung it from under the wheelchair. The dignity bag touched the floor; -CNA C did not clean the urinary catheter and did not ensure the dignity bag did not touch the floor. During interview on 3/12/20 at 2:35 P.M. CNA C said the following: -Catheter care is usually done with soap and water and a washcloth; -He/She used alcohol as he/she thought it would be more sterile due to the mucous he/she noted at insertion site; -The alcohol wipes could cause burning if he/she had cleaned deeper around site; -He/She should have cleaned at least four inches from the catheter insertion site outward; -No part of a urinary drainage system should ever touch the floor. Observation on 3/12/20 at 11:45 A.M. showed the resident sat in his/her wheelchair in the dining room with his/her urinary catheter bag located in a dignity bag hooked under his/her wheelchair. The resident rolled his/her wheelchair to the table and the urinary dignity bag and the urinary catheter tubing drug on the floor. During interview on 3/12/20 at 5:40 P.M. the Director of Nursing said the following: -Staff should maintain the resident's urinary catheter bag, dignity bag and tubing off the floor at all times; -Staff should clean the resident's urinary catheter tubing and insertion site with soap and water. Staff should not clean the insertion site with alcohol pads; -The urinary catheter bag on the floor could contribute to the cause of the resident's UTI.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to appropriately assess and reassess the safety and effectiveness of cane rails and one-quarter length bedrails in use for two residents (Resident #1 and #4) of 12 sampled residents who had bedrails in place on their beds. The facility census was 42. During interview on 3/12/20 at 5:27 P.M., the Director on Nursing said the facility did not have a side rail policy. Review of the Food and Drug Administration's bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265788	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCOTLAND COUNTY CARE CENTER	434 E SIGLER AVENUE MEMPHIS, MO 63555

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 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) safety guidelines: A Guide to Bed Safety, Bed rails in Hospitals, Nursing Homes, and Home Health Care, dated April 2010, showed the following: -Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movements, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm; -Assessment by the health care team will help to determine how to best keep the patient safe; -Potential risks of bed rails may include strangulation, suffocation, bodily injury or death when patients or part of their body are caught between rails and mattresses, more serious injuries from falls when patients climb over the rails, skin bruising cuts and scrapes, and feeling isolated or unnecessarily restricted; -When bed rails are used, perform an on-going assessment of the patient's physical and mental status and closely monitor high risk patients; -Use a proper size mattress with a raised foam edge to prevent patients from being trapped between the mattress and the bed rail; -Reduce the gaps between the mattress and the rails; -A process that requires ongoing patient evaluation and monitoring will result in optimizing bed safety; -Reassess the need for using bed rails on a frequent and regular basis. 1. Review of Resident #1's face sheet showed [DIAGNOSES REDACTED]. Review of the resident's care plan, dated 11/16/18 showed the following: -At risk for falls; -Remain free from injury; -Grab bars on bed to help with bed mobility. Review of the resident's Admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/30/19, showed the following: -Cognitively intact; -Lower extremity, impairment to one side; -Independent with bed mobility and transfers; -Fall in last two-six months; -Bed rails were not utilized. Observation on 3/10/20 at 10:50 A.M. showed the resident in bed with a bed cane attached to the upper portion of the bed frame on the left side of the bed, an approximate one inch gap was noted between the bed cane and the mattress. Review of the resident's medical record showed no documentation the facility completed an assessment to indicate the use of the cane rails on the resident's bed. 2. Review of Resident #4's face sheet showed [DIAGNOSES REDACTED]. Review of the resident's fall log showed the resident slid out of bed on 1/5/20 at 1:30 A.M. Review of resident's care plan, updated 1/5/20 showed the following: -Poor safety awareness and will at times refuse his/her walker; -The resident wants to be free from falls and injuries; -The care plan did not include the use of a cane rail. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Independent with bed mobility; -Limited assist of one staff for transfers; -Bed rails were not utilized. Observation on 3/10/20 at 12:14 P.M. showed a cane rail attached to the resident's bed frame on the right side nearest the head of the bed. Observation on 3/12/20 2:47 P.M. showed the resident lay in bed with a cane/ assist rail on the right side of his/her bed. The resident said he/she used the rail to help move in bed. Review of the resident's medical record showed no documentation the facility completed an assessment to indicate the use of a cane rail on the resident's bed. During interview on 3/12/20 at 5:27 P.M. the Administrator said the following: -They did not use side rails; -They had not performed side rail assessments for the residents; -They did not believe cane/assist rails were considered side rails.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain a system to monitor residents who used [MEDICAL CONDITION] medications (any medication capable of affecting the mind, emotions, and behavior) to ensure attempts were made for gradual dose reductions (GDR) in an effort to reduce or discontinue these medications for one resident (Resident #31), in a review of 12 sampled residents. The facility census was 42. Review of the facility policy Medication Regimen Review dated 4/07 showed the following: -Policy statement: The consultant pharmacist shall review the medication regimen of each resident at least monthly; -Policy Interpretation and Implementation: The consultant pharmacist will perform a medication regimen review (MRR) for every resident in the facility. Routine reviews will be done monthly. The primary purpose of this review is to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible; -As part of the MRR, the consultant pharmacist will evaluate whether any medications in a drug regimen present potentially significant drug-drug or drug-food interactions; Be alert to medications with potentially significant medication-related adverse consequences and to actual signs and symptoms that could represent adverse consequences; Identify unnecessary drugs; -The consultant will provide a written report to physicians for each resident with an identified irregularity. If the situation is serious enough to represent a risk to a person's life, health, or safety, the consultant pharmacist will contact the physician directly to report the information to the physician and will document such contacts. If the physician does not provide a pertinent response, or the consultant pharmacist identifies no action has been taken, he/she will then contact the medical director, or if the medical director is the physician of record, the administrator; -The consultant pharmacist will provide the Director of Nursing (DON) Services and Medical Director with a written, signed and dated copy of the report, listing irregularities found and recommendations for their solutions. A separate report will be sent to the attending physician that lists the resident's name, relevant drug, and the irregularity found. The attending physician must then document that the irregularity was identified and what, if any action was taken to address it. If no change, the physician must document their rationale in the medical record; -[MEDICAL CONDITION] drugs are any drugs that affect brain activity associated with mental process and behaviors. They include, but are not limited to: antipsychotics, antidepressants, antianxiety and hypnotics. 1. Review of Resident #31's Pharmacy Consultation Report dated 6/19/18 showed the following: -The resident had experienced a recent fall and received Duloxetine [MEDICATION NAME] (HCL) (antidepressant) which may cause or contribute to falls; -Recommendation to evaluate these medications as possibly causing or contributing to falls in this resident and minimize or discontinue any of these therapies if possible in order to minimize the risk of falls due to adverse drug effects; -The physician documented not wishing to implement any changes at that time. Review of the resident's March 2020 physician's order sheets (POS) showed the following: -[DIAGNOSES REDACTED]. Review of the resident's Pharmacy Consultation Report Dated 11/15/19 showed the following: -The resident received both duloxetine hcl and [MEDICATION NAME] hcl (antidepressant) for depression and was due for a review; -No signs or symptoms of depression noted per recent nursing notes; -Resident is a fall risk with increased confusion; -The Pharmacy Consultation Report only addressed a reduction in the resident's [MEDICATION NAME] HCL. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/06/20, showed the following: -No cognitive impairment; -No moods or behaviors; -Received antidepressant medications seven of the last seven days; -The MDS did not address the GDR section. Review of the resident's care plan dated 2/18/20 and last revised 3/10/20, showed the following: -The resident was at risk for falls due to his/her independence and occasional weakness; -His/Her gait was unsteady; -He/She had conditions that caused pain in his/her legs and feet most of the time that he/she took pain medication for; -He/She had four documented falls (10/10/18, 8/24/19, 10/30/19 and the most recent fall was 1/9/20); -The care plan did not address the resident's [DIAGNOSES REDACTED]. Review of the resident's medical record showed the following: -The resident received duloxetine hcl from 7/05/18 to 3/12/20 (greater than one year) with no documentation of a request for a GDR or a GDR completed; -The pharmacist completed monthly medication regimen reviews that did not address a GDR for this medication; -No documentation to show the physician had been contacted regarding GDRs for the resident's medications. During an interview on 3/12/20 at 5:30 P.M., the director of nursing (DON) said the following: -She was responsible for GDR tracking and ensuring GDRs were completed per regulation; -She was to monitor the pharmacist consultant reviews and the physician notifications for GDRs; -There was no GDR request for the resident's duloxetine [MEDICATION NAME]; -She was not aware there was no GDR for the resident's duloxetine [MEDICATION NAME].
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to administer medications with a medication error rate less than five percent (%) for two residents (Resident #31 and #291) in a review of 12 sampled residents and for one additional resident (Resident #13). There were 32 opportunities for error with 16 errors which resulted in a medication error rate of 50%. Further observation and review showed staff did not administer medications as instructed in regards to with or without food, on an empty stomach, chewed or allowed to dissolve on the resident's tongue and prepared medications,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265788	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCOTLAND COUNTY CARE CENTER	434 E SIGLER AVENUE MEMPHIS, MO 63555

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 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) leaving them in the medication cart, unlabeled and unidentified. The facility census was 42. Review of the facility policy Medication Administration Schedule dated 12/12 and updated 1/11/19 showed the following: Medications shall be administered according to established schedules. Policy Interpretation and Implementation 1. Medications are administered according to the following routine schedule: -Every eight hours- 6:00 A.M., 2:00 P.M. and 10:00 P.M.; -Every six hours-6:00 A.M., 12:00 P.M., 6:00 P.M. and 12:00 A.M.; -Every four hours-2:00 A.M., 6:00 A.M., 10:00 A.M., 2:00 P.M., 6:00 P.M. and 10:00 P.M.; -QID (Four times daily)-A.M., Noon, P.M. and HS (Hour of Sleep); -TID (Three times daily)-A.M., Noon, and P.M.; -BID (Two times)-A.m. and P.M.; -ac (before meals)-6:30 A.M., 11:30 A.M. and 4:30 P.M.; -pc (after meals); -Daily-A.M ; -Every morning-A.M ; 2. Routine medication administration schedules may be changed by the Quality Assessment and Assurance Committee; 3. A physician's order for specific times supersedes any routine schedule; 4. Residents may request alternate medication schedules. Such times must be documented on the resident's medication administration record and care plan; -Handwritten notation on the document read: The Director of Nursing (DON) said this is the current policy for medication pass as of 3/12/20. Review of the facility policy Administering Medications dated 12/12 showed the following: Policy Statement: -Medications shall be administered in a safe and timely manner, and as prescribed; Policy Interpretation and Implementation: 2. The DON will supervise and direct all nursing personnel who administer medications; 3. Medications must be administered in accordance with the orders, including required time frames; 4. Medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). Review of an undated paper in the front of the 300 Hall medication administration record (MAR) book showed A.M. administration times were 7:00 A.M. to 10:00 A.M. Review of the Nursing 2018 Drug Handbook showed the following instructions for [MEDICATION NAME] (a medication that replaces a hormone normally produced by the [MEDICAL CONDITION] to regulate the body's energy and metabolism): -Give medication at the same time each day on an empty stomach, preferably to 1 hour before breakfast; -May impair [MEDICATION NAME] absorption if administered with other medications. 1. Review of Resident #13's March 2020 POS showed the following: -[DIAGNOSES REDACTED].M. and P.M. medication pass; -Aspirin (heart health) 81 mg chewable tablet daily, scheduled for the A.M. medication pass; -[MEDICATION NAME] 50 mcg daily, scheduled for the A.M. medication pass; -[MEDICATION NAME] (diuretic) 40 mg twice daily, scheduled for the A.M. and noon medication pass; -[MEDICATION NAME] (eye vitamin), twice daily, scheduled for the A.M. and noon medication pass; -[MEDICATION NAME] 40 mg DR capsule daily, scheduled for the A.M. medication pass. Review of the resident's March 2020 MAR showed the following: -Aspirin 81 mg chewable tablet daily, scheduled for the A.M. medication pass, box warning instructions to take with food; -[MEDICATION NAME] 50 mcg daily, scheduled for the A.M. medication pass, box warning instructions to take on an empty stomach; -[MEDICATION NAME], twice daily, scheduled for the A.M. and noon medication pass, box warning instructions to take with food. Observation on 3/11/20 at 9:40 A.M. showed the resident eating breakfast in the west dining room. The resident had consumed all of his/her food at that time. Observation on 3/11/20 at 11:20 A.M. showed the following: -LPN B prepared the resident's A.M. medications and placed them in a plastic medication cup and administered them to the resident; -LPN B administered the resident's A.M. medications out of the facility documented time frame for the A.M. medication pass; -LPN B did not administer the resident's [MEDICATION NAME] on an empty stomach; -LPN B did not administer the resident's Aspirin with food; -LPN B did not prepare and administer the resident's Aspirin separately and have the resident chew the tablet; the resident consumed all of the prepared medications from the medication cup at the same time, swallowing the medication; -LPN B did not administer the resident's [MEDICATION NAME] with food. 2. Review of Resident #31's March 2020 POS showed the following: -[DIAGNOSES REDACTED].M. medication pass; -Potassium Chloride ER (supplement documented as prescribed for high blood pressure) 10 meq daily; -Pregabalin 200 mg twice daily, scheduled for the A.M. and P.M. medication pass; -[MEDICATION NAME] HCL (antidepressant) 10 mg, 2 caps three times daily, scheduled for the A.M., noon and P.M. medication pass. Observation on 3/11/20 at 11:25 A.M. showed the following: -LPN B prepared the resident's A.M. medications and placed them in a plastic medication cup and administered them to the resident; -LPN B administered the resident's A.M. medications out of the facility documented time frame for the AM medication pass. 3. Review of Resident #291's hospital discharge paperwork, dated 3/5/20, showed the resident had a [DIAGNOSES REDACTED].M. medication pass; -[MEDICATION NAME] (diuretic) 20 mg, scheduled for the A.M. medication pass and noon; -[MEDICATION NAME] 88 mcg daily, scheduled for the A.M. medication pass; -[MEDICATION NAME] (high blood pressure) 100 mg twice daily, scheduled for the A.M. and P.M. medication pass; -Aspirin 81 mg, scheduled for the A.M. medication pass; -[MEDICATION NAME] (antidepressant medication) 20 mg, scheduled for the A.M. medication pass. Observation on 3/11/20 at 9:35 A.M. showed the resident eating breakfast in his/her room. The resident had consumed over half of his/her food at that time. Observation of the medication cart, parked in the medication room, on 3/11/20 at 11:50 A.M. showed five medications in a medication cup in the top drawer of the medication cart. A resident's first name was written on the cup. During interview on 3/11/20 at 11:50 A.M. LPN B said the medications were Resident #291's morning medications. He/She placed the medications in the cup for the morning medication pass and the resident was not in his/her room. He/She did not know what medications were in the cup. Observation on 3/11/20 at 11:52 A.M. showed LPN B pulled Resident #291's medication cards from the cart, reviewed the resident's MAR and matched the medications in the cup with the cards and MAR. Review of the resident's MAR on 3/11/20 at 11:50 A.M. showed LPN B had signed out the following medications: [REDACTED]. During interview on 3/11/20 at 11:52 A.M. LPN B said the following: -The medications were Resident #291's [MEDICATION NAME] 20 mg, [MEDICATION NAME] 60 mg ER, aspirin 81 mg, [MEDICATION NAME] 20 mg, [MEDICATION NAME] 100 mg; -He/She signed out six medications on the resident's MAR this AM and did not administer the medications. He/She should not sign out the resident's medications until after administration; -There were five medications in the medication cup. [MEDICATION NAME] 88 mcg was missing from the cup. Observation on 3/11/20 at 11:55 A.M. showed the following: -LPN B obtained [MEDICATION NAME] 88 mcg from the resident's medication card and placed in the cup with the other five medication; -LPN B administered the resident's medications. During interview on 3/11/20 at 12:00 P.M. Resident #291 said the nurse just gave his/her morning medications. During interview on 3/11/20 at 12:02 P.M. LPN D/MDS Coordinator said the following: -Staff should administer [MEDICATION NAME] before breakfast on an empty stomach; -LPN B should have wasted the cup of medications and started over; -Staff should not sign out medications on the MAR when the medications were not administered. Staff should sign out the residents' medications after administration. During interview on 3/11/20 at 11:05 A.M. and 3:00 P.M., LPN B said the following: -He/She thought A.M. medication pass meant the medication pass was to be completed by 10:00 A.M.; He/She had seen a paper documenting such in the front of the 300 hall MAR; -The Director of Nurses (DON) told him/her the A.M. medication pass meant staff was to complete the medication pass by 12:00 noon; -He/She passed the medications at the times they were scheduled to be administered; -He/She did not know if the medications would be considered late if administered after 10:00 A.M. or 12:00 P.M.; -If a medication was scheduled for A.M. administration and noon administration, he/she really did not know how much time should be between the administrations; if the A.M. medication pass was late, and the noon medication pass on time, the administration times could be too close; he/she just did not know; -He/She did not know how [MEDICATION NAME] should be administered; -He/She had not noticed the medication administration record documenting administration box warning instructions for the resident's medications which included whether to administer medications with food, on an empty stomach or if they should be dissolved under the tongue or chewed; -He/She was the only person to pass the morning medications to all of the residents on all of the halls; -He/She was always slowed up on the medication pass because he/she did not know where all of the resident and stock bottles of medications were so he/she had to always look through every drawer before finding them; -There were also times he/she would be called off of a certain hall to go to another hall to administer an as needed requested medication to a resident; this caused starts and stops to the medication passes which contributed to the residents' medications being administered late. During an interview on 3/12/20 at 5:30 P.M. the DON said the following: -She would expect staff to administer medications as ordered; -[MEDICAL CONDITION] medication should be administered first thing in the morning; -She would expect staff to administer medications at ordered times if specific and/or follow the facility medication administration policy; -The facility policy for the liberal medication time frames was not clear; -Staff should not sign out residents' medications on the MAR if the medication was not administered. Staff should sign out residents' medications after administration; -Staff should not save residents' medications in a cup in the medication cart drawer. If the medication in the cup was not administered, staff should destroy the medication.

F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure two residents (Resident #39 and #291) of 12 sampled residents were free from significant medication errors. Staff failed to prime (remove the air) from a [MEDICATION NAME] (fast acting [MED]) [MEDICATION NAME] (prefilled pen of [MED], injected under the skin and used to treat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265788	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCOTLAND COUNTY CARE CENTER	434 E SIGLER AVENUE MEMPHIS, MO 63555

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) diabetes, dose dialed on the pen and injected through a new sterile needle attached to the pen prior to each administration) and a [MEDICATION NAME] (long acting [MED]) [MEDICATION NAME] needle as instructed by the manufacturer prior to administration of the physician prescribed dose resulting in administration of less than the ordered dose of [MEDICATION NAME] and [MEDICATION NAME]. The facility census was 42. Review of the facility policy Adverse Consequences and Medication Errors dated 4/14 showed the following: Policy Statement: The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the Attending Physician and Pharmacist, and to federal agencies as appropriate. Policy Interpretation and Implementation: 1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported; 2. An adverse consequence is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychological status. An adverse consequence may include: adverse drug/medication reaction, side effect, medication-medication interaction or medication-food interaction; 3. An adverse reaction (ADR), a form of adverse consequences, is defined as a secondary and usually undesirable effect of a drug and is different from the therapeutic and helpful effects of the drug. And ADR is any noxious and unintended response to a drug and occurs in doses for [MEDICATION NAME], [DIAGNOSES REDACTED]. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of medication; 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services; 6. Examples of medication errors include: omission (ordered but not administered), unauthorized drug (administered without physician order), wrong dose, wrong route of administration, wrong dosage form, wrong drug, wrong time and or wrong resident. Review of the facility policy [MED] Administration dated 9/14 showed: Purpose: To provide guidelines for the safe administration of [MED] to residents with diabetes. Preparation: The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of [MED] delivery system (s) prior to their use. 1. Review of the [MEDICATION NAME] package insert showed the following in part: -[MEDICATION NAME] was a disposable single-patient-use prefilled pen containing 300 units of [MEDICATION NAME] [MED]. Each turn (click) of the dose knob dialed one unit of [MED]. You could give from one to 60 units in a single injection; -You must prime (remove the air from the needle and cartridge) the pen before you set your dose and inject [MED]. You will do this by giving an air shot. This removes the air bubbles and ensures the pen and needle are working properly; -To do an air shot, turn the dose knob, dialing to select two units, placing the dial indicator on the number 2 in the dose window, hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top, push the dose knob in until it stops and the dial indicator is on the 0 in the dose window. Hold the dose knob in and count to five slowly. You should see [MED] at the tip of the needle. Repeat the priming procedure if you did not see [MED] at the tip of the needle; -If you do not prime before each injection you may get too much or too little [MED]; -Turn the dose knob and select the number of units you need to inject and administer the medication. 2. Review of the [MEDICATION NAME] package insert showed the following in part: -[MEDICATION NAME] was a disposable single-patient-use prefilled pen containing 300 units of [MEDICATION NAME] [MED]. Each turn (click) of the dose knob dialed one unit of [MED]. You could give from one to 60 units in a single injection; -You must prime (remove the air from the needle and cartridge) the pen before you set your dose and inject [MED]. You will do this by giving an air shot. This removes the air bubbles and ensures the pen and needle are working properly; -To do an air shot, turn the dose knob, dialing to select two units, placing the dial indicator on the number 2 in the dose window, hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top, push the dose knob in until it stops and the dial indicator is on the 0 in the dose window. Hold the dose knob in and count to five slowly. You should see [MED] at the tip of the needle. Repeat the priming procedure if you did not see [MED] at the tip of the needle; -If you do not prime before each injection you may get too much or too little [MED]; -Turn the dose knob and select the number of units you need to inject and administer the medication. 3. Review of Resident #39's Admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/19/20 showed the following: -Mild cognitive impairment; -[DIAGNOSES REDACTED]. Review of the resident's March 2020 Physician Order Sheets (POS) showed an order for [REDACTED].M. showed the following: -Licensed Practical Nurse (LPN) A removed the resident's [MEDICATION NAME] from the box in the medication cart, removed the [MEDICATION NAME] cap, cleaned the tip of the [MEDICATION NAME] with an alcohol pad and attached an injection needle to the [MEDICATION NAME]; -LPN A dialed the [MEDICATION NAME] to 5 U and administered the [MED] to the resident; -LPN A did not prime the [MEDICATION NAME] prior to preparing the resident's ordered 5 U [MED] dose. 4. Review of Resident #291's March 2020 POS showed the following: -admitted was 3/5/20; -[MEDICATION NAME] 20 U subq, daily in the morning (order date of [DATE]); -[MEDICATION NAME] 6 U subq, before meals (order date of [DATE]). Review of the resident's care plan, dated 3/10/20, showed the resident's [DIAGNOSES REDACTED].M. showed the following: -LPN A removed the resident's [MEDICATION NAME] from the box in the medication cart, removed the [MEDICATION NAME] cap, cleansed the tip of the [MEDICATION NAME] with an alcohol pad and attached an injection needle to the [MEDICATION NAME]; -LPN A dialed the [MEDICATION NAME] to 6 U and administered the [MED] to the resident; -LPN A did not prime the [MEDICATION NAME] prior to preparing the resident's ordered 6 U [MED] dose; -LPN A removed the resident's [MEDICATION NAME] from the box, removed the [MEDICATION NAME] cap, cleansed the tip of the [MEDICATION NAME] with an alcohol pad and attached an injection needle to the [MEDICATION NAME]; -LPN A dialed the [MEDICATION NAME] to 20 U and administered the [MED] to the resident; -LPN A did not prime the [MEDICATION NAME] prior to preparing the resident's ordered 20 U [MED] dose. During an interview on 3/11/20 at 7:06 A.M., LPN A said the following: -He/She thought priming the [MED] [MEDICATION NAME] was only necessary when the [MED] [MEDICATION NAME] was first used; -He/She was not aware he/she needed to prime an [MED] [MEDICATION NAME] prior to every preparation and administration. During an interview on 3/12/20 at 5:30 P.M. the director of nursing (DON) said the following: -She would expect staff to prime an [MED] [MEDICATION NAME] before administration; -If staff do not prime an [MED] [MEDICATION NAME], the resident would not receive the full-prescribed [MED] dose; -Not receiving a full-prescribed [MED] dose as ordered would be considered a medication error.

F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to return discontinued medications to the pharmacy and/or ensure the discontinued medications were destroyed in a timely manner for two additional residents (Resident #26 and #24), failed to ensure schedule II narcotic medications were stored appropriately behind two locked doors and failed to destroy schedule II narcotic used [MEDICATION NAME]es (narcotic pain medication patch applied to the skin) in a timely manner. The facility census was 42. Review of the facility policy Discarding and Destroying Medications dated 10/14 showed the following: Policy Statement: Medications should be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances; Policy Interpretation and Implementation: 1. All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of; 4. Schedule II, III, and IV controlled substances) will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous controlled medications; 5c. Disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident. 1. Review of Resident #26's Physician Order Sheet (POS) dated 1/17/20 showed Ertapenem (antibiotic medication administered by injection or intravenously 1 gram (gm) intramuscularly (IM) daily for nine days. Review of the resident's Medication Administration Record [REDACTED]. Review of the resident's POS dated 1/19/20 showed discontinue Ertapenem 1 gm on 1/20/20. Observation of the medication room on 3/11/20 at 11:00 A.M. showed Ertapenem 1 mg six vials dispensed 1/17/20 labeled with Resident #26's name sat on the counter beside the sink. 2. Observation of the medication room on 3/11/20 at 11:00 A.M. showed [MEDICATION NAME] 250 mg 80 capsules dispensed 6/15/19 sat in a plastic basket bedside the sink labeled with Resident #24's name. During interview on 3/12/20 at 11:30 A.M. the Director of Nursing (DON) said the following: -Resident #24 was never on [MEDICATION NAME] while a resident in the facility; -The resident's family brought the medication to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265788	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCOTLAND COUNTY CARE CENTER	434 E SIGLER AVENUE MEMPHIS, MO 63555

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** - Some	(continued... from page 5) facility from home a long time ago; -The medication was placed in the basket of medications that needed to be destroyed; -The facility was unable to keep those medications and staff should destroy the medication within one week. 4. Observation of the medication room on 3/11/20 at 11:00 A.M. showed the following in one plastic bag placed in an open plastic basket on the counter next to the sink: -[MEDICATION NAME] 75 microgram (mcg) nine packages each contained a used [MEDICATION NAME] with hand written label of a first name only; -[MEDICATION NAME] 12 mcg 75 packages each contained a used [MEDICATION NAME] with hand written label of a first name only; -[MEDICATION NAME] 25 mcg 11 packages each contained a used [MEDICATION NAME] with hand written label of a first name only. During interview on 3/11/20 at 11:15 A.M. Licensed Practical Nurse (LPN) D said the following: -He/She was the Residential Care Facility (RCF) manager; -The [MEDICATION NAME]es belonged to two residents who lived on the RCF side of the facility. The [MEDICATION NAME]es were found on the RCF in the medication cart and he/she brought them to the Skilled Nursing Facility (SNF) medication room in January or February 2020 for destruction. Staff had not destroyed the [MEDICATION NAME]es yet. He/She did not know why the used [MEDICATION NAME]es were stored in the open plastic basket and not destroyed. Staff should destroy the [MEDICATION NAME]es immediately when removed from the resident's skin and not store for later disposal. The [MEDICATION NAME]es still contained medication and were a schedule II narcotic. Staff should store schedule II narcotics behind two locked doors. The used [MEDICATION NAME]es were currently behind one locked door, the medication room door only. During interview on 3/11/20 at 11:10 A.M. and 3/12/20 at 5:40 P.M. the DON said the following: -Staff should destroy discontinued medications or return to the pharmacy within one week. Staff should not keep the discontinued medications on the counter in the medication room for more than 30 days; -The [MEDICATION NAME]es needed to be destroyed. The [MEDICATION NAME]es were used and then placed in the package of the new [MEDICATION NAME] after the patch was changed; -Staff should destroy used [MEDICATION NAME]es immediately after removal from the resident's skin and not accumulate the used [MEDICATION NAME]es for destruction at a later time. Staff should place the used [MEDICATION NAME] in the sharps container or in the Drug disposal in a bottle located in the medication room under the sink; -Staff should not keep used [MEDICATION NAME]es in a bag on the counter in the medication room. [MEDICATION NAME] was a schedule II narcotic and required storage under two locked doors. The bag of [MEDICATION NAME] used patches was only locked under one door, the medication room door.