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	08/19/2024

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on record review and interview, the facility failed to ensure all residents were free from significant medication errors when staff administered another resident's medication to one resident (Resident #1) resulting in an unsafe drop in blood pressure and hospitalization of the resident. Staff also failed to administer insulin as ordered and contact the physician regarding insulin not available for one resident (Resident #3) resulting in elevated blood sugar levels and hospitalization of the resident. A sampled of ten residents were reviewed in a facility with a census of 67. 1. Review of the facility policy titled Administering Medications, April 2019, showed the following: -Medications are administered in a safe and timely manner, and as prescribed; -The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions; -Medications are administered in accordance with prescribed orders, including any required time frame; -Medication errors are documented, reported, and reviewed by the QAPI (quality assurance and performance improvement) Committee to inform process changes of the need for additional staff training; -Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders); -The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include checking identification band; checking photograph attached to medical record; and if necessary, verifying the resident with other facility personnel; -The individual administering the medications checks the label three times to verify the right resident, right medication, right time, and right method (route) of administration before giving the medication; -Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the Director of Nursing Services. (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 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/16/24, at 10:25 A.M., Certified Medication Tech (CMT) A said the following: -He/she had been trained on seven rights of medication administration, which included the right resident, right medication, right dose, right time, right route, right documentation, and right reason; -Staff should verify resident and medication by the resident picture in the computer and the resident name on the medication; -He/she worked on the morning of 08/12/24 and had the medication cart in front of Resident #2's room and was preparing medications for Resident #2; -Resident #1 walked down the hall with physical therapy staff; -Resident #1 stopped at the medication cart and he/she handed the resident a cup of medication and a cup of water; -Almost immediately the he/she realized he/she had given the wrong medication to the resident and had the resident spit out as much medication as he/she could; -He/she notified the charge nurse and the resident was seated near the nurses' station; -The CMT believed that all of Resident #2's morning medications were in the cup given to Resident #1. -The nurse contacted the physician and when the resident's blood pressure was too low, the resident was was sent to the emergency room ; -This occurred at approximately 11:00 A.M. as the CMT was behind with the morning medications; -The CMT did not administer any additional medications to Resident #1. Review showed the facility did not provide an investigation related to the medication error. Review of Resident #1's face sheet (brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included cerebral infarction (stroke), encephalopathy (a disease that affects the function or structure of your brain), dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), hypertension (high blood pressure), and paroxysmal atrial fibrillation (type of irregular heartbeat that causes the heart to beat quickly and erratically for a few hours or days); -A picture of the resident on the face sheet. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 08/06/24, showed severe cognitive impairment and use of oxygen. Review of the Resident #1's care plan, last updated 08/09/24, showed staff should administer medications as ordered. Review of Resident #2's face sheet showed the following: -Original admitted [DATE]; -Re-admitted [DATE]; -Diagnoses included osteomyelitis (bone infection that causes inflammation and swelling in the bone) of vertebra lumbar region (lower back), chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), and sepsis (an infection that has spread throughout the body); -No picture of the resident. Review of Resident #2's admission MDS, dated [DATE], showed severe cognitive impairment and use of oxygen. Review of Resident #2's care plan, last updated 08/13/24, showed the following: -Resident currently receiving medications that has black box warnings (required warning the U.S. Food and Drug Administration (FDA) for certain medications that carry serious safety risks); -Medications with black box warning are flagged on the Medication Administration Record (MAR); -Staff should administer medications as ordered. Review Resident #2's physician's orders, current as of 08/16/24, showed the following: -An order, dated 07/23/24, carvedilol (treats high blood pressure and helps prevent heart disease) 37.5 milligrams (mg), give 37.5 mg two times day related to hypertension. Administer at 8:00 A.M.; -An order, dated 07/23/24, for Xarelto (can treat and prevent blood clots) 2.5 mg, give 2.5 mg two times day related to hypertension. Administer at 8:00 A.M.; -An order, dated 07/24/24, ascorbic acid (vitamin C) 500 mg, give two tablets one time day related to osteomyelitis of vertebra. Administer medication between 7:00 A.M. and 10:00 A.M.; -An order, dated 07/24/24, for losartan potassium (can treat high blood pressure) 50 mg, give one tablet one time day related to hypertension. Administer medication between 7:00 A.M. and 10:00 A.M.; (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-An order, dated 07/24/24, for Amitizia (used to treat certain types of constipation) 24 micrograms (mcg), give one capsule two times day related to constipation. Administer medication between 7:00 A.M. and 10:00 A.M. and between 4:00 P.M. and 7:00 P.M.; -An order, dated 07/26/24, for spironolactone (used to treat certain types of edema and high blood pressure) 12.5 mg, give 12.5 mg one time day related to hypertension. Administer medication between 7:00 A.M. and 10:00 A.M.; -An order, dated 08/06/24, for hydralazine HCL (used to treat high blood pressure) 25 mg, give three tablets three times day related to hypertension. Administer at 9:00 A.M.; -An order, dated 08/06/24, for amlodipine besylate (lowers blood pressure) 10 mg, give 10 mg one time day related to high blood pressure. Administer medication between 7:00 A.M. and 10:00 A.M.; -An order, dated 08/06/24, aspirin 81 mg, give 81 mg one time day related to high blood pressure. Administer medication between 7:00 A.M. and 10:00 A.M.; -An order, dated 08/06/24, CoQ10 100 mg (antioxidant that the body produces naturally), give one capsule one time for supplement. Administer medication between 7:00 A.M. and 10:00 A.M.; -An order, dated 08/06/24, for fenofibrate (can lower high cholesterol and triglyceride levels) 54 mg, give 54 mg one time day related to hypercholesterolemia (high cholesterol). Administer medication between 7:00 A. M. and 10:00 A.M.; -An order, dated 08/06/24, for pantoprazole sodium (used for heartburn) 20 mg, give one tablet one time day for acid reflux. Administer medication between 7:00 A.M. and 10:00 A.M.; -An order, dated 08/06/24, for docusate sodium (helps soften stool) 100 mg, give 200 mg two times per day related to constipation. Administer at 8:00 A.M.; -An order, dated 08/07/24, for aspirin (used to relieve mild or chronic pain and to reduce fever and inflammation) 81 mg, give 81 mg two times day related to hypertension. Administer at 8:00 A.M.; -An order, dated 08/07/24, for Effer-K 10 meq (dietary supplement that raises potassium levels when they are too low), give one tablet two times day for supplement. Administer at 8:00 A.M.; -An order, dated 08/08/24, for Milk [NAME] (supplement can be used for liver disorders and gallbladder problems) 150 mg, give 600 mg one time day for liver disease. Administer medication 8:00 A.M.; -An order, dated 08/08/24, for multiple vitamin, give one tablet one time day for supplement. Administer medication at 8:00 A.M.; -An order, dated 08/09/24, for acidophilus probiotic (used to promote the growth of good bacteria in the body), give one capsule two times day for prophylactic treatment until 08/19/24. Administer medication between 7:00 A.M. and 10:00 A.M.; -An order, dated 08/10/24, for Keflex (used to treat certain infections) 500 mg, give 500 mg three times day for infection until 08/15/24. Administer at 9:00 A.M. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the Resident #2's Medication Administration Record, dated 08/01/24 through 08/31/24, showed the following: -A picture of the resident; -Staff documented the resident's morning medications for 08/12/24 as administered. Review Resident #1 physician's orders, current as of 08/12/24, showed the following: -Picture of the resident on the MAR; -An order dated 08/02/24, for docusate sodium 100 mg, give one capsule two times day for constipation, administer between 7:00 A.M. and 10:00 A.M. (half the dose that was administered in error); -An order dated 08/02/24, losartan potassium 25 mg, give one tablet two times day for hypertension, administer between 7:00 A.M. and 10 A.M. (half the dose that was administered in error); -The resident did not have orders for any additional medication administered in error. Review of Resident #1's nurse's progress note dated 08/12/24, at 11:04 A.M., showed it was brought to the nurse's attention that the resident was given another resident's medication. Upon review of the medication given the nurse noticed that several medications could inadvertently affect the resident's blood pressure. The nurse notified the physician and received orders to transfer the resident to the emergency department if his/her systolic blood pressure was less than 90 millimeters of mercury (mm/Hg). Staff took the resident's blood pressure which measured 85/49 mm/Hg. Staff called emergency medical services (EMS) for transport to the emergency department for evaluation and treatment. Review of the Resident #1's MAR, dated 08/01/24 to 08/31/24, showed on 08/12/24 staff documented the resident's morning medications were not given due to resident being hospitalized . During an interview on 08/16/24, at 11:00 A.M., Registered Nurse (RN) E said the following: -Staff should verify resident for medication administration with two identifiers, including a picture in the resident chart, the resident's date of birth, the resident's name; -The nurse was notified Resident #1 receive the incorrect medication at about 11:00 A.M.; -The nurse had the resident sit in front of the nurses' station and not go to the physical therapy office; -The nurse had the CMT write list of all medication possibly administered; -The nurse reviewed the MAR to determine what was given; -The nurse noted the resident received Coreg 37.5 mg (brand name for carvedilol) and called the physician; (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-The nurse MAR tells staff what to do at what time. During an interview on 08/16/24, at 2:25 P.M., VP (Vice President) Clinical Services said the following: -Staff are expected to immediately report a medication error; -Staff should notify the physician after assessing the resident; -Staff should follow the physician orders and the family should be contacted; -The resident should be closely monitored for up to 72 hours if remain in the building; -There were seven rights of medication administration, right resident, right medication, right route, right strength, right time, right documentation, and right reason; -Staff should verify resident by looking at the picture on the computer and checking the resident name on the door. Staff could also ask the resident or other staff to verify the name; -She was aware of the error that occurred with Resident #1. During an interview on 08/13/24, at 3:40 P.M., the DON said staff should be aware of the seven rights of medication administration. During an interview on 08/19/24, at 8:45 A.M., the Administrator said that staff should verify residents by looking at the picture in the computer and the resident names on the door. If there was not a picture in the computer staff should ask the resident name or ask coworkers if necessary. The social services staff had some trouble with the app for the resident pictures in the computer software. She was aware of the medication error but VP was handling the education. 2. Review of the facility policy titled Insulin Administration, dated September 2014, showed the following: -The policy provides the guidelines for the safe administration of insulin to resident with diabetes; -The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order; -The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies, before giving the insulin; -Staff to notify the physician if the resident has signs and symptoms of hypoglycemia (low blood sugar level) that are not resolved by following the facility protocol for hypoglycemia management. Review of Resident #3's face sheet showed the following: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-admitted [DATE]; -Diagnoses included type 2 diabetes mellitus with hyperglycemia (high blood sugar) and pure hyperglycemia; -No picture of the resident was on the face sheet. Review of the resident's hospital nursing discharge plan, dated 06/17/24, showed the following medication orders: -Insulin aspart (Novolog FlexPen - rapid acting insulin used to help lower blood sugar levels), inject 44 units with breakfast and lunch, and 35 units with supper, plus medium dose sliding scale. The next dose due on 06/17/24 at 6:00 P.M.; -Insulin glargine-lixisenatide (Soliqua 100/33 - long acting insulin used to treat diabetes), inject 46 units subcutaneous (under the skin) daily. The next does due on 06/17/24 at 9:00 P.M. Review of the resident's physician's orders, active as of 06/17/24, showed the following: -An order, dated 06/17/24, for Soliqua Solution Pen-injector 100-33 units-mcg/ml, inject 46 units subcutaneously at bedtime related to type 2 diabetes mellitus with hyperglycemia; -An order, dated 06/17/24, for Novolog FlexPen 100 unit/ml, inject 35 units subcutaneously in the afternoon related to Type 2 diabetes mellitus with hyperglycemia; -An order, dated 06/17/24, for Novolog FlexPen 100 unit/ml, inject 44 units subcutaneously two times day related to Type 2 diabetes mellitus with hyperglycemia; -An order, dated 06/17/24, for Novolog FlexPen 100 unit/ml, inject per sliding scale of if blood glucose level measured 150 mg/deciliter (dL) to 200 mg/dL, administer three units of insulin; if blood glucose level measured 201 mg/dL to 250 mg/dL, administer five units of insulin; if blood glucose level measured 251 mg/dL to 300 mg/dL, administer seven units of insulin; if blood glucose level measured 301 mg/dL to 350 mg/dL, administered nine units of insulin; if blood glucose level measured 351 mg/dL to 400 mg/dL, administered 11 units of insulin subcutaneously (below the skin) before meals and at bedtime related to Type 2 diabetes mellitus with hyperglycemia. Review of the resident's MAR, dated 06/01/24 through 06/30/24, showed the following: -On 06/17/24, at 5:00 P.M., staff documented Novolog Flex pen, 35 units as administered and blood glucose level at 269 mg/dL; -On 06/17/24, at 5:00 P.M., staff documented Novolog Flex pen, 7 units sliding scale administered and blood glucose at 269 mg/dL; -On 06/17/24, at 8:00 P.M., staff documented Novolog Flex pen, 5 units sliding scale administered and blood glucose at 250 mg/dL; (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-On 06/17/24, at 8:00 P.M., staff documented Soliqua Pen-injector not administered and see nurse notes. Review of the resident's nurse progress note showed staff documented the following: -On 06/17/24, at 3:24 P.M., resident admitted for skilled services and had history of insulin-dependent diabetes mellitus type 2 and was on insulin; -On 06/17/24, at 4:35 P.M., admission orders received from hospital; -On 06/17/24, at 8:30 P.M., insulin was unavailable and awaiting pharmacy delivery. Staff unable to give medication. (Staff did not document any notification to the physician of medication unavailable.) Review of the resident's MAR, dated 06/01/24 through 06/30/24, showed the following: -On 06/18/24, at 7:00 A.M., staff documented resident blood glucose as 468 mg/dL and Novolog sliding scale documented as held and see progress notes; -On 06/18/24, at 7:00 A.M., staff documented Novolog FlexPen 44 units as administered. Review of the resident's nurses' showed the staff did not document why the noted sliding scale insulin was held or notification of the physician at that time. Review of the resident's nurse progress note dated 06/18/24, at 9:41 A.M., showed resident had a shower, and the bath aide stated the resident's speech was not making any sense. Resident's blood sugar was 469 mg/dL. Nurse notified on call provider and received an order to give 13 units of Novolog at this time. Staff keeping the resident at nursing station to monitor. Review of the resident's physician's orders, active as of 06/17/24, showed an order, dated 06/18/24, for Novolog 100 unit/ml, inject 13 unit subcutaneously one time only for hyperglycemia. Review of the resident's MAR, dated 06/01/24 through 06/30/24, showed on 06/18/24, at 10:36 A.M., staff documented Novolog FlexPen 13 units one time only administered. Review of the resident's nurse progress note showed staff documented the following: -On 06/18/24, at 10:38 A.M., resident continued with elevated blood sugar at 448 mg/dL at 10:00 A.M. Vital signs showed blood pressure 76/52 mg/Hg (normal 120/80), pulse 54 (normal 60-100), respiration 17 (normal 12-20), oxygen 93% and (normal 95-100%) on room air. Notable decline in mental status. Nurse notified on call provider and new orders received to transport resident to emergency department for evaluation and treatment. Ambulance arrived and transporting resident at the time; -On 06/18/24, at 10:51 A.M., the resident transferred to the hospital. Review showed the facility did not provide an investigation of the medication error. During an interview on 08/16/24, at 11:00 A.M., RN F said the following: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-Staff should contact the pharmacy for missing medications on admission for stat (immediate) fill, especially critical medication such as insulin; -Staff should check the emergency kit to see if the medication is available there; -If unable to get the medication from the pharmacy, the nurse should notify the physician to receive new orders for a different medication or whether okay to hold until available from the pharmacy; -The nurse vaguely remembered the resident and said that the resident was difficult to keep aroused and alert that morning and after contacting the provider the resident was sent to the emergency room ; -The nurse was not aware the resident had not received the bedtime dose of insulin as ordered. During an interview on 08/16/24, at 12:18 P.M., LPN D said the following: -If a medication was not available, staff should mark the medication as not available and notify the DON; -If insulin was not available the nurse would contact the pharmacy to get sent immediately and check the emergency kit; -When insulin was not available the nurse should call the doctor to let him/her know and see if could give anything else; -Usually, the pharmacy delivered by nighttime, but sometimes not until the next morning. During an interview on 08/13/24, at 3:40 P.M., the DON said staff should call the pharmacy if medication was not available. Staff should contact the DON of medication errors. She was aware of the medication error. During an interview on 08/16/24, at 2:25 P.M., VP Clinical Services said the following: -Staff are expected to notify the DON or Assistant Director of Nursing (ADON) if a medication was not available; -Nursing staff should notify the physician if the medication would not be available regardless of the medication type; -The doctor should have the option to change the medication or approve to be held until received from the pharmacy; -After a medication error staff should do a root cause analysis to review why the error occurred. MO00240494 MO00238817