STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrew's at Francis Place	400 Summerville Blvd Eureka, MO 63025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 46104 Based on interview and record review, the facility failed to prevent misappropriation/diversion (the unauthorized removal) of controlled substances (medication that is regulated by the United States Drug Enforcement Administration (DEA) due to the potential of causing dependency and abuse) for 11 residents (Residents #11, #14, #15, #16, #17, #18, #13, #10, #19, #12 and #20) who resided on both the Northeast and Southwest side of the facility. The census was 103. Review of the facility's Resident Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy, revised date 1/2017, showed: -Policy: The facility affirms the right of our residents to be free from verbal, sexual, physical, mental abuse, neglect, misappropriation of resident property, crime, corporal punishment, exploitation and/or involuntary seclusion. This facility is committed to establishing a resident sensitive and secure environment. The facility will not knowingly employ or otherwise engage a person who has a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, and involuntary seclusion, mistreatment of residents or misappropriation of resident property or exploitation. Individuals who have been convicted of abusing, neglecting, mistreating individuals, or criminal activity prohibited by license and regulation, will not be employed; -Investigating and reporting of abuse and neglect: -2. There are two types of reporting procedures; (internal reporting procedures and external reporting procedures) for the reporting of all alleged, suspected or witnessed incidents of abuse; -3. The internal reporting procedures are distinct and based on the facility reporting procedures. The investigation will consist of: -a. An interview with the person(s) reporting the incident; -b. Interviews with any witnesses to the incident; -c. An interview with the resident; -d. A review of the resident's medical record; (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Additional considerations: -Reasonable suspicion of crime: -If the events indicate there is a reasonable suspicion of crime involving a resident that results in serious bodily injury, the report must be made immediately after forming the suspicion, but not later than two hours after forming the suspicion. Otherwise, the report must be made within twenty-four hours to the DHSS Regional Office and local law enforcement; -Reporting can be done by telephone, electronic mail, fax or other means within the specified timelines of the law; -Attachment B, facility self-report form: -3. The reporting facility's documentation must include the following information: -A. Specific description of the incident (the date, time, and location of the alleged incident); -B. The names, social security numbers, date of birth and cognitive status of the resident(s); -C. A description of the resident(s) injury; -D. Names, addresses, telephone numbers and position or relationship of the witness(es). For employees, also include date of birth and social security number; -E. What corrective actions the facility has taken to prevent the incident from reoccurring; -F. Statements must be signed and dated; -G. All pertinent information on staff/resident perpetrators; -H. Any other supporting information, i.e., nursing notes, monthly summaries, resident assessment instrument, care plan, physician notes, etc; -Attachment C, Notice reporting reasonable suspicion of a crime: -All employees of the facility have the following responsibilities and rights under Federal law: -If you reasonably suspect that a crime has occurred against a resident or person receiving care in the facility you must report that suspicion to the ED, who will then coordinate timely reporting to the police and DHSS Regional Office/Hotline or you may report it directly to those agencies; -You must make the report within two hours after you first suspect that a crime has occurred if the suspected crime involves serious bodily injury to the individual or within twenty-four hours if there is no serious bodily injury involved; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Note: If you fail to report your reasonable suspicion of a crime, you may be subject to a civil monetary penalty of up to $300,000 and/or you may be excluded from participation in any Federal health care program. Review of the facility's Discrepancies, Loss, and/or Diversion of Medications policy, effective 5/2018, showed: -Policy: All discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and report filed; -Procedures: -A. Immediately upon the discovery or suspicion of a discrepancy, suspected loss of diversion, the Administrator/ED, Director of Nursing (DON) and Consultant Pharmacist are notified, and an investigation conducted. The DON leads the investigation: -1. The information is not to be discussed with other individuals; -2. During the process, the Consultant Pharmacist will verify suspected loss; -B. Discrepancy in a drug count: -1. The DON investigates the discrepancy and researches all the records related to medication administration and the supply of the medication, including medication reconciliation. Medication reconciliation is made from the last known date and time of reconciliation (e.g., during the last shift count, receipt of a full medication container, etc.). A thorough search in all drug storage areas, the resident's room and other locations where medications may have been used/placed during the medication administration are made to locate any missing container or medication supply; -2. After a thorough investigation has been completed and the discrepancy cannot be reconciled, the remaining supply is documented with date and time and the accountability process restarts at this point. The discrepancy is documented unable to reconcile.; -3. Accountability of the medication in question should be checked several times in the following days to assure that accountability is being maintained; -4. Any corrective action that the DON feels is appropriate should be taken; -5. Appropriate agencies, required by state regulation will be notified; -C. Loss of a supply of a medication: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A. The DON and the consultant pharmacist in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications; -B. Medications supplied by the provider pharmacy shall identify medications as controlled medicines, either as a part of the label (i.e., a red letter C stamped on the label), or by sending a controlled medicine count sheet with the medication, or both; -C. All controlled substances, Schedule two controlled substance (CII, medication with higher potential of dependency and abuse), Schedule three controlled medication (CIII, medication with low to moderate potential of dependency and abuse), Schedule four controlled substance (CIV, medication with low potential of dependency and abuse), Schedule five controlled substance (CV, lowest potential of dependency and abuse)) CII through CV are stored and maintained in a locked cabinet or compartment. If refrigeration is required, the refrigerator or a container kept in the refrigerator is locked; -E. Accurate accountability of the inventory of all controlled medicines is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the Medication Administration Record (MAR): -1. Date and time of administration (MAR, Accountability Record); -2. Amount administered (Accountability Record); -3. Remaining quantity (Accountability Record); -4. Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record); -F. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container (i.e., not back in inventory). It must be destroyed according to facility policy and the disposal documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules. This does not apply to controlled medicines packaged in unit-dose containers that are unopened (vials, ampules, patches); -H. All controlled medications arc reordered when a minimum five-day supply remains to allow time for acquisition and transmittal of the required original written prescription to the provider pharmacy, if necessary. Review of the facility's Controlled Substance Audit policy, review date of 2/2019, showed: -Policy statement: To keep accurate records of all controlled substances in accordance with State and Federal laws; -Equipment: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1. Key to locked box where controlled substances for residents on the division for which the Certified Medication Technician (CMT)/Certified Medication Aide (CMA)/Nurse is assuming responsibility are kept; -2. Individual Resident's Controlled Substance Record and Narcotic Count Sign-In Sheet for CMT/CMA/Charge Nurse to inventory together at change of shift; -Procedure: -1. Drugs are to be stored in the same order as the Controlled Records for a fast and efficient audit; -2. When a controlled substance is administered to a resident the Medication Card is to be initialed next to where the pill is punched out by the person who is administering the drug; -3. When a controlled substance is administered to a resident the CMT/CMA/Nurse will sign his/her name under administered by, fill in the date, time, total on hand, amount given and amount remaining; -4. On-coming CMT/CMA/Nurse will actually count drugs. Off-going CMA/CMT/Charge Nurse will follow and verify record; -5. All controlled drugs will be counted between each shift for safe, accurate accountability; -6. When audit is complete, both CMA/CMT/Charge Nurse from each shift will sign audit sheet in appropriate spaces; -7. Narcotic keys will only be carried by the CMT/CMA or by the Nurse, but not by both the CMT/CMA and a Nurse; -8. When a controlled substance record is full, the form is to be forwarded to the Wellness Director/Resident Care Director/DON. 1. Review of the facility's investigation, not dated, showed: -Interview regarding allegation of missing narcotics: It was brought to the attention of the DON on 1/22/24 that there were some irregularities noted on the narcotic sign out sheets. The DON began investigating narcotic sign out sheets and Medication Administration Records for comparison. On 1/24/24, the pharmacy consultant reported to DON and ED that four oxycodone (opioid used to treat moderate to severe pain) were missing from the emergency kit; -Interview of Resident #12 was interviewed by Nurse Manager B. Resident #12 was asked when he/she usually takes his/her pain medication. The resident reported typically he/she just takes it one time in the evening around bedtime; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Additional party #1 information: ED; -Additional party #2 information: DON; -Subject information: LPN B; -Charges: Elder Abuse, third degree, stealing - controlled substance/meth (CII) manufacturing material; -Property #1 information: -Property roles: stolen; -Property classification: drug/narcotics; -Quantity: one; -Article: oxycodone; -Property value: $200.00; -Property #2 information: -Property roles: stolen; -Property classification: drug/narcotics; -Quantity: one; -Article: acetaminophen/hydrocodone (Norco, opioid, used for moderate-to-severe pain control); -Property value: $1.00; -Property #3 information: -Property roles: stolen; -Property classification: drug/narcotics; -Quantity: one; -Article: Percocet (Percocet, opioid, used for moderate-to-severe pain control); -Property value: $1.00; -Property #4 information: -Property roles: stolen; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Property classification: drug/narcotics; -Quantity: one; -Article: Ativan (Lorazepam, used to treat anxiety); -Property value: $1.00; -Incident property totals: -Total stolen value: $203.00; -Narrative: - On 02/02/2024 at 2:31 P.M., Police Officer (PO) A was dispatched to the facility for a theft of narcotics. Upon PO A arrival, he/she met with the ED and DON who stated their employee LPN B had been observed on video stealing various narcotics which included: Oxycodone, Norco, Percocet and Ativan which were all controlled substances. The narcotics totaled 60 Units on 10 different days. Per the facility policy, the facility investigated LPN B where he/she could be observed taking the medication from the lock box and placing it into his/her pocket. LPN B was informed by the facility someone had been removing medication and not providing it to the residents in the facility and was requested to complete a drug screen on 1/26/2024. LPN B declined to provide a drug screen and voluntarily resigned that day. The facility was made aware LPN B's nursing license was placed on probation which was terminated on 12/23/2023 for a previous charge of possession of a controlled substance. LPN B was hired by the facility on 1/08/2024 and officially started on 1/10/2024. Upon review of the video surveillance, LPN B can be observed stealing the narcotics on: 1/10/2024, 1/12/2024, 1/13/2024, 1/14/2024, 1/15/2024, 1/16/2024, 1/18/2024, 1/19/2024, 1/22/2024, 1/23/2024, 1/24/24. It should be noted there were also four Oxycodone missing from the facility's emergency kit, but cannot be tied to LPN B. The facility has a Narcotic Sign Out sheet which was audited due to the medication concern. Upon the audit, one signature was noted signing out several medications for several different patients, including one who did not have a medication order in their file. The facility reported LPN B to the State Board of Nursing, as well as DHSS. At this time, I have not received the videos from the facility. Once obtained, will be attached to this report. Charges will be submitted to the Prosecuting Attorney's Office; -Investigative information: -Narrative: -On 02/03/2024 at approximately 11:00 A.M., PO A attempted to make contact with the facility in an attempt to obtain the video footage of the incident. I was informed the video was still unavailable and would likely not be available until 02/05/2024; -On 02/07/2024, 02/08/2024, and 02/12/2024, PO A attempted to obtain the video footage from the facility in which PO A was informed the footage was not ready; -On 02/09/2024, I sent an email to DON and the ED of the facility requesting the video footage - which I have not received a response to at this time; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-PO A will continue to follow up; -Narrative: On 02/13/2024, PO A entered a Wanted into REJIS (provides data processing services and online information systems for police) for LPN B; -Narrative: On 02/15/2024, PO A received video footage which appeared to show LPN B placing the medication into his/her pocket and leaving. The video has been uploaded and placed into evidence per department policy. 3. Review of summary of termination conversation with LPN B, dated 2/28/24, showed: -Summary of termination conversation with LPN B from: ED: On 1/26/24, LPN B was asked to meet with the DON and ED regarding our investigation into missing narcotics. The ED and DON informed LPN B at the start of the investigation that we would also be completing a drug screen at the conclusion of our meeting and LPN B was agreeable to submitting a drug test. The DON asked LPN B if he/she was aware of any misappropriation of medications during the time he/she was working or if he/she may have knowledge or information from any co-workers. LPN B said no, he/she was not aware of anything missing or had no knowledge of anyone else that he/she works with here at the facility. The ED asked LPN B if at any time in his/her career had concerns been brought up against him/her regarding misappropriation of medications and LPN B once again stated no - nothing. The ED took a second and asked again and he/she repeated no, there were never any concerns of this nature. The ED then excused himself from the conversation to go and print off a letter addressed to LPN B from the State Board of Nursing regarding an investigation against him/her about misappropriation of medications (in his/her past). The letter was a follow up (warning), requesting that LPN B complete a treatment program and after a period of time with approval, he/she was allowed to continue working in the nursing field as an LPN. I asked LPN B to review the letter that I printed, and he/she read the letter and stated that the letter was inaccurate (meaning they messed up that facts) of this investigation. LPN B stated that he/she understood that this did not look good on his/her behalf (meaning that we caught him/her in a lie when asked earlier in the conversation). At this point, LPN B said he/she would not be able to participate in a drug test and we informed him/her that he/she would be self-terminating his/her position at the facility and LPN B said he/she understood. LPN B collected his/her personal belongings and was escorted out the front door by the DON. Immediately following, we contacted the State Board of Nursing, the DHSS, and the ED spent the rest of the afternoon making calls to the families to make them aware of the incident. 4. Review of statement from LPN C, undated, showed: -On January 22 LPN C noticed that one of Resident #14's Oxycodone had been slowly being signed out by the same nurse. Since LPN C has been employed at the facility this resident has not had complaints of pain or requested pain medication, nor has the resident showed non-verbal signs of pain. LPN C also noticed that Resident #10's Ativan had two tablets taken and signed out wasted. LPN C reported this to the DON immediately. 5. Review of LPN B's Employee Timesheet, dated 1/7/24 through 2/3/24, showed: -Monday, 1/8/24, from 9:30 A.M. to 1:00 P.M., LPN, Inservice/Orientation; -Monday, 1/8/24, from 3:20 P.M. to 11:45 P.M., LPN Skilled Nursing Facility (SNF); (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tuesday, 1/9/24, from 2:30 P.M. to Wednesday 1/10/24 12:00 A.M., LPN SNF; -Wednesday, 1/10/24, from 2:30 P.M. to 11:20 P.M., LPN SNF; -Friday, 1/12/24, from 2:30 P.M. to Saturday 1/13/23 7:45 A.M., LPN SNF; -Saturday, 1/13/24, from 2:30 P.M. to Sunday 1/14/24 7:15 A.M., LPN SNF; -Sunday, 1/14/24, from 2:30 P.M. to Monday 1/15/24 7:30 A.M., LPN SNF; -Monday, 1/15/24, from 8:30 P.M. to Tuesday 1/16/24 7:40 A.M., LPN SNF; -Tuesday, 1/16/24, from 2:53 P.M. to Wednesday 1/17/24 3:55 A.M., LPN SNF; -Thursday, 1/18/24, from 2:32 P.M. to 11:37 P.M., LPN SNF; -Friday, 1/19/24, from 2:41 P.M. to Saturday 1/20/24 8:11 A.M., LPN SNF; -Monday, 1/22/24, from 2:37 P.M. to 11:22 P.M., LPN SNF; -Tuesday, 1/23/24, from 7:43 A.M. to 11:40 P.M., LPN SNF; -Wednesday, 1/24/24, from 2:51 P.M. to Thursday 1/25/24 12:00 A.M., LPN SNF. 6. Review of Resident #11's quarterly Minimum Data Set (MDS). a federally mandated assessment completed by facility staff, dated 1/3/24, showed: -Cognitively intact; -High-Risk drug classes use and indication, opioid: -Not checked as taking; -Not checked as indicated; -Pain management: -Been on scheduled pain medication regimen, no; -Received PRN pain medications, no; -Pain presence, no; -Pain frequency, not rated; -Pain effect on sleep, not rated; -Pain interference with day-to-day activities, not rated; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included hip fracture, pain in right hip, scoliosis (curvature of the spine), asthma and cognitive communication deficit. Review of the Physician Order Sheet (POS), dated 11/1/23 through 2/29/24, showed, Hydrocodone-Acetaminophen (Norco, opioid, used for moderate-to-severe pain control) 5-325 milligram (mg) one tablet every six hours as needed (PRN) for pain, with an order date of 11/7/23 and a discontinue date of 2/19/24. Review of the resident's controlled drug record for Norco 5-325 mg every six hours PRN for pain, dispensed 11/8/23, showed LPN B signed out the medication on the following dates: -One tablet on 1/10/24 at 5:00 P.M.; -One tablet on 1/13/24 at 7:00 P.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46104 Based on interview and record review, the facility failed to ensure all alleged violations involving misappropriation/diversion (the unauthorized removal) of controlled substances (medication that is regulated by the United States Drug Enforcement Administration (DEA) due to the potential of causing dependency and abuse) were reported within twenty-four hours to the Department of Health and Senior Services (DHSS), law enforcement, and the Board of Nursing after the facility was made aware of allegations of diversion for 11 residents (Residents #11, #14, #15, #16, #17, #18, #13, #10, #19, #12 and #20) by two nurses, Licensed Practical Nurse (LPN) C and LPN D on the morning of 1/22/24. The census was 103. Review of the facility's Resident Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy, revised date 1/2017, showed: -Policy: The facility affirms the right of our residents to be free from verbal, sexual, physical, mental abuse, neglect, misappropriation of resident property, crime, corporal punishment, exploitation and /or involuntary seclusion. This facility is committed to establishing a resident sensitive and secure environment. The facility will not knowingly employ or otherwise engage a person who has a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, and involuntary seclusion, mistreatment of residents or misappropriation of resident property or exploitation. Individuals who have been convicted of abusing, neglecting, mistreating individuals, or criminal activity prohibited by license and regulation, will not be employed; -Investigating and reporting of abuse and neglect: -2. There are two types of reporting procedures; (internal reporting procedures and external reporting procedures) for the reporting of all alleged, suspected or witnessed incidents of abuse; -3. The internal reporting procedures are distinct and based on the facility reporting procedures. The investigation will consist of: -a. An interview with the person(s) reporting the incident; -b. Interviews with any witnesses to the incident; -c. An interview with the resident; -d. A review of the resident's medical record; -e. An interview with staff members (on all shifts) having contact with the resident during the period of the alleged incident; -f. Interviews with the resident's roommate, family members, and visitors; and; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-g. A review of circumstances surrounding the incident; -4. Refer to the Guidelines for Facility Self-Report Form (See Attachment B) to report to DHSS; - The facility will follow the external reporting process based on the licensure requirements for the facility. Skilled nursing facilities will follow Centers for Medicare & Medicaid Services (CMS) guidelines and state licensure; -5. Any unusual incident involving the reporting of a reasonable suspicion of a crime involving a resident will be reported to DHSS and any local police department per regulatory requirement and CMS guidelines; -6. The facility will immediately investigate reports by staff and board members under this policy, and third party reports of abuse or neglect, in accordance with the investigation procedures addressed in this policy; -7. The Executive Director (ED) and/or their designee, in conjunction with other executive staff as appropriate, will ensure that it takes appropriate action in response to alleged, witnessed or un-witnessed incident of resident abuse or neglect; -8. The ED and/or their designee will notify the facility management services, the DHSS Regional Office (or the DHSS Hotline), resident representative, personal attending physician and medical director of the ensuing investigation and any action taken so far; -9. The ED and/or their designee will report to the facility management services, the DHSS Regional Office, resident representative, personal attending physician and medical director the results of the reasonable alleged, suspected or witnessed incident of abuse and neglect investigations. -10. The ED and/or their designee in conjunction with the facility management services will determine the appropriate management action(s) to be taken as a result of the findings of investigation, confirm action to be taken with Human Resources at the facility and notify DHSS Regional Office and police (if deemed necessary) of actions taken; -Management roles and responsibilities: -4. The ED and/or their designee will assure the employee(s) whom are alleged to have committed the abuse or neglect are suspended pending investigation until the investigation is completed and a final report is made. -6. If the events indicate there is a reasonable suspicion of crime involving a resident that results in serious bodily injury, the report must be made immediately after forming the suspicion, but not later than two hours after forming the suspicion. Otherwise, the report must be made within twenty-four hours to the DHSS Regional Office and the local police department; -7. Maintain the security and integrity of the physical evidence at the incident, including documenting this evidence appropriately; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Reporting can be done by telephone, electronic mail, fax or other means within the specified timelines of the law; -Attachment B, facility self-report form: -3. The reporting facility's documentation must include the following information: -A. Specific description of the incident (the date, time, and location of the alleged incident); -B. The names, social security numbers, date of birth and cognitive status of the resident(s); -C. A description of the resident(s) injury; -D. Names, addresses, telephone numbers and position or relationship of the witness(es). For employees, also include date of birth and social security number; -E. What corrective actions the facility has taken to prevent the incident from reoccurring; -F. Statements must be signed and dated; -G. All pertinent information on staff/resident perpetrators; -H. Any other supporting information, i.e., nursing notes, monthly summaries, resident assessment instrument, care plan, physician notes, etc; -Attachment C, Notice reporting reasonable suspicion of a crime: -All employees of the facility have the following responsibilities and rights under Federal law: -If you reasonably suspect that a crime has occurred against a resident or person receiving care in the facility you must report that suspicion to the ED, who will then coordinate timely reporting to the police and DHSS Regional Office/Hotline or you may report it directly to those agencies; -You must make the report within two hours after you first suspect that a crime has occurred if the suspected crime involves serious bodily injury to the individual or within twenty-four hours if there is no serious bodily injury involved; -Note: If you fail to report your reasonable suspicion of a crime, you may be subject to a civil monetary penalty of up to $300,000 and/or you may be excluded from participation in any Federal health care program. Review of the facility's Discrepancies, Loss, and/or Diversion of Medications policy, effective 5/2018, showed: -Policy: All discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and report filed; -Procedures: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A. Immediately upon the discovery or suspicion of a discrepancy, suspected loss of diversion, the Administrator/ED, Director of Nursing (DON) and Consultant Pharmacist are notified, and an investigation conducted. The DON leads the investigation: -1. The information is not to be discussed with other individuals; -2. During the process, the Consultant Pharmacist will verify suspected loss; -B. Discrepancy in a drug count: -1. The DON investigates the discrepancy and researches all the records related to medication administration and the supply of the medication, including medication reconciliation. Medication reconciliation is made from the last known date and time of reconciliation (e.g., during the last shift count, receipt of a full medication container, etc.). A thorough search in all drug storage areas, the resident's room and other locations where medications may have been used/placed during the medication administration are made to locate any missing container or medication supply; -2. After a thorough investigation has been completed and the discrepancy cannot be reconciled, the remaining supply is documented with date and time and the accountability process restarts at this point. The discrepancy is documented unable to reconcile.; -3. Accountability of the medication in question should be checked several times in the following days to assure that accountability is being maintained; -4. Any corrective action that the DON feels is appropriate should be taken; -5. Appropriate agencies, required by state regulation will be notified; -C. Loss of a supply of a medication: -1. The DON investigates the suspected loss and researches all the records related to medication receipt, its use since receipt, all persons involved with medication administration and the supply of the medication and identifies the last known point in time that the medication was available. The dispensing pharmacy should be notified, and the pharmacy should verify that the medication was actually dispensed. A thorough search in all drug storage areas, the resident's room and other locations where medications may have been used/placed during the medication administration are made to locate any missing container or medication supply; -2. After a thorough investigation has been completed and the supply cannot be found, a supply must be obtained for the resident; -3. Document the loss and the investigation process. Notify the prescriber and family if doses have been missed; -4. If the loss involves a controlled substance, all the controlled drug accountability procedures and documentation should be reviewed and audited; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3. When a controlled substance is administered to a resident the CMT/CMA/Nurse will sign his/her name under administered by, fill in the date, time, total on hand, amount given and amount remaining; -4. On-coming CMT/CMA/Nurse will actually count drugs. Off-going CMA/CMT/Charge Nurse will follow and verify record; -5. All controlled drugs will be counted between each shift for safe, accurate accountability; -6. When audit is complete, both CMA/CMT/Charge Nurse from each shift will sign audit sheet in appropriate spaces; -7. Narcotic keys will only be carried by the CMT/CMA or by the Nurse, but not by both the CMT/CMA and a Nurse; -8. When a controlled substance record is full, the form is to be forwarded to the Wellness Director/Resident Care Director/DON. 1. Review of the facility investigation, not dated, showed: -Interview regarding allegation of missing narcotics: It was brought to the attention of the DON on 1/22/24 that there were some irregularities noted on the narcotic sign out sheets. The DON began investigating narcotic sign out sheets and Medication Administration Records for comparison. On 1/24/24, the pharmacy consultant reported to DON and ED that 4 oxycodone (opioid used to treat moderate to severe pain) were missing from the emergency kit; -Resident #12 was interviewed by Nurse Manager B. Resident #12 was asked when he/she usually takes his/her pain medication. The resident reported typically he/she just takes it one time in the evening around bedtime; -Interview with witness: On 1/26/24, LPN B was brought in for interview regarding the medications in question. The DON explained the facility was investigating some medication that has been in question and just speaking with the nurses who have been signing out the medications. The facility asked LPN B for a urine specimen. LPN B said, If you give me a few minutes, I can. DON asked LPN B, How do you decide when to give a resident pain medication? LPN B said, When they express they are in pain or look like they are in pain, then I give them something. DON asked, Have you ever had this type of thing happen anywhere you worked before? LPN B responded, No. LPN B said, I am not going to be able to do your drug screen because my back hurts and I took some of my spouse's medication. The facility does have a few video clips where it appears that LPN B put narcotic medications in his/her pocket. The facility also has MARs and Narcotic Sign Out Sheets that demonstrate this complaint; -Interviews with other staff working at the time: Not Applicable (NA); -Interview with other residents on the same hall: NA; -Interview of other staff members: NA; -Review of resident's chart: NA; (continued on next page)

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	265195	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrew's at Francis Place	400 Summerville Blvd Eureka, MO 63025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Outcome: LPN B voluntarily resigned on 1/26/24, families were notified, the local police department was notified and the Missouri Board of Nursing was notified; -Complaint report to the Missouri Board of Nursing, dated 2/2/24: -On 1/20/24, it was brought to the attention of the DON that residents who do not usually take much pain medication are suddenly taking more doses than expected. DON began auditing narcotic sign out sheets and noted same signature appearing multiple times for numerous residents. Upon comparison of narcotic sign out sheets to the MAR, it was noted that 60 times a narcotic was signed out but not documented by the same nurse. It was also noted a narcotic was signed out for a resident who did not have an active order. On 1/22/24, pharmacy consultant was in to audit the emergency medication kit and noted 4 oxycodone to be missing from a card. Pharmacy consultant stated at that time there is no way for the pharmacy to tell who may have taken the 4 oxycodone because they only audit once a month and the camera only shows the face of the person using the system, not their hands. LPN B was identified as the signature that continued to show as the individual signing out the narcotics on the individual resident count sheets. On 1/26/24, LPN B was brought in for interview in regard to the medications in question. DON explained the facility was investigating some medication that has been in question and just speaking with the nurses who have been signing out the medications. The DON requested a urine specimen. LPN B said, If you give me a few minutes, I can. DON asked LPN B, How do you decide when to give a resident pain medication? LPN B said, When they express they are in pain or look like they are in pain, then I give them something. DON asked, Have you ever had this type of thing happen anywhere you worked before? LPN B said, No. LPN B said, I am not going to be able to do your drug screen because my back hurts and I took some of my spouses medication. The facility does have a few video clips where it appears that LPN B put the narcotic medications in his/her pocket. The facility also has MAR and narcotic sign out sheets that demonstrate this complaint; -Description of complaint: -Date of incidents: 1/26/24; -Time: 3:00 P.M.; -Has this complaint been reported to any other agency, court, or other entity: yes; -Name: DHSS; -The facility included MARs and controlled drug records (narcotic sign out sheets) for 10 residents (Residents #19, #17, #12, #13, #16, #18, #20, #15, #11 and #14); -The facility did not recognize the additional resident, Resident #10 in the investigation, who was reported to the DON on 1/22/24. 2. Review of Police Department Investigative Report, dated 2/2/24, showed: -Date/Time received: 2/2/24 at 2:30 P.M.; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Date/Time dispatch: 2/2/24 at 2:31 P.M.; -Date/Time arrival: 2/2/24 at 2:35 P.M.; -Offense: Stealing/Elder Abuse; -Victim #1 information: Resident #18; -Victim #2 information: Resident #15; -Victim #3 information: Resident #13; -Victim #4 information: Resident #16; -Victim #5 information: Resident #12; -Victim #6 information: Resident #11; -Victim #7 information: Resident #14; -Victim #8 information: Resident #17; -Victim #9 information: Resident #19; -Victim #10 information: Resident #20; -Resident #10 was not identified; -Additional party #1 information: ED; -Additional party #2 information: DON; -Subject information: LPN B; -Charges: Elder Abuse, third degree, stealing - controlled substance/meth (CII) manufacturing material; -Property #1 information: -Property roles: stolen; -Property classification: drug/narcotics; -Quantity: one; -Article: oxycodone; -Property value: $200.00; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Property #2 information: -Property roles: stolen; -Property classification: drug/narcotics; -Quantity: one; -Article: acetaminophen/hydrocodone (Norco, opioid, used for moderate-to-severe pain control); -Property value: $1.00; -Property #3 information: -Property roles: stolen; -Property classification: drug/narcotics; -Quantity: one; -Article: Percocet (Percocet, opioid, used for moderate-to-severe pain control); -Property value: $1.00; -Property #4 information: -Property roles: stolen; -Property classification: drug/narcotics; -Quantity: one; -Article: Ativan (Lorazepam, used to treat anxiety); -Property value: $1.00; -Incident property totals: -Total stolen value: $203.00; -Narrative: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 02/02/2024 at 2:31 P.M., Police Officer (PO) A was dispatched to the facility for a theft of narcotics. Upon PO A arrival, he/she met with the ED and DON who stated their employee LPN B had been observed on video stealing various narcotics which included: Oxycodone, Norco, Percocet and Ativan which were all controlled substances. The narcotics totaled 60 Units on 10 different days. Per the facility policy, the facility investigated LPN B where he/she could be observed taking the medication from the lock box and placing it into his/her pocket. LPN B was informed by the facility someone had been removing medication and not providing it to the residents in the facility and was requested to complete a drug screen on 1/26/2024. LPN B declined to provide a drug screen and voluntarily resigned that day. The facility was made aware LPN B's nursing license was placed on probation which was terminated on 12/23/2023 for a previous charge of possession of a controlled substance. LPN B was hired by the facility on 1/08/2024 and officially started on 1/10/2024. Upon review of the video surveillance, LPN B can be observed stealing the narcotics on: 1/10/2024, 1/12/2024, 1/13/2024, 1/14/2024, 1/15/2024, 1/16/2024, 1/18/2024, 1/19/2024, 1/22/2024, 1/23/2024, 1/24/24. It should be noted there were also four Oxycodone missing from the facility's emergency kit, but cannot be tied to LPN B. The facility has a Narcotic Sign Out sheet which was audited due to the medication concern. Upon the audit, one signature was noted signing out several medications for several different patients, including one who did not have a medication order in their file. The facility reported LPN B to the State Board of Nursing, as well as DHSS. At this time, I have not received the videos from the facility. Once obtained, will be attached to this report. Charges will be submitted to the Prosecuting Attorney's Office; -Investigative information: -Narrative: -On 02/03/2024 at approximately 11:00 A.M., PO A attempted to make contact with the facility in an attempt to obtain the video footage of the incident. I was informed the video was still unavailable and would likely not be available until 02/05/2024; -On 02/07/2024, 02/08/2024, and 02/12/2024, PO A attempted to obtain the video footage from the facility in which PO A was informed the footage was not ready; -On 02/09/2024, I sent an email to DON and the ED of the facility requesting the video footage - which I have not received a response to at this time; -PO A will continue to follow up; -Narrative: On 02/13/2024, PO A entered a Wanted into REJIS (provides data processing services and online information systems for police) for LPN B; -Narrative: On 02/15/2024, PO A received video footage which appeared to show LPN B placing the medication into his/her pocket and leaving. The video has been uploaded and placed into evidence per department policy. 3. Review of summary of termination conversation with LPN B, dated 2/28/24, showed: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Summary of termination conversation with LPN B from: ED: On 1/26/24, LPN B was asked to meet with the DON and ED regarding our investigation into missing narcotics. The ED and DON informed LPN B at the start of the investigation that we would also be completing a drug screen at the conclusion of our meeting and LPN B was agreeable to submitting a drug test. The DON asked LPN B if he/she was aware of any misappropriation of medications during the time he/she was working or if he/she may have knowledge or information from any co-workers. LPN B said no, he/she was not aware of anything missing or had no knowledge of anyone else that he/she works with here at the facility. The ED asked LPN B if at any time in his/her career had concerns been brought up against him/her regarding misappropriation of medications and LPN B once again stated no - nothing. The ED took a second and asked again and he/she repeated no, there were never any concerns of this nature. The ED then excused himself from the conversation to go and print off a letter addressed to LPN B from the State Board of Nursing regarding an investigation against him/her about misappropriation of medications (in his/her past). The letter was a follow up (warning), requesting that LPN B complete a treatment program and after a period of time with approval, he/she was allowed to continue working in the nursing field as an LPN. I asked LPN B to review the letter that I printed, and he/she read the letter and stated that the letter was inaccurate (meaning they messed up that facts) of this investigation. LPN B stated that he/she understood that this did not look good on his/her behalf (meaning that we caught him/her in a lie when asked earlier in the conversation). At this point, LPN B said he/she would not be able to participate in a drug test and we informed him/her that he/she would be self-terminating his/her position at the facility and LPN B said he/she understood. LPN B collected his/her personal belongings and was escorted out the front door by the DON. Immediately following, we contacted the State Board of Nursing, the DHSS, and the ED spent the rest of the afternoon making calls to the families to make them aware of the incident. 4. Review of statement from LPN C, undated, showed: -On January 22 LPN C noticed that one of the Resident #14's, Oxycodone had been slowly being signed out by the same nurse. Since LPN C has been employed at the facility this resident has not had complaints of pain or requested pain medication, nor has the resident showed non-verbal signs of pain. LPN C also noticed that Resident #10's Ativan had two tablets taken and signed out wasted. LPN C reported this to the DON immediately. 5. Review of LPN B's Employee Timesheet, dated 1/7/24 through 2/3/24, showed: -Monday, 1/8/24, from 9:30 A.M. to 1:00 P.M., LPN, Inservice/Orientation; -Monday, 1/8/24, from 3:20 P.M. to 11:45 P.M., LPN Skilled Nursing Facility (SNF); -Tuesday, 1/9/24, from 2:30 P.M. to Wednesday 1/10/24 12:00 A.M., LPN SNF; -Wednesday, 1/10/24, from 2:30 P.M. to 11:20 P.M., LPN SNF; -Friday, 1/12/24, from 2:30 P.M. to Saturday 1/13/23 7:45 A.M., LPN SNF; -Saturday, 1/13/24, from 2:30 P.M. to Sunday 1/14/24 7:15 A.M., LPN SNF; -Sunday, 1/14/24, from 2:30 P.M. to Monday 1/15/24 7:30 A.M., LPN SNF; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30687 Based on interview and record review, the facility failed to prevent further misappropriation/diversion (the unauthorized removal) of controlled substances (medication that is regulated by the United States Drug Enforcement Administration (DEA) due to the potential of causing dependency and abuse) by not following the facility's policy for suspension during an investigation. Licensed Practical Nurse (LPN) C and LPN D reported alleged violations of misappropriation/diversion by LPN B on the morning of 1/22/24. The facility allowed LPN B to continue working on 1/22/24, 1/23/24, and 1/24/24, while the facility investigated the allegation. LPN B continued the misappropriation/diversion with nine residents (Resident #11, #15, #16, #17, #18, #13, #19, #12 and #20) during the three days LPN B was not suspended. The facility also failed to submit a completed investigation of a resident's missing [NAME] (a device that allow you to use your voice to access information from the web, play music and control smart home devices) to the Department of Health and Senior Services (DHSS) within the required timeframe (Resident #1). In addition, the facility failed to conduct a thorough investigation, by not interviewing additional staff and residents, regarding a resident's missing wallet and money (Resident #8). The sample was 20. The census was 103. Review of the facility's Resident Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy, revised date 1/2017, showed: -Policy: The facility affirms the right of our residents to be free from verbal, sexual, physical, mental abuse, neglect, misappropriation of resident property, crime, corporal punishment, exploitation and/or involuntary seclusion. This facility is committed to establishing a resident sensitive and secure environment. The facility will not knowingly employ or otherwise engage a person who has a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, and involuntary seclusion, mistreatment of residents or misappropriation of resident property or exploitation. Individuals who have been convicted of abusing, neglecting, mistreating individuals, or criminal activity prohibited by license and regulation, will not be employed. -Investigating and reporting of abuse and neglect: -2. There are two types of reporting procedures; (internal reporting procedures and external reporting procedures) for the reporting of all alleged, suspected or witnessed incidents of abuse; -3. The internal reporting procedures are distinct and based on the facility reporting procedures. The investigation will consist of: -a. An interview with the person(s) reporting the incident; -b. Interviews with any witnesses to the incident; -c. An interview with the resident; -d. A review of the resident's medical record; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-7. Maintain the security and integrity of the physical evidence at the incident, including documenting this evidence appropriately; -8. Reporting must be done by either calling the DHSS Regional Office or calling the Hotline within the specified timelines of the law; -Theft/Misappropriation: -The facility must timely report any reasonable suspicion of a crime against a resident of, or who is receiving care from the facility; -Reports must be submitted to the DHSS Regional Office during normal business hours or through the DHSS Hotline and at least one law enforcement agency of jurisdiction. (Law enforcement is defined as the full range of potential responders to elder abuse, neglect and exploitation including: police, sheriffs, detectives, public safety officers, prosecutors, medical examiners, investigators and coroners.); -If there is not serious bodily injury, the report must be made not later than 24 hours after forming the suspicion; -The facility is subjected to civil money penalty and exclusion sanctions for failure to meet the reporting obligations of the statute; therefore, any reasonable suspicion of a crime against a resident shall be reported to the Department of Health and Senior Services and to the police department if warranted; -Investigation Path: -Definition: Misappropriation (theft) of resident property is the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent; -Determination whether a missing item is theft: All missing items need to be investigated in accordance with the facility's missing items protocol. However, the loss of an item in and of itself does not constitute theft. The theft of socks, underwear, housecoats. glasses, or dentures, IS very unlikely, despite the initial concerns of an upset resident or family member; -There are two specific instances where theft should be considered: -The theft value of a piece of property. Any missing money, jewelry, watches, or large fixed property, such as radios or TVs should be considered and treated as a possible theft, until there are clear indications that the property was mislaid or lost by means other than theft; -Decision to Proceed: -If there is a suspicion of theft involved, proceed with investigation procedures mentioned in steps six and seven of investigating and reporting of abuse and neglect; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6. The facility will immediately investigate reports by staff and board members under this policy, and third party reports of abuse or neglect, in accordance with the investigation procedures addressed in this policy; -7. The ED and/or their designee, in conjunction with other executive staff as appropriate, will ensure that it takes appropriate action in response to alleged, witnessed or un-witnessed incident of resident abuse or neglect; -Additional considerations: -Reasonable suspicion of crime: -If the events indicate there is a reasonable suspicion of crime involving a resident that results in serious bodily injury, the report must be made immediately after forming the suspicion, but not later than two hours after forming the suspicion. Otherwise, the report must be made within twenty-four hours to the DHSS Regional Office and local law enforcement; -Reporting can be done by telephone, electronic mail, fax or other means within the specified timelines of the law; -Attachment B, facility self-report form: -3. The reporting facility's documentation must include the following information: -A. Specific description of the incident (the date, time, and location of the alleged incident); -B. The names, social security numbers, date of birth and cognitive status of the resident(s); -C. A description of the resident(s) injury; -D. Names, addresses, telephone numbers and position or relationship of the witness(es). For employees, also include date of birth and social security number; -E. What corrective actions the facility has taken to prevent the incident from reoccurring; -F. Statements must be signed and dated; -G. All pertinent information on staff/resident perpetrators; -H. Any other supporting information, i.e., nursing notes, monthly summaries, resident assessment instrument, care plan, physician notes, etc; -Attachment C, Notice reporting reasonable suspicion of a crime: -All employees of the facility have the following responsibilities and rights under Federal law: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrew's at Francis Place	400 Summerville Blvd Eureka, MO 63025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If you reasonably suspect that a crime has occurred against a resident or person receiving care in the facility you must report that suspicion to the ED, who will then coordinate timely reporting to the police and DHSS Regional Office/Hotline or you may report it directly to those agencies; -You must make the report within two hours after you first suspect that a crime has occurred if the suspected crime involves serious bodily injury to the individual or within twenty-four hours if there is no serious bodily injury involved; -Note: If you fail to report your reasonable suspicion of a crime, you may be subject to a civil monetary penalty of up to $300,000 and/or you may be excluded from participation in any Federal health care program. Review of the facility's Discrepancies, Loss, and/or Diversion of Medications policy, effective 5/2018, showed: -Policy: All discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and report filed; -Procedures: -A. Immediately upon the discovery or suspicion of a discrepancy, suspected loss of diversion, the administrator/ED, Director of Nursing (DON) and Consultant Pharmacist are notified, and an investigation conducted. The DON leads the investigation: -1. The information is not to be discussed with other individuals; -2. During the process, the Consultant Pharmacist will verify suspected loss; -B. Discrepancy in a drug count: -1. The DON investigates the discrepancy and researches all the records related to medication administration and the supply of the medication, including medication reconciliation. Medication reconciliation is made from the last known date and time of reconciliation (e.g., during the last shift count, receipt of a full medication container, etc.). A thorough search in all drug storage areas, the resident's room and other locations where medications may have been used/placed during the medication administration are made to locate any missing container or medication supply; -2. After a thorough investigation has been completed and the discrepancy cannot be reconciled, the remaining supply is documented with date and time and the accountability process restarts at this point. The discrepancy is documented unable to reconcile.; -3. Accountability of the medication in question should be checked several times in the following days to assure that accountability is being maintained; -4. Any corrective action that the DON feels is appropriate should be taken; -5. Appropriate agencies, required by state regulation will be notified; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A. The DON and the consultant pharmacist in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications; -B. Medications supplied by the provider pharmacy shall identify medications as controlled medicines, either as a part of the label (i.e., a red letter C stamped on the label), or by sending a controlled medicine count sheet with the medication, or both; -C. All controlled substances, (schedule two controlled substance (CII, medication with higher potential of dependency and abuse), Schedule three controlled medication (CIII, medication with low to moderate potential of dependency and abuse), Schedule four controlled substance (CIV, medication with low potential of dependency and abuse), Schedule five controlled substance (CV, lowest potential of dependency and abuse)) CII through CV are stored and maintained in a locked cabinet or compartment. If refrigeration is required, the refrigerator or a container kept in the refrigerator is locked; -E. Accurate accountability of the inventory of all controlled medicines is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the Medication Administration Record (MAR): -1. Date and time of administration (MAR, Accountability Record); -2. Amount administered (Accountability Record); -3. Remaining quantity (Accountability Record); -4. Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record); -F. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container (i.e., not back in inventory). It must be destroyed according to facility policy and the disposal documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules. This does not apply to controlled medicines packaged in unit-dose containers that are unopened (vials, ampules, patches); -H. All controlled medications arc reordered when a minimum five-day supply remains to allow time for acquisition and transmittal of the required original written prescription to the provider pharmacy, if necessary. Review of the facility's Controlled Substance Audit policy, review date of 2/2019, showed: -Policy statement: To keep accurate records of all controlled substances in accordance with State and Federal laws; -Equipment: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1. Key to locked box where controlled substances for residents on the division for which the Certified Medication Technician (CMT)/ Certified Medication Aide (CMA)/Nurse is assuming responsibility are kept; -2. Individual Resident's Controlled Substance Record and Narcotic Count Sign-In Sheet for CMT/CMA/Charge Nurse to inventory together at change of shift; -Procedure: -1. Drugs are to be stored in the same order as the Controlled Records for a fast and efficient audit; -2. When a controlled substance is administered to a resident the Medication Card is to be initialed next to where the pill is punched out by the person who is administering the drug; -3. When a controlled substance is administered to a resident the CMT/CMA/Nurse will sign his/her name under administered by, fill in the date, time, total on hand, amount given and amount remaining; -4. On-coming CMT/CMA/Nurse will actually count drugs. Off-going CMA/CMT/Charge Nurse will follow and verify record; -5. All controlled drugs will be counted between each shift for safe, accurate accountability; -6. When audit is complete, both CMA/CMT/Charge Nurse from each shift will sign audit sheet in appropriate spaces; -7. Narcotic keys will only be carried by the CMT/CMA or by the Nurse, but not by both the CMT/CMA and a Nurse; -8. When a controlled substance record is full, the form is to be forwarded to the Wellness Director/Resident Care Director/DON. 1. Review of Resident #11's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 1/3/24, showed: -Cognitively intact; -High-Risk drug classes use and indication, opioid: -Not checked as taking; -Not checked as indicated; -Pain management: -Been on scheduled pain medication regimen, no; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Received PRN pain medications, no; -Pain presence, no; -Pain frequency, not rated; -Pain effect on sleep, not rated; -Pain interference with day-to-day activities, not rated; -Diagnoses included hip fracture, pain in right hip, scoliosis (curvature of the spine), asthma and cognitive communication deficit. Review of the physician order summary (POS), dated 11/1/23 through 2/29/24, showed Hydrocodone-Acetaminophen (Norco, opioid, used for moderate-to-severe pain control) 5-325 milligram (mg) one tablet every six hours as needed (PRN) for pain, with an order date of 11/7/23 and a discontinue date of 2/19/24. Review of the resident's controlled drug record for Norco 5-325 mg every six hours PRN for pain, dispensed 11/8/23, showed LPN B signed out the medication on the following dates between 1/22/24 and 1/24/24: -One tablet on 1/23/24 at 10:00 A.M.; -The medication was signed out six times by LPN B in January. The medication was only signed out one other time in January as administered by another nurse. Review of the electronic MAR (eMAR), dated 1/1/24 through 1/31/24, showed 1/23/24 Norco 5-325 mg every six hours PRN for pain, no documentation that PRN pain medication was administered at 10:00 A.M., pain level for day shift was documented as zero by LPN B. 2. Review of Resident #15's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -High-Risk drug classes use and indication, opioid: -Checked as taking; -Checked as indicated; -Pain management: -Been on scheduled pain medication regimen, yes; -Received PRN pain medications, no; -Pain presence, yes; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pain frequency, almost constantly; -Pain effect on sleep, frequently; -Pain interference with day-to-day activities, almost constantly; -Pain intensity, rating scale 0-10 (pain level 1 through 10; 0 = no pain, 1 through 3 = mild pain, 4 through 6 = moderate pain, 7 through 10 = severe pain), 10; -Diagnoses included dementia, heart failure, respiratory failure, high blood pressure, low back pain and chronic pain. Review of the POS, dated 11/1/23 through 2/29/24, showed: -Oxycodone-Acetaminophen (Percocet, opioid, used for moderate-to-severe pain control) 10-325 mg 1 tablet every six hours PRN for pain, with an order date of 9/11/23; -Morphine Sulfate (MS Contin, opioid, used for moderate-to-severe pain control) 15 mg extended release (ER) 1 tablet four times daily (6:00 A.M., 12:00 P.M., 5:00 P.M., 9:00 P.M.) for pain, with an order date of 10/23/23, discontinue date of 2/16/23. Review of the resident's controlled drug record for Percocet 10-325 mg every 6 hours PRN for pain, dispensed 12/20/23, showed LPN B signed out the medication on the following dates between 1/22/24 and 1/24/24: -One tablet on 1/22/24 at 3:00 P.M.; -One tablet on 1/22/24 at 10:00 P.M.; -One tablet on 1/23/24 at 9:00 A.M.; -One tablet on 1/23/24 at 3:00 P.M.; -One tablet on 1/23/24 at 8:00 P.M.; -One tablet on 1/24/24 at 3:00 P.M.; -One tablet on 1/24/24 at 8:00 P.M.; -LPN B signed out the Percocet 10-325 mg every 6 hours PRN for pain on 1/23/24 at 3:00 P.M. and 8:00 P. M., which was more frequent than the physician order of one tablet every 6 hours; -LPN B signed out the Percocet 10-325 mg every 6 hours PRN for pain on 1/24/24 at 3:00 P.M. and 8:00 P. M., which was more frequent than the physician order of one tablet every 6 hours. Review of the resident's controlled drug record for MS Contin 15 mg four times (6:00 A.M., 12:00 P.M., 5:00 P.M., 9:00 P.M.) daily for pain, dispensed 1/15/24, showed LPN B signing out the medication on the following dates between 1/22/24 and 1/24/24: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One tablet on 1/22/24 at 4:00 P.M.; -One tablet on 1/22/24 at 9:00 P.M. Review of the resident's controlled drug record for MS Contin 15 mg four times (6:00 A.M., 12:00 P.M., 5:00 P.M., 9:00 P.M.) daily for pain, dispensed 1/19/24, showed LPN B signed out the medication on the following dates between 1/22/24 and 1/24/24: -One tablet on 1/23/24 at 12:00 P.M.; -One tablet on 1/23/24 at 4:00 P.M.; -One tablet on 1/23/24 at 9:00 P.M.; -One tablet on 1/24/24 at 4:00 P.M.; -One tablet on 1/24/24 at 9:00 P.M. Review of the eMAR, dated 1/1/24 through 1/31/24, showed MS Contin 15 mg four times (6:00 A.M., 12:00 P.M., 5:00 P.M., 9:00 P.M.) daily for pain, no documentation as administered between 1/22/24 and 1/24/24, on 1/23/24 at 9:00 P.M. 3. Review of Resident #16's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -High-Risk drug classes use and indication, opioid: -Not checked as taking; -Not checked as indicated; -Pain management: -Been on scheduled pain medication regimen, yes; -Received PRN pain medications, no; -Pain presence, no; -Pain frequency, occasionally; -Pain effect on sleep, rarely or not at all; -Pain interference with day-today activities, rarely or not at all; -Diagnoses included Alzheimer's (dementia), high blood pressure, cognitive communication deficit and stroke. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the POS, dated 11/1/23 through 2/29/24, showed: -Lorazepam (Ativan, used to treat anxiety) 0.5 mg every 24 hours PRN for anxiety for 14 days, order date of 10/23/23, discontinue date of 11/14/23; -Lorazepam 0.5 mg every 24 hours PRN for anxiety for 14 days, with an order date of 1/16/24, discontinue date of 1/30/24. Review of the resident's controlled drug record for Lorazepam 0.5 mg 1 tablet every 24 hours PRN for anxiety, dispensed 9/12/23, showed LPN B signed out the medication on the following dates between 1/22/24 and 1/24/24, one tablet on 1/24/24 at 4:00 P.M. Review of the eMAR, dated 1/1/24 through 1/31/24, showed Lorazepam 0.5 mg 1 tablet every 24 hours PRN for anxiety, no documentation that PRN anxiety medication was administered on 1/24/24 at 4:00 P.M. 4. Review of Resident #17's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -High-Risk drug classes use and indication, opioid: -Checked as taking; -Checked as indicated; -Pain management: -Been on scheduled pain medication regimen, no; -Received PRN pain medications, yes; -Pain presence, yes; -Pain frequency, rarely or not at all; -Pain effect on sleep, rarely or not at all; -Pain interference with day-today activities, rarely or not at all; -Pain intensity, rating scale 0-10, 3; -Diagnoses included coronary artery disease (CAD, arteries that supply blood to heart muscle become hardened and narrowed), high blood pressure, muscle weakness, difficulty in walking and repeated falls. Review of the POS, dated 11/1/23 through 2/29/24, showed Tramadol (Ultram, used to relieve moderate to moderately severe pain) 50 mg 1 tablet every six hours PRN for pain, order date of 10/11/23. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's controlled drug record for Tramadol 50 mg 1 tablet every six hours PRN for pain, dispensed 12/18/23, showed LPN B signed out the medication on the following dates between 1/22/24 and 1/24/24: -One tablet on 1/23/24 at 8:00 A.M.; -One tablet on 1/24/24 at 3:00 P.M. Review of the eMAR, dated 1/1/24 through 1/31/24, showed, the following between 1/22/24 and 1/24/24: -1/23/24 Tramadol 50 mg every six hours PRN for pain, no documentation that PRN pain medication was administered at 8:00 A.M., pain level for day shift was documented as zero by LPN B; -1/24/24 Tramadol 50 mg every six hours PRN for pain, no documentation that PRN pain medication was administered at 3:00 P.M., pain level for evening shift was documented as zero by LPN B. 5. Review of Resident #18's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -High-Risk drug classes use and indication, opioid: -Not checked as taking; -Not checked as indicated; -Pain management: -Been on scheduled pain medication regimen, yes; -Received PRN pain medications, yes; -Pain presence, yes; -Pain frequency, frequently; -Pain effect on sleep, rarely or not at all; -Pain interference with day-today activities, rarely or not at all; -Pain intensity, rating scale 0-10, 5; -Diagnoses included dementia, high blood pressure and respiratory failure. Review of the POS, dated 11/1/23 through 2/29/24, showed, Norco 5-325 mg one tablet every 12 hours PRN for pain, ordered 11/22/23, discontinue date 3/18/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included a-fib, heart failure, respiratory failure, intervertebral disc degeneration (breakdown of one or more of the discs that separate the bones of the spine, causing pain in the back or neck) and chronic pain. Review of the POS, dated 11/1/23 through 2/29/24, showed: -Morphine sulfate (opioid, used to help relieve moderate to severe pain) solution 20 MG/Milliliter (ML), give 0. 25 ml two times a day (10:00 A.M. and 4:00 P.M.) for chronic pain, order date 12/27/23, discontinued 2/23/24; -Methadone Hydrochloride (HCL) (opioid, used to treat moderate to severe pain) 10 mg one tablet three times a day (6:00 A.M., 2:00 P.M., 9:00 P.M.) for pain, ordered on 12/29/24, discontinued 3/8/24; -Oxycodone HCL (opioid, used to treat moderate to severe pain) 5 mg one tablet every eight hours PRN for pain, ordered on 6/19/23. Review of the resident's controlled drug record for Oxycodone HCL 5 mg one tablet every eight hours PRN for pain, dispensed 6/19/23, showed LPN B signed out the medication on the following dates between 1/22/24 and 1/24/24: -One tablet on 1/22/24 at 5:00 P.M.; -One tablet on 1/23/24 at 10:00 A.M.; -One tablet on 1/24/24 at 6:00 P.M.; -LPN B signed out the residents scheduled pain medication at the same time as the PRN medication on 1/23/24 at 10:00 A.M. Review of the resident's controlled drug record for Methadone HCL 10 mg one tablet three times a day (6:00 A.M., 2:00 P.M., 9:00 P.M.), second sheet labeled dispensed 1/10/24, showed LPN B signed out the medication on the following dates between 1/22/24 and 1/24/24:: -One tablet on 1/22/24 at 8:00 P.M.; -One tablet on 1/23/24 at 2:00 P.M.; -One tablet on 1/23/24 at 9:00 P.M.; -One tablet on 1/24/24 at 9:00 P.M. Review of the resident's controlled drug record for Morphine sulfate 0.25 ml two times a day (10:00 A.M. and 4:00 P.M.) for chronic pain, received 6/3/23, showed LPN B signed out the medication on the following dates, between 1/22/24 and 1/24/24: -1/22/24, 0.25 ml at 4:00 P.M.; -1/23/24, 0.25 ml at 10:00 A.M.; (continued on next page)

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	265195	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrew's at Francis Place	400 Summerville Blvd Eureka, MO 63025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/23/24, 0.25 ml at 4:00 P.M.; -1/24/24, 0.25 ml at 4:00 P.M. Review of the eMAR, dated 1/1/24 through 1/31/24, showed: -Methadone HCL 10 mg one tablet three times a day (6:00 A.M., 2:00 P.M., 9:00 P.M.) for pain: -Signed out on 1/22/24 at 9:00 P.M.; -Signed out on 1/23/24 at 2:00 P.M.; -Signed out on 1/23/24 at 9:00 P.M.; -Signed out on 1/24/24 at 9:00 P.M. Review of the eMAR, dated 1/1/24 through 1/31/24, showed: -Morphine sulfate solution 20 MG/ML give 0.25 ml two times a day (10:00 A.M. and 4:00 P

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 30687 Based on observation, interview and record review, the facility failed to follow a Nurse Practitioner's (NP) order of a stat (immediate) x-ray of a resident's right shoulder and right humerus (upper arm bone) after the resident had a fall while ambulating with his/her rollater walker (Resident #2). In addition, the facility failed to document the incident of the resident's fall in his/her medical record and failed to investigate the fall. The sample size was 20. The census was 103. Review of the facility's Fall Risk Reduction, review dated 2/2019, showed the following: -Purpose: To identify residents at risk for falls and implement interventions to reduce risks, to ensure appropriate and prompt follow up of resident falls to reduce risk of further falls and to measure effectiveness of fall reduction interventions; -Actions Steps Following a Fall: -First be sure that the resident is safe; -Do not move the resident until the resident has been assessed by a licensed nurse; -Don't move the resident if you suspect possible fracture; -Provide basic first aide if indicated; -Make sure the resident is comfortable; -Ask the resident what were you doing just prior to the fall, what was different this time (even residents with dementia may be able to tell you). -Observe and preserve the fall scene. Preserve any faulty equipment involved; -Call 911, as indicated by severity of injury and vital signs; -Contact the resident's physician (or NP on-call); -Take additional appropriate action as indicate; -Investigate the fall and review in Resident At Risk Meeting; -Documentation in the Medical Record: -Time of fall; -What happened-THE FACTS; -Findings of resident physical evaluation/assessment; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Conduct an updated fall risk assessment and time the physician was notified. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/26/24, showed the following: -Severe cognitive impairment; -No moods or behaviors; -No impairment of extremities and ambulation with a walker; -Diagnoses of high blood pressure and dementia; -One fall with no injury and one fall with an injury. Review of the facility's video footage, dated 2/14/24 at approximately 6:31 P.M., showed the resident ambulating with his/her walker and falling to the floor. At approximately 6:32 P.M., a dietary aide ran down the hall to get help. At approximately 6:35 P.M., Registered Nurse (RN) M arrived. The resident was assisted to a wheelchair by two Certified Nurse Aides (CNA). Review of the resident's medical record, showed no documentation regarding this fall. During an interview on 2/20/24 at 12:12 P.M., the resident said his/her arm hurts but did not remember how he/she hurt it. Observation at that time, showed the resident had a shoulder sling on his/her right arm. During an interview on 2/22/24 at 7:45 A.M., RN M said he/she was told a resident had a fall. He/She went to assess the resident, got him/her in a wheelchair and took him/her back to his/her room. The resident was not complaining of pain. RN M called the on-call nurse for the facility, but did not remember who he/she called. He/She called the NP and the NP gave an order for an x-ray. The NP did not give the order for the x-ray to be stat. RN M said he/she called the x-ray company but could not get in touch with anyone. He/She gave report to the oncoming Charge Nurse, but did not document in the resident's chart. He/She said he/she was never trained to chart in the facility's electronic health record system. He/She was not able to schedule the x-ray but did not call the NP back. He/She just passed on the information about the fall in report. During an interview on 2/21/24 at 2:42 P.M., Licensed Practical Nurse (LPN) N said he/she came on duty on the night shift and RN M was working. RN M told him/her a resident had a fall but RN M did not remember the resident's name. LPN N said another CNA told him/her the name of the resident who had the fall. LPN N went to work the floor so RN M could finish working on the fall documentation. LPN N said he/she heard RN M call someone but did not know who. LPN N was not made aware the stat x-ray order was given. LPN N would have followed up on the order had he/she known. The resident was monitored during the night shift and did not complain of any pain. The resident has dementia so he/she may not have complained. He/She did not see any documentation on the resident's fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nurse's note, dated 2/15/24 at 10:57 A.M., showed this nurse had contacted NP O about the resident having excruciating pain in his/her right arm and the resident is unable to move his/her extremity. The NP informed this nurse that resident had a fall last night that RN M had reported and he/she had ordered stat x-rays to right shoulder and right humerus. This nurse put in stat order for right shoulder and right humerus through to the x-ray company and called and notified resident's family. The orders were processed and oncoming shift staff to be made aware. During an interview on 2/20/24 at 1:43 P M., LPN C said the resident was complaining of pain to his/her right shoulder on 2/15/24. The resident's right shoulder was swollen and he/she did not get anything in report from the night nurse. LPN C called the NP and was informed stat x-rays were ordered on the evening of 2/14/24. LPN C notified the Nurse Manager and called for the stat x-ray for the resident. During an interview on 2/27/24 at 9:59 A.M., Nurse Manager (NM) A said the Director of Nursing (DON) is on call from Monday 7:00 A.M. to Friday at 3:00 P.M. NM A found out about the fall on 2/15/24 during the day shift from LPN C. RN M told him/her he/she was familiar with the facility's electronic health record system because he/she had worked with the system in the past. At 1:50 P.M., NM A said he/she was not made aware of the fall or the x-rays until LPN C told him/her. He/She expected the stat x-ray orders to be followed as given. Review of the resident's radiology report, dated 2/15/24 at 2:54 P.M., showed the following: -Procedure: X-ray right humerus two views; -Findings: There is an age-indeterminate (presumed acute or subacute) complex fracture. Review of the nurse's note, dated 2/15/24 at 4:06 P.M., showed, the x-ray was completed at the bedside today following fall on 2/14/24. The x- ray report was received and reported to NP. This nurse was instructed to send the resident to hospital immediately for treatment. The resident's right humerus was broken. Review of the resident's nurse's notes, dated 2/15/24 at 10:21 P M., showed the resident back from the hospital visit. The resident was sent out with a complaint of pain in his/her right arm. The resident was sent back from hospital with new orders for Hydrocodone-acetaminophen (treatment for pain) 5/325 milligrams (mg) one tablet as needed (PRN) every six hours. During an interview on 2/21/24 at 2:21 P.M., NP O said on 2/14/24 at 7:00 P.M., RN M called about a resident with pain to the right arm. An order for a stat x-ray of the resident's right shoulder and humerus was ordered. NP O said he/she was not aware the order was not followed. Mostly likely the resident was in pain. NP O said had RN M called back and said he/she could not contact the x-ray company, an order for the resident to be sent to the hospital for evaluation would have been given. The resident returned from the hospital with pain medication. During an interview on 2/27/24 at 10:08 A.M., the DON said she was the on-call person and she did not receive a call from RN M regarding the fall. She expected RN M to follow the fall protocol and follow the NP's orders. The Administrator was present and agreed with the DON. MO00231576 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46104

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30687 Based on interview and record review, the facility failed to provide two person care in accordance with the care plan, during perineal (the areas between and including the hips, to include the anal and genital areas) care which resulted in a resident rolling out of bed onto the floor for one of 20 sampled residents (Resident #1). The census was 103. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/5/24, showed the following: -Moderate cognitive impairment; -No moods or behaviors; -Impairment of lower extremities on both sides; -Dependent for toileting hygiene, helper must do everything; -Dependent for rolling left to right; -Diagnoses of multiple sclerosis (MS, a potentially disabling disease of the brain and spinal cord) and depression. Review of the resident's care plan, dated 7/19/23, showed the following -Focus: The resident has an activity of daily living (ADL) self-care performance deficit; -Goal: Resident will maintain current level in ADL performance through next review; -Intervention: BED MOBILITY: The resident is dependent on two staff to turn and reposition in bed. Review of the resident's nurse's note, dated 2/6/24 at 1:22 A.M., showed upon arriving for my shift, I witnessed the Certified Nurse Aide (CNA) running down the hall to the nurses station to ask staff for help. A resident had fallen on the floor while he/she was cleaning the resident. This nurse along with several other staff hurried to the room. Upon entering the resident's room, this nurse saw the resident on the floor belly down and his/her head resting on his/her arm. The resident was conscious and said he/she wanted to get up and he/she was not sure what happened. There were two small abrasions to outer right thigh noted. Triple antibiotic ointment was applied to area smaller than a dime and the resident's family and doctor were notified. During an interview on 2/20/24 at 9:33 A.M., the resident said he/she had a fall from his/her bed while being cleaned. The resident said two people should give him/her care at all times for safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/24 at 10:46 A.M. CNA J said he/she had positioned the resident on his/her left side. CNA J said he/she had his/her left hand on the resident's shoulder while providing perineal care. The bed was about waist high and the bed was about five to six inches away from the wall. All of a sudden, the resident rolled and slid down the wall and onto the floor. CNA J said he/she was not aware the resident was a two person assist during care. CNA J found out after the incident, from the Charge Nurse. CNA J would look at the resident's medical record to see how to assist the resident but the information was not there. CNA J was not familiar with the facility's iPhone. CNA J has only worked with the resident a couple of times. During an interview on 2/27/24 at 11:15 A.M., CNA K said CNAs can look at the designated facility's iPhone to see the care of a resident. Observation at that time, with CNA K, showed documentation in the facility's iPhone, the resident required two person assistance during care. CNA K said if a resident cannot turn on their own, the resident should be a two person assist. During an interview on 2/27/24 at 11:25 A.M., CNA L said he/she has the resident today on his/her assignment. CNA L heard from a previous CNA the resident had a fall. CNA L was not aware the facility's iPhone could access the resident care information. CNA L did not use it. CNA L would look at the resident's chart for information on the resident's care. During an interview on 2/28/24 at 8:37 A.M., the Director of Nursing (DON) said CNAs coming on shift will do rounds with the previous CNA who will tell what they know about each resident. The DON said the CNAs can access the resident information through the facility's iPhone which has the resident's care plan and how to give care. Staff are educated on this system upon hire at orientation. The DON said she was not aware CNAs did not know how to access the information through the facility's iPhone. The DON expected staff to check the facility iPhone before giving care. At that time, the Administrator agreed with the DON. MO00231576 46104