STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265225	A. Building B. Wing	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Living Center	415 Sidney Street, Saint James, MO 65559

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 39439 Based on interview and record review, facility staff failed to prevent the misappropriation of one resident's (Resident #1's) narcotic medications when Certified Nurse Assistant (CNA) A took the medication without authorization of the residents or the residents' responsible parties. The facility census was 53. 1. Review of the facility's Abuse Prohibition Policy, dated November 2017, showed the policy defined misappropriation of resident's property as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. 2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment instrument, dated 9/17/2023, showed staff assessed the resident as follows: -Cognitively Intact; -Diagnosis of pain in the right hip, and hypertrophic osteoarthropathy (a syndrome that is characterized by a periosteal reaction of the long bones without an underlying bone lesion; -Received scheduled pain management; -Received as needed pain medication. Review of the resident's Physician's Order Sheets (POSs), dated November 2023, showed an order for Oxycodone (narcotic pain medication) 10 milligrams (mg) take one half tablet by mouth every four hours. Review of the resident's Controlled Substance Log, dated 10/17/2023, showed the residentt received a medication card of 30 oxycodone 10 mg pills from the pharmacy. Review showed staff documented the total card count for the cart. Review of the resident's Controlled Drug Receipt form, dated 10/17/2023, showed the card of 30 oxycodone 10 mg had been entered on the form and none of the pills had been signed out as given. (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 - Few	Review of the facility's investigation, dated 10/27/23, showed Licensed Practical Nurse (LPN) B notified the Assistant Director of Nursing (ADON) CNA A had accessed the medication cart and administered Resident #1's narcotic pain medication. The facility identified when the medication was counted Resident #1's entire 30 count card was unaccounted for. The ADON notified the Administrator and the investigation started. The staff notified the police department, the resident's primary care physician (PCP), the appropriate state agency, and the resident's responsible party of the misappropriation. The Administrator terminated CNA B on 10/28/23 for misappropriation of resident's narcotic medication. During an interview on 11/3/23 at 11:30 A.M., LPN B said one of the techs came to him/her and reported CNA A had been in the medication cart. He/She said, I immediately counted the card and realized there was a full card of 30 oxycodone 10 mg missing for Resident #1. LPN B said he/she then went to CNA A and confronted him/her and he/she said Resident #1 had asked for a pain pill so he/she got the keys and gave it. When he/she asked where the card was and he/she could not produce it. He/She said He/she went into the office and contacted the ADON to report it. LPN B said the ADON arrived within ten minutes and the next thing he/she knew CNA A had bolted out the front door. The police arrived shortly after he/she had left and they never found the card of missing narcotics. During an interview on 11/3/23 at 12:00 P.M., the ADON said he/she was called by LPN B around 1:00 A.M. who reported CNA A had gotten into the medication cart and given a resident a pain medication. ADON said he/she decided to just head there since he/she is only a few minutes away. Upon arrival he/she was informed CNA A had fled out of the facility through the field and there was a missing card of oxycodone 10 mg for Resident #1. During an interview on 11/3/23 at 2:00 P.M., The Administrator and Director of Nursing (DON) said the nurses have in the past left the keys in a drawer at the nurses station and they would expect them to keep them on their person even when they are on a break as long as they are not leaving the facility. CNA A got the keys and got into the cart and passed an oxycodone 10 mg pill to Resident #1 and had reported to staff that he/she was a CMT. When the keys were returned to LPN B he/she found the entire card of oxycodone 10 mg was missing from the cart. The police were notified, Primary Care Physician notified, Investigation was started, and CNA A was terminated. During an interview on 11/9/23 at 8:40 A.M., CNA C said he/she had answered a call light and when he/she returned to the nurse's station CNA A asked what the resident wanted and he/she told him/her the resident was requesting a pain pill. CNA C said CNA A then got into the medication cart and was signing something in the book. CNA C said he/she got up and went to the other side where a different CNA was working to ask if CNA A was a Certified Medication Technician (CMT) because he/she did not believe he/she was but he/she did not know how to look it up. CNA C said he/she did not go to the nurse first because he/she was on break. CNA C said another nurse LPN E had come to the facility and so LPN B asked LPN E what he/she should do because he/she was fairly new to the facility. CNA A began acting strange at that point he/she had his/her bag and was clutching it under his/her arm as he/she walked around going in and out of bathrooms from one to the other. When the two LPN's went into the office they watched CNA A, first he/she tried to exit out a side door, then when he/she couldn't get out that door he/she walked down the other hall and the next thing he/she knew the front door alarm was sounding. CNA C said by the time he/she got to the front door CNA A was running through the field and was out of sight. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/9/23 at 9:33 A.M., LPN E said he/she had come to the facility to bring lunch and the staff was questioning him/her about whether CNA A was a CMT or not because he/she had reported passing Resident #1's narcotic pain pill. He/She said, I advised them to contact the ADON because I did not think he/she was a CMT. LPN B had also reported the entire card of 30 oxycodone 10 mg was missing. LPN B then contacted the ADON, and the police. LPN E said during this time CNA A had exited out the front door before the police could arrive. During an interview on 11/9/23 at 12:30 P.M., CNA F said he/she was working the hall with CNA A the night the police were called because he/she had gotten into the medication cart and gave Resident #1 a pain pill. He/She said this was maybe the third or fourth time he/she had worked with CNA A and he/she seemed nice. CNA F said this night however he/she was acting bizarre like going from one bathroom to another and would stay in there for like 15 minutes or so and then go to another one. He/She said at one point CNA A even disappeared for like 20 minutes and no one could find him/her. CNA F said there was also an incident earlier in the shift where a resident who is very alert and oriented began to scream and when he/she entered his/her room the resident reported that CNA A had tried to take his/her tray with his/her medications on it. CNA F said shortly before CNA A left the facility he/she had heard the medication drawer slam and he/she thought that is odd because the nurse had gone on break and when he/she got to the nurse's station CNA A was in the med cart. CNA F said he/she went to the nurse and reported it. When LPN B confronted CNA A he/she reported that he/she was a CMT. During an interview on 11/20/23 at 10:45 A.M., CNA A said he/she was told by LPN B to give the resident a pain pill and the keys were on top of the medication cart. He/She said the pill he/she gave was the last one in the card so he/she placed it at the nurse's station once given and he/she is unaware of where the other 29 pills went or why no one had signed any as given. He/She said yes he/she was aware that he/she was unlicensed to pass the medication to residents. CNA A said he/she could not explain why other staff reported that he/she got into the cart without permission and could not find the card of oxycodone after he/she got the keys back from him/her and counted the cart. MO00226478

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 39439 Based on interview and record review, facility staff failed to ensure oncoming and off-going staff members verified and reconciled the narcotic count as accurate at each shift change. The facility census was 53. 1. Review of the facility's Narcotic Count Policy, undated, showed staff are directed as follows: -Controlled substances are available only to Licensed Practical Nurses (LPN's), Registered Nurses (RN's), pharmacists, and certified medical technicians (CMT's); -One RN, LPN, CMT going off duty and one RN, LPN, or CMT coming on duty must count and justify accuracy of narcotics supply for each individual resident at the change of each shift; -After the supply is counted and justified, the nurses/CMT records the date and his/her signature, verifying the count is correct. 2. Review of the Narcotic Inventory Sheet, dated October 2023, showed staff did not document or record a signature to signify the count had been completed as follows: -10/1/23 all shifts (day 6-2, evening 2-10, and night 10-6); -10/2/23 day shift; -10/3/23 day shift; -10/4/23 day shift; -10/5/23 day and night shift; -10/6/23 evening and night shift; -10/7/23 all three shifts; -10/8/223 all three shifts; -10/9/23 day shift; -10/10/23 day shift; -10/11/23 day shift; -10/12/23 day shift; -10/13/23 day and night shifts; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/14/23 evening and night shift; -10/15/23 all three shifts; -10/16/23 evening shift; -10/17/23 evening shift; -10/18/23 night shift; -10/19/23 night shift; -10/20/23 evening and night shifts; -10/21/23 evening and night shifts; -10/22/23 evening and night shifts; -10/23/23 day and night shifts; -10/24/23 day and night shifts; -10/25/23 night shift; -10/26/23 day and night shift; -10/28/23 all three shifts; -10/29/23 all three shifts; -10/30/23 night shift; -10/31/23 night shift. During an interview on 11/3/23 at 12::00 P.M., the Assistant Director of Nurses (DON) said staff are expected to count narcotics with two nurses every shift. During an interview on 11/3/23 at 1:15 P.M., LPN H said one coming on duty and the one going off duty are supposed to count the narcotics and sign the narcotic count sheet. During and interview on 11/3/23 at 2:00 P.M., The Administrator and Director of Nurses (DON) said they expect nurses to sign together when coming on and leaving shift and they should be signing the count sheet as completed. The DON said the nurses have the bad habit of completing the count but they don't sign the book. He/She that is one thing that he/she plans to start some in-services with the licensed staff about to assure the counts are getting completed and signed. MO00226478