STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265253	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Healthcare & Rehabilitation Center	206 West First Street Lamar, MO 64759

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to protect each resident's right to be free from abuse from staff, when a staff member continued to provide cares to a resident against the resident's wishes and refusals for one resident (Resident #17). The facility had a census of 104. Review of the facility's policy titled Abuse Prevention Program, undated, showed the following: -The facility will not tolerate verbal (any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to a resident or their families or within hearing distance, regardless of their age, ability to comprehend, or disability), sexual (non-consensual sexual contact of any type with a resident), physical (not limited to hitting, biting, kicking), or mental (humiliation, harassment, and threat of punishment or deprivation) abuse, corporal punishment, involuntary seclusion (separation of a resident), neglect, or misappropriation of resident property (deliberate misplacement, exploitation), by employees, family members, visitors, or other residents; -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, or good or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents,irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including the abuse facilitated or enabled through the use of technology. Willful, laws used in the definition of abuse, means the individual must have acted deliberately, no that the individual must have intended to inflict injury or harm. 1. Review of Resident #17's face sheet showed the following: -admission date of 11/26/24; -Resident on hospice services; -Diagnoses included stroke with right sided hemiplegia (paralysis of one side of the body) and hemiparesis (partial paralysis on one side of the body), respiratory failure, depression, and osteoarthritis (a degenerative joint disease where the cartilage that cushions the ends of bones wears away over time). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS - a federally-mandated assessment tool completed by facility staff), dated 03/02/25, showed the following: -Cognitively intact; -Did not reject cares of exhibit any behavioral symptoms; -Functional limitation to range of motion in both lower extremities; -Dependent on staff for assistance with toileting hygiene, lower body dressing, and transfers; -Required substantial or maximal mobility assistance of staff with rolling left to right in bed, and with moving from lying to sitting or sitting to lying in bed; -Always incontinent of bowel and bladder. Review of the resident's care plan, revised on 04/11/25, showed the following: -Resident required substantial to dependent staff assistance wish most activities of daily living (ADLs); -Resident was dependent on staff assistance with transfers, lower body dressing, and putting on/taking off footwear; -Resident required substantial assistance with bed mobility; -Resident is noted to be resistive to care, especially during incontinence cares. He/she has multiple bowel movements during the night and does not want to be changed more than a couple of times. He/she believes staff is being rough with him/her if they need to change him/her more that he/she would like; -Resident has noted to swing out at staff during incontinent cares; -Educate the resident/family/caregiver on the possible outcomes of not complying with treatment or care; -Give clear explanation of all care activities prior to and as they occur during each contact; -If the resident resists with ADLs, reassure the resident, leave and return 5 to 10 minutes later and try again; -If possible, negotiate a time for ADLs so that the resident participates in the decision making process. Return at the agreed upon time; -Provide the resident with opportunities for choice during provision; -Provide consistency in care to promote comfort with ADLs. Maintain consistency in timing of ADLs, caregivers and routine, as mush as possible; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff to have the charge nurse explain to the resident why changing in necessary due to his/her wound and encourage/assist with changing. Review of the facility's abuse investigation involving the resident showed the following: -On 04/07/25, at 10:30 A.M., a hospice nurse reported the resident said one of the aides, working on the night of 04/06/25, rolled the resident over and the resident said the aide hurt him. The charge nurse and hospice nurse assessed the resident and found no injuries. The resident said the aide wiped his/her buttocks too hard and was rough. The facility began an investigation, notified the Department of Health and Senior Services (DHSS), and suspended the alleged perpetrator (AP), Certified Nurse Assistant (CNA) T. The CNA said he/she was unaware of any issues or concerns with the resident or his/her care of the resident. Other residents and staff interviewed denied any abuse; -On 04/10/25, after completing interviews, the management team met and did not feel this was abuse and that staff needed to involve the charge nurse when the resident was denying cares. Hospice also saw the resident twice per week and had seen no issues with any staff. The hospice aide did say the resident required encouragement to take a shower or a bed bath; -At that time, the facility took CNA T off of suspension and allowed him/her to return to work. The resident said he/she was okay with the CNA taking care of him/her and said, I don't care. I just want to sleep at night. Staff explained to the resident the importance of cleaning up after incontinence for the resident's skin. The resident said, I know, okay, yeah, yeah, I get it. During an interview on 04/14/25, at 11:55 A.M., CNA T said the following: -The facility suspended him/her because the resident said he/she was too aggressive during cares; -He/she recalled a few nights prior when the resident was cranky with CNA T and did not want to be changed after an incontinent episode; -At times, the resident did not like for staff to wake him/her up at night, even to change after incontinence of bowel or bladder; -The aide said when the resident refused to be changed, he/she changed the resident anyway; -The resident would say things like, I'm gonna turn you in, and Leave me alone, I'm trying to sleep, but when the resident said these things the aide continued on with changing the resident; -At times, the resident would yell, No! and would kick at the aide during cares; -When asked if he/she had ever reported the resident's refusals to a nurse, the aide said he/she did not believe so; -The aide said he/she did not want the resident to lay wet or soiled because that would be bad for the resident's skin. Observation and interview of the resident on 04/14/25, at 1:35 P.M., showed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident lay on his/her bed. The resident's bed was against the wall one one side; -The resident said there were approximately three aides (unsure of names) on the night shift who insisted on changing his/her incontinent brief/bedding when he/she did not want to be changed; -He refused care at times because these staff wipe his/her buttocks roughly. He/she refused to be changed after incontinent episodes at times due to the aides wiping him/her rough and turn him/her roughly and quickly. -If the staff were not rough, he/she would not refuse to be changed. During an interview on 04/15/25, at 10:16 A.M., Licensed Practical Nurse (LPN) W said the following: -If the resident refused or was resistive to being changed after an incontinent episode, the CNA should notify the charge nurse; -As a charge nurse, LPN W would advise the CNA to step away for a few minutes and attempt to re-approach or get someone else to try to talk with the resident; -Forcing cares on a resident would be considered abuse. During an interview on 04/15/25, at 12:13 P.M., Certified Nurse Aide (CNA) X said the following: -The resident refused to get out of bed at times; -He/she allowed some staff to care for him/her and refused other staff; -The resident said one girl on the night shift was a little rough with cares; -If the resident refused assistance with changing after incontinence, the aide should ask a different co-worker to try; -If the resident refused the second aide, the aides should notify the charge nurse of the resident's refusals; -The resident had the right to refuse cares. During an interview on 04/15/25 at 1:17 P.M., the MDS Coordinator/Infection Preventionist said the following: -He/she worked as an MDS Coordinator and nurse aide educator, but occasionally worked caring for residents; -If a resident refused cares, the aide should stop and notify the charge nurse and the nurse should go in an investigate the reason for the resident's refusal. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/25, at 1:46 P.M., the Assistant Director of Nursing (ADON) said the following: -The resident reported CNA T wiped his/her bottom too hard, but did not say staff were forcing care after he/she refused; -If a resident refused care, the CNA should have stopped and reported to the nurse; -The resident has the right of refusal; -The ADON said he/she asked the CNA if he/she rolled the resident too hard or forced him/her to roll over and the aide denied the allegations; -The CNA did not mention the resident was adamantly refusing cares; -It was not appropriate for staff to force a resident to do anything against their will; -The facility suspended the CNA during the investigation, but did not find any abuse. During an interview on 04/15/25 at 2:34 P.M., the Director of Nursing, said the following: -The ADON interviewed the CNA about the resident's allegation and the CNA said the resident had frequent bowel movements; -The aide said the resident declined the cares a lot; -The aide did not report this and he/she continued care after the resident refused; -If the resident refused cares, the aide should have left the room, and asked a different aide to attempt cares and tried a different approach to getting the resident to cooperate or ask the charge nurse for assistance; -Staff should not force cares on the resident because the resident had the right to refuse care and forcing care would be kind of like abuse. During an interview on 04/15/25 at 3:41 P.M., the facility Administrator said the following: -If a resident refused care, the aide should go and get another aide to try and assist the resident; -The aide should never force cares on a resident; -Making a resident do something against their will would be abuse; -The Administrator said the facility would be again suspending CNA T, in light of the new information of him/her allegedly forcing cares and conducting an investigation. MO00252384, MO00252718, MO00252720

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents from misappropriation of personal property when a staff member took two narcotic pain medication tablets from Resident #5's supply and when Resident #6, had over $700 of fraudulent purchases on his/her debit card made by a facility employee. The effected two sampled residents. The facility census was 98. Review of the facility policy titled, Abuse Prevention Program, dated 1999, showed the following: -Objective: Zero tolerance of verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property, by employees, family members, or other residents; -To develop and implement a system for identifying, preventing, and reporting any incident, or suspected incident, of abuse, neglect, mistreatment, or misappropriation of resident property; -Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent; -The Administrator shall keep the resident and/or his/her responsible party informed of the progress and the results of the investigation. 1. Review of Resident #5's face sheet showed: -Diagnoses of chronic pain, low back pain, anxiety disorder, major depression, and stroke. Review of the resident's care plan, revised on 05/25/25, showed: -Resident is at risk for increased pain and discomfort related to a diagnosis of chronic pain; -Follow up with the resident's physician and pain management as needed; -Medication provided as prescribed; -Monitor for effectiveness of medication; -Monitor for increased pain and discomfort; -Provide diversionary activities as needed; -Therapy to screen quarterly and as needed. Review of the resident's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 05/28/25, showed: -Cognitively intact; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Independent with most activities of daily living (ADLs); -No behavioral symptoms; -Diagnoses of schizophrenia, anxiety, and depression; -Staff administered as needed (PRN) pain medication; -Resident expressed frequent complaints of pain and rated his/her pain at an '8' (on a numeric scale of 0-10, with 10 being the most severe pain). Review of the resident's physician orders showed an order, dated 05/16/25, for Hydrocodone-Acetaminophen (Norco- a pain medication) oral tablet 5/325 milligram (mg). Staff to administer one tablet by mouth every 6 hours as needed for pain. Review of the resident's medication administration record for May 2025, showed: -An order for Hydrocodone-Acetaminophen oral tablet 5/325 mg. Give one tablet by mouth every 6 hours as needed for pain; -On 05/19/25 at 8:20 A.M., staff administered a dose of the medication for a pain level of '8' with effective results; -On 05/19/25 at 7:47 P.M., staff documented administration of a dose of the pain medication for a pain level of '9' with effective results; -Staff did not document administration of any other doses of the pain medication on 05/19/25. -Certified Medication Technician (CMT) D did not document he/she administered any doses of the resident's pain medication on the MAR on 5/19/25. Review of the resident's-controlled medication count sheet showed the following information: -Drug name: Norco 5/325 mg; -Directions: one tablet by mouth every 6 hours as needed for pain (PRN). Review of the facility's-controlled drug count signature page showed the following: -On 05/19/25 at 2:00 P.M., CMT D signed as the incoming staff; -On 05/19/25 at 10:00 P.M., CMT D signed as the outgoing staff; -On 05/19/25 at 10:00 P.M., Registered Nurse (RN) E signed as the incoming staff. Review of the resident's progress notes showed: -No entries dated 05/19/25. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Medication Administration Record (MAR) for May 2025 showed: -An order for Hydrocodone-Acetaminophen oral tablet 5/325 mg. Give one tablet by mouth every 6 hours as needed for pain; -On 05/20/25 at 10:45 A.M., a nurse documented administration of one dose of the medication for a pain level of '8' with effective results. Review of the resident's-controlled medication count sheet showed the following information: -Drug name: Norco 5/325 mg; -Directions: one tablet by mouth every 6 hours as needed for pain (PRN); -On 05/20/25 at 10:45 A.M., LPN A signed out one tablet of the medication for administration; On 05/20/25 at 6:45 P.M., LPN A and the ADON destroyed one tablet of the medication and did a corrected count. Review of the resident's progress notes showed: -No entries dated 05/20/25. During a phone interview on 06/05/25 at 1:21 P.M., Registered Nurse (RN) E said the following: -He/she worked full time at the facility 3:00 P.M. to 3:00 A.M., or sometimes until 7:00 A.M.; -On the night of 05/19/25 at around 11:00 P.M., CMT D was preparing to leave for the night (at the end of the CMT's shift); -RN E counted the controlled medications with CMT D and found Resident #6's Norco card contained 2 pills less than what the controlled medication count showed he/she should have in the medication card; -The CMT was unsure what happened to the medications; -RN E refused to take over responsibility for the cart with 2 missing pills; -The CMT went outside to his/her car and returned and said he/she was now ready to count; -The RN thought the CMT might have brought the pills inside from his/her car, but the replaced pills matched the exact appearance and number as the pills already in the card; -The CMT taped the 2 pills into the card and the nurse assumed responsibility for the cart and the CMT went home; -On 05/20/25 at approximately 5:00 P.M., RN E notified the ADON and the Administrator that CMT D taped two pills into Resident #5's Norco card on 05/19/25; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The ADON immediately audited the entire cart and removed the remaining taped in pill; -RN E said he/she did not think about the potential danger of the medication; -RN E said he/she assumed maybe the CMT had stolen and then returned the medications due to the count being short; -RN E said he/she sat in on a meeting with CMT D on 05/20/25 along with the DON, ADON, and Administrator; -During the meeting, CMT D said he/she had a personal prescription for Norco and on the night of 05/19/25, when he/she could not locate 2 of Resident #5's Norco, he/she went to his/her own car and pulled 2 pills from his/her prescription bottle to replace the resident's missing Norco tablets. He/she then taped the 2 pills into the resident's medication card; -CMT D denied taking any of the resident's pain medications, but said he/she was unsure where the two resident Norco tablets were; -In the meeting, the ADON said the nurse was supposed to sign with the CMT when administering PRN pain medications, but he/she was not aware of that before the meeting; -Generally, RN E assessed a resident's pain and documented the administration of the PRN medications on the resident's MAR, as well as the resident's pain level; -The CMTs generally gave residents their PRN pain medication and signed them off on the controlled medication count sheet. During an interview on 06/04/25 at 1:43 P.M., Resident #5 said the following: -He/she had chronic back pain and staff administered as needed (PRN) pain medication to treat the resident's pain; -The resident was not aware of any misappropriation of his/her property or medications. During an interview on 06/04/25 at 3:21 P.M., the Assistant Director of Nursing (ADON) said the following: -On 05/20/25, RN E reported that on the night of 05/19/25 at approximately 10:00 P.M., RN E began his/her shift and started counting the narcotics with off going Certified Medication Technician (CMT), CMT D. At that time, Resident #5's Norco medication card was short by 2 tablets when compared to the narcotic count sheet. RN E refused to accept the cart because of the missing pills. CMT E told the RN E, he/she had a personal prescription for the exact same medication in his/her vehicle and went out to his/her vehicle and came back in with two loose pills. CMT E then taped the pills into the resident's medication card. On 05/20/25, the ADON checked the resident's Norco card and found Licensed Practical Nurse (LPN) A administered one of the taped in pills earlier on 05/20/25 and the ADON and another nurse destroyed the second taped in pill. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 06/05/25 at 11:38 A.M., Pharmacist H, a representative of the facility's local pharmacy said the following: -It is not acceptable practice for an employee to take their personal prescription medication and place that medication in a resident's medication card and/or to administer that medication to a resident. During a phone interview on 06/05/25 at 4:08 P.M., CMT D said the following: -On the night of 05/19/25, he/she counted the cart by him/herself, and the controlled medication count was correct; -CMT D then gave his/her medication cart keys to RN E and finished his/her charting; -Approximately one hour later, he/she returned to count the controlled medications with RN E and at that time Resident #5's Norco card was 2 pills short according to the count sheet; -The CMT said he/she freaked out and went to his/her car and obtained 2 of his/her own personal Norco which were the same exact strength and taped his/her personal medication into the resident's Norco card, so the count would be correct; -When he/she returned to work on the afternoon of 05/20/25, he/she was told by the DON and ADON to come to the office and he/she told the DON, ADON, Administrator what he/she had done; -He/she had never taken any resident medications out of the facility or for personal use; -RN E was aware the CMT went to his/her car and obtained the 2 pills and RN E did not say anything about not doing it at the time; The CMT said he/she had never misappropriated any resident medication, but was unsure what happened to the resident's two Norco; -CMT D said he/she should not have replaced the resident's missing medication with his/her own personal medication and that it was, The dumbest thing I've ever done in my life. During an interview on 06/05/25 at 5:40 P.M., the Administrator said the following: -Two staff (nurses or CMTs), the oncoming and off going, should count the controlled resident medications at the beginning and end of each shift; -If the count is off, staff should do another count with another nurse, if the count is still off, the staff should contact the Administrator, or the ADON, DON, or on call nurse to notify of the situation; -CMT D should not have used personal medications to replace missing resident medications; -RN E should have reported immediately when this occurred. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #6's quarterly MDS, dated [DATE], showed: -admitted to the facility on [DATE] from the hospital; -Cognitively intact; -Resident required partial to moderate assistance of staff with toileting, showers, dressing, and transfers; -Resident required use of a walker or a wheelchair for mobility. Review of the resident's January 2025 monthly bank statement for his/her Direct Express card (provided by the facility with erroneous charges highlighted) showed the following charges allegedly not made by the resident: -On 01/03/25 charge for $81.19 at Wal-Mart; -On 01/03/25 charge for $1.61 at Wal-Mart; -On 01/06/25 charge for $162.80 at Amazon.com; -On 01/07/25 charge for $44.42 at Amazon.com -On 01/07/25 charge for $31.36 at Wal-Mart; -On 01/07/25 charge for $36.10 at Amazon.com; -On 01/11/25 charge for $55.31 at Amazon.com; -On 01/24/25 charge for $60.49 at Amazon.com. Total for January 2025 = $473.28. Review of the resident's February 2025 monthly bank statement for his/her Direct Express Card (provided by the facility with erroneous charges highlighted) showed the following charges allegedly not made by the resident: -On 02/01/25 charge for $17.25 at Amazon.com -On 02/02/25 charge for $96.52 at Amazon.com -On 02/02/25 charge for $63.88 at Amazon.com -On 02/06/25 charge for $89.87 at Amazon.com -On 02/06/25 charge for $41.21 at Amazon.com Total for February 2025 = $308.73. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Healthcare & Rehabilitation Center	206 West First Street Lamar, MO 64759

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	January and February 2025 total charges = $782.01 Review of the resident's care plan, revised on 05/31/25, showed: -Resident is at risk for impaired social interactions and disorganized thought process related to a diagnoses of a personal history of traumatic brain injury and bipolar (manic/depression); -Self report made 05/20/25 of money misappropriation by an ex-staff member; -Resident will ask for assistance from Social Services (SS) or the office manager with his/her funds if he/she has any issues or questions; -Assist with financial concerns as needed. Review of the resident's progress notes showed no notes related to the resident's allegations of misappropriation of property. During an interview on 06/04/25 at 11:05 A.M., the Business Office Manager (BOM) said the following: -Resident #6 received a monthly social security benefit and social security placed the resident's money directly on a debit card, called a Direct Express card. -The previous Activity Director (AD) shopped for the residents at the facility and used the resident's Direct Express card for purchasing items for the resident, such as cigarettes; -On the morning of 05/20/25, Resident #6 told a staff member about a financial issue. The resident said sometime in February 2025, he/she had noticed a money shortage on his/her Direct Express money card. The resident requested a card replacement. Shortly after that occurred, the AD at that time came to the resident and said the AD's daughter had mistakenly used the resident's card for personal purchases. The AD and the resident went through the resident's financial statements and figured out which purchases were allegedly made by the AD's daughter. The AD said he/she would pay the money back by purchasing cigarettes and candy for the resident until the amount was paid off. The resident said he/she was okay with that arrangement, but once the former AD was terminated, the resident did not receive any more cigarettes, candy, or payments from the former AD; -Per the resident, the AD reported the allegation to the Administrator; -After discovering the issue, the BOM reviewed all transaction statements with the resident and came up with approximately $700.00 worth of purchases that the resident did not make. Some of these included items like blackout curtains, curtain rods, cleaning supplies, bras, and storage tubs. The resident did not have any of these items in his/her possession. During an interview on 06/05/25 at 11:37 A.M., Resident #6 said the following: -The resident had money taken from his/her debit card; (continued on next page)

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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 - Few	-In December 2024 or January 2025, the resident had given the Activity Director (AD) his/her debit card to purchase the resident cigarettes and candy; -The resident suspected the AD had misappropriated approximately $700.00 dollars by making unauthorized purchases on his/her debit card during January-February 2025; -He/she discovered the unapproved debits on his/her debit card and the former AD admitted using the resident's debit card for his/her own purchases and promised to reimburse the resident by purchasing the resident cigarettes and candy, but once the facility fired the AD, the resident did not hear from the AD again; -The resident reported the situation to CNA G approximately 2 weeks ago; -This surveyor reviewed bank statements for January and February 2025 with the resident; -Resident #6 said he/she and the BOM had reviewed the bank statements and highlighted transactions which the resident did not authorize, this surveyor reviewed statements with resident and unauthorized purchases made in January and February 2025 totaled $782.01 and resident said that was correct and said he/she did not make those purchases. During a phone interview on 06/05/25 at 3:12 P.M., the former AD said the following: -In February 2025, Resident #6 claimed he/she did not make some of the purchases on his/her debit card; -The resident accused the former AD of making the charges for personal purchases; -The former AD said at that time, in February 2025, he/she reported the allegations to Social Services, and they assisted the resident in canceling his/her debit card and obtaining a new one; -The former AD said he/she overheard Resident #6 tell Staff F from the business office that someone was using his/her debit card for Amazon purchases; -The former AD said he/she had used the resident's card for purchases, but only for items the resident requested, and this occurred during December 2024, January 2025, and part of February 2025, but did not occur after the resident had his/her card canceled in February 2025; -The former AD said he/she did not use the resident's debit card for any personal purchases and did give the resident receipts for all purchases he/she made for the resident. During a phone interview on 06/05/25 at 4:23 P.M., Certified Nurse Assistant (CNA) G said the following: -On 05/19/25, Resident #6 informed CNA G that approximately 5-6 months prior, he/she caught the former AD stealing from him. Resident #6 said the former AD was using his/her debit card for purchases the resident had not approved and for items the resident did not receive; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident said he/she estimated the AD had stolen approximately $600.00 from his/her debit card; -The resident said at first the former AD said one of the AD's family members had accidentally used the card, but the former AD eventually confessed to using the resident's debit card for personal purchases; -The former AD told the resident he/she would start paying the resident back by purchasing the resident cigarettes and peanut candy; -The resident then said he/she had informed Social Services about the stolen money; -After the resident told CNA G about the stolen money, the CNA immediately reported the situation to another staff, and they called the DON and reported the resident's allegation. During an interview on 06/05/25 at 4:35 P.M., Social Services (SS) said the following: -During February 2025, Resident #6 came to SS and reported someone else was making purchases on his/her debit card; -SS assisted the resident in canceling the current debit card and ordering a new one so no one would use the card; -SS assisted the resident in reporting the fraudulent charges to the Direct Express Hotline; -The resident had recently been in jail and in the hospital before admitting to the facility in December of 2024; -The resident said the charges were from before becoming a resident of the facility; -The SS said he/she notified the facility Administrator of the resident's allegations of card fraud in February 2025; -The SS said he/she did not notify Adult Protective Services or the elder abuse hotline of the allegation and was unsure if the Administrator made a hotline call. During an interview on 06/05/25 at 4:45 P.M., Staff F said the following: -He/she worked in the business office; -In February 2025, Resident #6 reported to Staff F and to the former AD that he/she suspected someone took money from his/her card and the former AD told the resident he/she would review debit card statements with the resident; -Staff F did not report the resident's concerns to anyone, because he/she thought the former AD reported the issue to the Administrator. During an interview on 06/05/25 at 5:02 P.M., the Director of Nursing (DON) said the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff should not use resident debit cards for personal purchases or take any money from residents; -If a resident needed an item purchased, that transaction would need to go through the business office. During an interview on 06/05/25 at 5:40 P.M., the Administrator said the following: -The former AD was using Resident #6's debit card for resident purchases; -The AD did not notify the facility staff that she had used the resident's debit card to her own personal purchases; -If the resident reported fraudulent charges on his/her debit card to SS, then SS should have reported that allegation to the Administrator, but the SS had not notified the Administrator; -The Administrator became aware that the former AD was misappropriating money from Resident #6 approximately 2 weeks ago, at which time, the facility hotlined the allegation and began an investigation and notified the police; -The facility educated staff to not make any purchases for residents and not to assist resident's with any purchases -If resident's needed to purchase items, all transactions should go through the business office. MO00254534 MO00254563

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to management and within two hours to the State Survey Agency (Department of Health and Senior Services - DHSS) when possible abuse was witnessed by staff involving two residents (Resident #32 and #57). The facility census was 104. Review of the facility's policy titled Abuse Prevention Program, undated, showed the following: -The facility will not tolerate verbal (any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to a resident or their families or within hearing distance, regardless of their age, ability to comprehend, or disability), sexual (non-consensual sexual contact of any type with a resident), physical (not limited to hitting, biting, kicking), or mental (humiliation, harassment, and threat of punishment or deprivation) abuse, corporal punishment, involuntary seclusion (separation of a resident), neglect, or misappropriation of resident property (deliberate misplacement, exploitation), by employees, family members, visitors, or other residents. Review of the facility's policy titled Abuse Investigation and Reporting, revised July 2017, showed the following: -All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and or injuries of unknown source, shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported; -An alleged violation involving abuse will be reported by the facility Administrator to the state licensing agency within two hours, local and state ombudsman, the residents represented, law enforcement officials, the resident's physical, and the facilities medical director. 1. Review of Resident #32's face sheet (brief look at resident information) showed the following information: -admission date of 03/20/20; -Diagnoses include high blood pressure, irregular heartbeat, and diabetes. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 03/26/25, showed the following information: -Moderate cognitive impairment; -Required substantial to maximum assistance from staff for bathing, toileting, and mobility; -No behavioral symptoms such as abusing others sexually, screaming at others, or disrobing. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised 04/09/25, showed the resident required assistance from staff to complete daily tasks such as dressing and grooming. Review of the resident's progress note, dated 02/06/25, showed the resident was lethargic, felt sick, and was experiencing vomiting and chest pain. The resident was sent to the hospital via ambulance at 11:51 A.M. Review of the resident's admission History and Physical from the admitting hospital, dated 02/06/25, showed the following: -History received from the nurse at the long term care facility; -The nurse reports the resident was in a normal state of health until this morning. There was a naked resident who had jumped on top of him/her this morning and after this the resident became altered and was not able to speak; -The nurse also noticed the resident had a cough on this day, the nurse does not believe the naked resident hurt him/her; -The nurse denied the resident having any symptoms prior to this date; -The resident was diagnosed with sepsis (a life threatening medical emergency caused by the body's overwhelming response to an infection, often triggering a chain reaction that can lead to organ failure and death) and pneumonia (a lung infection that causes inflammation and fluid buildup in the air sacs) while at the hospital and was discharged back to the facility on [DATE]. Review of the resident's progress notes, dated 02/06/25 through 04/06/25, showed staff did not document regarding the resident being involved in a possible sexual abuse allegations/incident. 2. Review of Resident #57's face sheet showed the following information: -admission date of 02/04/25; -Diagnoses included schizophrenia (a chronic mental disorder that affects a person's ability to think, feel, and behave), depression, and kidney disease. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 02/10/25, showed the following information: -Moderate cognitive impairment; -Requires partial to moderate assistance from staff for bathing and hygiene and is independent for mobility; -No behavioral symptoms such as abusing others sexually, screaming at others, or disrobing. Review of the resident's care plan, revised 04/09/25, showed the resident should be monitored for behaviors every shift related to medication use. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Nurse Practitioner visit note, dated 02/06/25, showed the following: -The resident was being seen for a new admission; -It was noted that this morning (02/06/25) the resident stripped down naked and jumped onto another resident who was lying in bed in his/her own room and this resident was making vulgar statements while on top of the other resident; -Staff reported the resident had been at baseline since the incident and there have been no further behaviors of this nature. Review of the resident's progress notes, dated 02/06/25 through 04/06/25, showed staff did not document regarding the resident being involved in a possible sexual abuse allegations/incident. 3. Review of DHSS records showed staff did not report the allegation of possible abuse involving Resident #32 and Resident #57. 4. During interviews on 04/11/25, at 1:40 P.M. and 2:40 P.M., Licensed Practical Nurse (LPN) W said the following: -Approximately one month ago, Resident #57 got on top of Resident #32; -LPN W could not remember the specifics and could not recall if the residents were clothed or not; -LPN W did not believe there was any sexual penetration and said neither resident had any injuries that he/she recalled; -LPN W said he/she thought he/she documented in the resident progress notes; -The LPN looked in the electronic health record, but was unable to find documentation about the resident to resident interaction in either resident's medical record; -LPN W said he/she guessed he/she did not document in the resident's progress note as he/she should have; -If he/she was working at the time of the situation, he/she would separate the residents from one another, ensure both residents were not injured, notify the residents' next of kin, their physicians, and notify the facility Administrator, Director of Nursing (DON), or the Assistant Director of Nursing (ADON); -The facility would then have two hours to notify DHSS of the events, as this would be an allegation of sexual abuse. During an interview on 4/11/25 at 2:45 P.M., Nurse Assistant (NA) AA said the following: -He/she worked on the day of the interaction between Resident #57 and Resident #32; -Late morning, the NA walked down the hall and observed Resident #57 in Resident #32's room; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #32 was fully dressed sitting in a wheelchair; -Resident #57 was in front of Resident #32 slightly squatted against the resident's legs and was completely naked; -Upon entering the room, Resident #57 asked Resident #32 for sexual intercourse and Resident #32 threw both hands up in the air and said, Help me.; -The NA entered the room and separated the two residents and redirected Resident #57 to return to his/her room and assisted Resident #57 with dressing; -The NA said he/she immediately notified the charge nurse, LPN W and the LPN notified the DON over the phone and then went down the hall to talk to the DON; -This occurrence would be an example of sexual abuse and he/she reported the incident immediately; -The facility should report the allegation of abuse within two hours to DHSS. During an interview on 04/15/25, at 10:51 A.M., Certified Nursing Assistant (CNA) Q said the following: -All allegations of abuse should be reported immediately; -He/she was aware of a recent issue between the two residents. He/she was not on staff that day but did hear about it; -He/she was warned to keep an eye on Resident #57, but since the incident, the resident has kept to his/herself; -As far as he/she knew, the incident was reported; -If he/she were to witness or hear of an allegation of abuse, he/she would report it to the charge nurse, the charge nurse would take it up the ladder from there. During an interview on 04/15/25, at 12:17 P.M., Certified Medication Technician (CMT) R said the following; -A resident getting naked and entering another residents room would be a problem; -He/she was aware of the recent issue between the two residents. He/she was on shift during the incident. By the time he/she got to the residents, they were not on top of each other, however it was verbally apparent what Resident #57 wanted, and Resident #32 was stunned; -He/she reported it to the charge nurse and he/she should have taken it up the ladder from there. During an interview on 04/15/25, at 12:49 P.M., Registered Nurse (RN) L said the following -He/she was not on shift the day of the incident, but did hear about it; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If he/she were the nurse on shift, he/she would have separated both residents, assessed both residents, obtained statements from all staff on shift and both residents, documented the occurrence, and contacted whoever was on call that day; -The Director of Nursing (DON) or Administrator should have reported the incident to the state within two hours. During an interview on 04/15/25, at 1:17 P.M., the MDS Coordinator/Infection Preventionist said the following: -If there was ever a resident to resident reported to him, he would report it to management or call the state himself; -The incident between the two residents would be considered an allegation of sexual abuse and should have been reported to the state within two hours by the Assistant Director of Nursing (ADON), DON, or Administrator. During an interview on 04/15/25, at 1:46 P.M., the ADON said the following: -She was not at the facility when the incident took place, however it could be considered an allegation of sexual abuse; -The nurse handling the incident was expected to put a progress note in regarding the incident, do an assessment of both residents, document an incident report, notify the physician and family, and report it to the nurse on call. The nurse on call should have reported it to the state within two hours. During an interview on 04/15/25, at 2:35 P.M., the DON said the following: -She was on shift the day of the incident and was informed by the nurse; -The nurse reported to her that Resident #57 was found standing in Resident #32's room, but was easily redirected; -She went down to assess Resident # 32 as he/she was feeling ill and needed to be hospitalized ; -She was not aware of the entire situation and had she been, she would have interpreted it as an allegation of sexual abuse and would have reported that to the state within two hours; -The nurse handling the incident should have documented the incident, separated the residents, assessed the residents for injuries and/or trauma, started behavior charting, notified her, the resident's families, and the residents physician. During an interview on 04/15/25, at 3:44 P.M., the Administrator said the following: -She was not ware of the entire situation and had she been, she would have considered it inappropriate; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse handling the incident should have documented, reported and investigated the immediately. MO00252718

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all allegations of possible abuse were thoroughly investigated and the investigation provided to the State Survey Agency (Department of Health and Senior Services - DHSS) within five days when possible abuse was witnessed by staff involving two residents (Resident #32 and #57). The facility census was 104. Review of the facility's policy titled Abuse Prevention Program, undated, showed the following: -The facility will not tolerate verbal (any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to a resident or their families or within hearing distance, regardless of their age, ability to comprehend, or disability), sexual (non-consensual sexual contact of any type with a resident), physical (not limited to hitting, biting, kicking), or mental (humiliation, harassment, and threat of punishment or deprivation) abuse, corporal punishment, involuntary seclusion (separation of a resident), neglect, or misappropriation of resident property (deliberate misplacement, exploitation), by employees, family members, visitors, or other residents. Review of the facility's policy titled Abuse Investigation and Reporting, revised July 2017, showed the following: -All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and or injuries of unknown source, shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported; -The administrator will assign the investigation to an appropriate individual, provide any supporting documents relative to the alleged incident to the person in charge of the investigation, keep the resident and residents representative informed of the progress of the investigation, ensure that any further potential abuse, neglect or mistreatment is prevented, and protect the safety and privacy of the resident; -The individual conducting the investigation will review the completed documentation forms, review the resident's medical record to determine what events led up to the incident, interview the persons reporting the incident, interview any witnesses, interview the resident, interview the resident's physician, interview staff members, interview the residents roommate, and review all events leading up to the alleged incident; -An alleged violation involving abuse will be reported by the facility Administrator to the state licensing agency within two hours, local and state ombudsman, the residents representative, law enforcement officials, the resident's physical, and the facility's medical director. 1. Review of Resident #32's face sheet (brief look at resident information) showed the following information: -admission date of 03/20/20; -Diagnoses include high blood pressure, irregular heartbeat, and diabetes. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 03/26/25, showed the following information: -Moderate cognitive impairment; -Required substantial to maximum assistance from staff for bathing, toileting, and mobility; -No behavioral symptoms such as abusing others sexually, screaming at others, or disrobing. Review of the resident's care plan, revised 04/09/25, showed the resident required assistance from staff to complete daily tasks such as dressing and grooming. Review of the resident's progress note, dated 02/06/25, showed the resident was lethargic, felt sick, and was experiencing vomiting and chest pain. The resident was sent to the hospital via ambulance at 11:51 A.M. Review of the resident's admission History and Physical from the admitting hospital, dated 02/06/25, showed the following: -History received from the nurse at the long term care facility; -The nurse reports the resident was in a normal state of health until this morning. There was a naked resident who had jumped on top of him/her this morning and after this the resident became altered and was not able to speak; -The nurse also noticed the resident had a cough on this day, the nurse does not believe the naked resident hurt him/her; -The nurse denied the resident having any symptoms prior to this date; -The resident was diagnosed with sepsis (a life threatening medical emergency caused by the body's overwhelming response to an infection, often triggering a chain reaction that can lead to organ failure and death) and pneumonia (a lung infection that causes inflammation and fluid buildup in the air sacs) while at the hospital and was discharged back to the facility on [DATE]. Review of the resident's progress notes, dated 02/06/25 through 04/06/25, showed staff did not document regarding the resident being involved in a possible sexual abuse allegations/incident. 2. Review of Resident #57's face sheet showed the following information: -admission date of 02/04/25; -Diagnoses included schizophrenia (a chronic mental disorder that affects a person's ability to think, feel, and behave), depression, and kidney disease. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 02/10/25, showed the following information: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Healthcare & Rehabilitation Center	206 West First Street Lamar, MO 64759

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Moderate cognitive impairment; -Requires partial to moderate assistance from staff for bathing and hygiene and is independent for mobility; -No behavioral symptoms such as abusing others sexually, screaming at others, or disrobing. Review of the resident's care plan, revised 04/09/25, showed the resident should be monitored for behaviors every shift related to medication use. Review of the resident's Nurse Practitioner visit note, dated 02/06/25, showed the following: -The resident was being seen for a new admission; -It was noted that this morning (02/06/25) the resident stripped down naked and jumped onto another resident who was lying in bed in his/her own room and this resident was making vulgar statements while on top of the other resident; -Staff reported the resident had been at baseline since the incident and there have been no further behaviors of this nature. Review of the resident's progress notes, dated 02/06/25 through 04/06/25, showed staff did not document regarding the resident being involved in a possible sexual abuse allegations/incident. 3. Review of DHSS records showed staff did not provide a written investigation completed when the potential abuse was occurred involving Resident #32 and Resident #57. 4. During an interview on 04/15/25, at 10:51 A.M., Certified Nursing Assistant (CNA) Q said the following: -He/she is aware of a recent issue between the two residents. He/she was not on staff that day but did hear about it; -He/she was warned to keep an eye on Resident #57, but since the incident, the resident has kept to his/herself; -As far as he/she knows, the incident was investigated appropriately. During an interview on 04/15/25, at 12:17 P.M., Certified Medication Technician (CMT) R said the following; -A resident getting naked and entering another residents room would be a problem; -He/she was aware of the recent issue between the two residents. He/she was on shift during the incident. By the time he/she got to the residents, they were not on top of each other, however it was verbally apparent what Resident #57 wanted, and Resident #32 was stunned; -Staff checked on the resident's often after the incident with no further concerns. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/25, at 12:49 P.M., Registered Nurse (RN) L said the following: -He/she was not on shift the day of the incident, but did hear about it; -If he/she were to be the nurse on shift, he/she would have separated both residents, assessed both residents, obtain statements from all staff on shift and both residents, document the occurrence, and contact whoever was on call that day. During an interview on 04/15/25, at 1:46 P.M., the ADON said the following: -The nurse handling the incident is expected to put a progress note in regarding the incident, do an assessment of both residents, document an incident report, notify the physician and family, and report it to the nurse on call. During an interview on 04/15/25, at 2:35 P.M., the Director of Nursing (DON) said the following: -She was on shift the day of the incident and was informed by the nurse; -The nurse reported to her that Resident #57 was found standing in Resident #32's room, but was easily redirected; -She went down to assess Resident # 32 as he/she was feeling ill and needed to be hospitalized ; -She was not aware of the entire situation and had she been, she would have interpreted it as an allegation of sexual abuse; -The nurse handling the incident should have documented the incident, separated the residents, assessed the residents for injuries and/or trauma, started behavior charting, notified her, the resident's families, and the residents physician -After reporting the incident to the state, an investigation should have taken place and been submitted to the state within five days. During an interview on 04/15/25, at 3:44 P.M., the Administrator said the following: -She was not ware of the entire situation and had she been, she would have considered it inappropriate; -The nurse handling the incident should have documented, reported, and investigated the immediately. MO00252718

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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. Based on observation, interview, and record review the facility failed to provide the highest quality of care and ensure that all residents receive treatment and care in accordance with professional standards of practice when the facility failed to document care and treatment refusals for one resident (Resident #2) with skin concerns, that ultimately led to infection. The facility census was 98. Review of the facility's undated policy, titled Wound and Skin Care Protocols, showed the following information: -The Director of Nursing (DON) will be responsible for reviewing weekly wound reports and monitoring progress/decline of any wound and assuring compliance with current standards of would care practice; -The interdisciplinary plan of care will address problems, goals, and interventions directed toward the prevention and/or treatment of impaired skin integrity/pressure injuries. Review of the facility's undated policy, titled Assessment and Documentation, showed the following information: -Assess the wound etiology, resident's overall condition, nutritional needs, pain/pain control, need for pressure reducing devices, and management of infection/bacterial burden. Review of the resident's face sheet (brief look at resident information) showed the following information: -re-admission date to the facility of 09/25/24; -Diagnoses include high blood pressure, obesity, and chronic pain. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff) dated 02/18/25, showed the following: -Cognitively intact; -Required substantial to maximum assistance from staff for mobility; -No open lesions on the skin. Review of the resident's care plan, dated 05/21/25, showed the following: -Measure wounds weekly; -Pressure reducing device to bed and wheelchair; -Provide assistance with mobility; -Wound care per physician order. (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 skin assessment, dated 04/08/25, showed the following: -During skin assessment, LPN A observed three new open areas to reddened right pannus (an overhand of excess skin and fat that hands below the abdomen) and one open area to the left abdominal fold; -All areas were cleansed with wound wash, patted dry, nystatin (an antifungal medication that treats infections caused by yeast) was applied to closed gaulded (reddened/ chaffed)areas, and interdry (moisture wicking fabric with antimicrobial silver) was applied to open areas; -The residents Physician was notified; -No measurements included. Review of the resident's April 2025 Physician Order Sheet (POS), showed the following information: -An order dated 04/02/25; Cleanse wound to left side fold with wound cleanser, apply skin prep to peri-wound (skin surrounding wound.) Apply polymem pink (non-adhesive hydrophilic pads that are designed to facilitate healing) and cover with opsite (transparent adhesive film), change on Monday, Wednesday, and Friday; -An order dated 04/01/25; Cleanse would and dry area to right pannus. Apply barrier cream, place interdry (moisture wicking fabric with antimicrobial silver) and change daily; Review of the resident's skin assessment, dated 04/15/25, showed the following: -Left abdominal fold MASD (Moisture Associated Skin Damage) measured 0.8 centimeters (cm) by 1.2 cm depth, and 0.1 cm wound bed; -Wound care performed per orders. No significant changes to left abdominal fold. Area continues to remain fragile; -The resident is up in the wheelchair a significant part of the day; -Right pannus not measured but was extremely gaulded. The resident was educated on keeping the area clean and dry; -Physician aware. Review of the resident's skin assessment, dated 04/22/25, showed the following: -Left abdominal fold MASD measured 0.5 cm in width by 0.8 cm depth, with 0.1 cm wound bed; -Would care performed per orders. Left abdominal fold wound measured smaller. [NAME] along fold, and continues to be fragile; -Right pannus continued to be gaulded; -Physician aware (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 skin assessment, dated 04/29/25, showed the following: -Left abdominal fold MASD measured 0.4 cm in width by 0.6 cm depth, with 0.1 cm wound bed; -Would care performed per orders. Left abdominal fold wound measured smaller. [NAME] along fold, and continues to be fragile; -Right pannus continued to be gaulded, three open areas to the right groin measuring 0.5 cm x 1.0 cm; -Physician aware. Review of the resident's April 2025 Treatment Administration Record, showed the following: -Right Pannus treatment was not administered on 04/02, 04/09, 04/13, 04/16, and 04/25 due to the resident refusing; -Right pannus treatment was not administered on 04/10, 04/15, 04/17, and 04/28. No supporting documentation of reasoning. -Left abdominal fold treatment was not administered on 04/02, 04/09, 04/16, and 04/25 due to the resident refusing; -Left abdominal fold treatment was not administered on 04/28. No supporting documentation of reasoning. Review of the resident's skin assessment, dated 05/06/25, showed the following: -Left abdominal fold MASD measured 0.4 cm in width by 0.6 cm depth, with 0.1 cm wound bed; -Would care performed per orders. Left abdominal fold wound measured smaller. [NAME] along fold, and continues to be fragile; -Right pannus continued to be gaulded, three open areas to the right groin measuring 0.5 cm x 1.0 cm; -Physician aware. Review of the resident's skin assessment, dated 05/14/25, showed the following: -Left abdominal fold MASD measured 0 cm in width by 0 cm depth, with 0 cm wound bed; -Would care performed per orders. Left abdominal fold wound measured smaller. [NAME] along fold, and continues to be fragile; -Right pannus continued to be gaulded; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Right pannus wound number one measuring 1.5 cm x 1.5 cm with 0.2 cm depth. Right pannus wound number two measuring 1.8 cm x 1.2 cm x 0.2 depth; -Physician aware; -Resident refuses to use inderdry and insists staff place pillowcases under his/her abdominal folds instead. The resident was educated. Review of the resident's POS showed the following: -An order dated 05/15/25, at 10:33 P.M., for Cephalexin (a type of antibiotic called cephalosporin, that works by killing bacteria) 500 milligram (mg) tablet; give one tablet by mouth (po) two times a day (bid) for left abdominal wall cellulitis for seven days. Review of the resident's MAR showed the following: -An order dated 05/16/25 for Cephalexin 500 mg tablet; give one tablet po bid for left abdominal wall cellulitis for 12 administrations. Review of the resident's progress notes dated 05/17/25 through 05/20/25, showed the resident remained on antibiotics for cellulitis. The resident's left abdominal fold continued with redness, pain, and warmth to touch. No physician notification documented, and no new order requests. Review of the resident's May 2025 POS showed the following: -An order dated 05/16/25 to cleanse two wounds to abdominal pannus with wound cleanser, apply skin prep to peri-wound, apply calcium alginate to wound beds, cover with 4x4 island dressing and change daily; Review of the resident's May 2025 MAR showed the following: -Right pannus treatment not administered on 05/07, 05/12-13, 05/16, and 05/27. No supporting documentation as to why; -Right pannus treatment not administered on 05/08 or 05/24 due to the resident refusing; -Two wounds to abdominal pannus treatment not administered on 05/16 or 05/27 due to the resident refusing. -Two wounds to abdominal pannus treatment not administered on 05/24 due to the resident refusing; -Left abdominal treatment not administered on 05/07 or 05/12. No supporting documentation as to why; -Left abdominal treatment not administered on 05/14 due to the resident refusing; -Left abdominal treatment was discontinued on 05/15. (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 skin assessment, dated 05/21/25, showed the following: -Left abdominal fold MASD measured 0 cm in width by 0 cm depth, with 0 cm wound bed; -Would care performed per orders. [NAME] along fold, and continues to be fragile; -Right pannus continued to be gaulded; -Right pannus wound number one measuring 2.0 cm x 2.0 cm with 0.2 cm depth. Right pannus wound number two measuring 2.0 cm x 1.0 cm x 0.2 depth; -Physician aware; -Resident refuses to use inderdry and insists staff place pillowcases under his/her abdominal folds instead. The resident was educated. Review of the resident's progress note dated 05/24/25 at 7:31 P.M.; showed the resident had a change of condition and was lethargic and had worsening of the cellulitis on his/her pannus. Redness and warmth has spread across the entire abdominal fold. Labs and new antibiotics ordered. Review of the resident's May 2025 POS showed the following: -An order dated 05/24/25 for Cefuroxime (antibiotic that belongs to the class of medications known as cephalosporin antibiotics that treats bacterial infections) 500 mg; take one tablet po bid for cellulitis for seven days Review of the resident's EMR, showed no additional skin assessments after 05/21/25. During an interview on 06/04/25, at 3:23 P.M., The Assistant Director of Nursing (ADON) said the following: -The resident often refuses care; -Skin assessments are not being completed on a consistent basis but she is not aware of any not being completed; -If resident refuses care she expects to see it documented in the progress notes; -She expects skin assessments to be completed weekly. During an interview on 06/05/25, at 10:20 A.M., The resident said the following: -He/she feels like a lot of his/her treatments have not been administered; -When staff do complete his/her treatment, it is only once a day and it should be more often; -The staff save him/her for last because he/she has to be in a seated position in the wheelchair otherwise staff are not able to get to it while he/she lays in bed; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The lack of treatment administration is what he/she believes caused the cellulitis; -He/she does not often refuse, unless he/she is in bed. But he/she always tells the staff to just come back when he/she is up in his/her wheelchair and they do not come back. During an interview on 06/04/25, at 3:55 P.M., Licensed Practical Nurse (LPN) A said the following: -He/she completes skin assessments on residents, along with other charge nurses; -He/she is not sure if skin assessments are getting completed weekly, but they should be; -Resident refusals should be documented. During an interview on 06/05/25, at 1:50 P.M., LPN B said the following: -Any wound assessments should be completed by LPN A or the Director of Nursing (DON); -Staff nurses complete weekly skin assessments when they are scheduled; -The resident has two wounds under the pannus, he/she believes it is due to the amount of weight the abdomen is and that causes pulling; -If he/she was alerted of a new wound, he would follow their wound protocol which includes to document the area and initiate a treatment until it can be assessed by the DON; -If a resident refuses treatments, that should be documented and care planned. During an interview on 06/05/25, at 2:15 P.M., The DON said the following: -Wound assessments that include measurements and descriptors are completed by her and/or LPN A, they are done weekly; -Skin assessments are also expected to be completed weekly by the staff nurses; -The resident has two wounds under the pannus which were caused by the weight of the abdomen and pulling; -If a resident refuses treatment, she expects that to be documented and care planned. During an interview on 06/05/25, at 5:32 P.M., The MDS/Care Plan coordinator said all wounds, wound care, and refusal status should be noted in the care plan. During an interview on 06/05/25, at 5:40 P.M., The Administrator said the following: -Skin assessments are expected to be completed weekly; -All resident refusals, wounds, and wound care should be documented and care planned. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00255059

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to provide the highest quality of care when the facility failed to accurately and completely monitor and document wounds on the skin assessments and care plan pressure ulcers/injuries (skin injuries caused by prolonged pressure, friction, or shear, resulting in tissue damage) for one resident, Resident #1. The facility census was 98. Review of the facility's undated policy, titled Wound and Skin Care Protocols, showed the following information: -The Director of Nursing (DON) will be responsible for reviewing weekly wound reports and monitoring progress/decline of any wound and assuring compliance with current standards of would care practice; -All residents will be assessed by the charge nurse for risk of skin breakdown using the Braden scale (a tool filled out by facility staff, used to assess a resident's risk of developing pressure injuries) on admission, re-admission, and with any major change in condition; -The interdisciplinary plan of care will address problems, goals, and interventions directed toward the prevention and/or treatment of impaired skin integrity/pressure injuries. Review of the facility's undated policy, titled Assessment and Documentation, showed the following information: -Assess the wound etiology, resident's overall condition, nutritional needs, pain/pain control, need for pressure reducing devices, and management of infection/bacterial burden; -A complete wound assessment and documentation will be done weekly on all pressure injuries until healed; to include the location of the wound, stage, size, appearance of the wound bed, surrounding skin (peri-wound), and drainage. Review of the resident's face sheet (brief look at resident information) showed the following information: -re-admission date to the facility of 03/08/24; -Diagnoses include multiple sclerosis (MS- is a chronic, unpredictable disease of the central nervous system, primarily affecting the brain, spinal cord, and optic nerves), high blood pressure, and kidney failure. Review of the resident's annual Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 02/10/25, showed the following information: -Cognitively intact; -Required substantial to maximum assistance from staff for mobility; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Is at risk for the development of pressure ulcers/injury; -Does not have any unhealed pressure ulcers/injuries at stage 1 (intact skin, non-blanchable redness) or higher. Review of the resident's progress note, dated 04/12/25, showed the following: -Upon re-positioning the resident, a new open sore was found to the left buttock, measuring 3.5 centimeters (cm) in length, 1.5 cm in width , and 0.0 cm depth; -Wound bed had beefy red tissue, no drainage was present, and peri-wound was within normal limits; -Area cleansed and treatment applied. The resident was repositioned, and pillow placed to offload. Physician and hospice notified; -New orders to cleanse wound to left buttock with wound wash; pat dry, and apply silicone bordered dressing, change every other day and as needed until healed. Review of the resident's 04/05/25 through 06/30/25 Physician Order Sheet (POS), showed the following: -Cleanse wound to left buttock with wound wash; pat dry, apply silicone border dressing and change dressing very other day and as needed until healed. Review of the resident's care plan, dated 04/15/25, showed the following information: -At risk for skin break down and pressure injuries related to decreased mobility and incontinence; -Observe skin for changes daily with resident care; -Provide skin audits per schedule and as needed; -Assist with cleaning and repositioning as needed; -The care plan did not address the resident's wound and or treatment. Review of the resident's weekly skin assessment, dated 04/18/25, showed the resident did not have any skin issues. Review of the resident's weekly skin assessment, dated 04/25/25, showed the resident did not have any skin issues and refused to have a skin assessment performed. Review of the resident's April 2025 Treatment Administration Record (TAR) showed the resident did not miss any wound care treatments. Review of the resident's May 2025 TAR showed the resident had one missed treatment on 05/20/25 with no supporting documentation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's weekly skin assessment, dated 05/05/25, showed the resident did not have any skin issues. Review of the resident's weekly skin assessment, dated 05/09/25, showed the resident refused to have a skin assessment performed. Review of the resident's weekly skin assessment, dated 05/16/25, showed the resident did not have any skin issues. Review of the resident's Electronic Medical Record (EMR) showed the resident did not have another skin assessment after 05/16/25. Review of the resident's Braden Scale for Predicting Pressure Ulcer Risk evaluation, dated 05/26/25, showed the resident assessed as at moderate risk for developing pressure ulcers. Review of the resident's June 2025 TAR showed the resident did not miss any wound care treatments. During an interview on 06/04/25, at 1:38 P.M., the resident said the following: -He/she has a wound to his/her buttocks, and he/she has to ask the staff to perform wound care as they do not do it without being told to; -When he/she does get staff to provide care, he/she believes they just put a patch on the wound; -The patch often gets soiled, and the staff don't change it how they should; -He/she does not believe nursing staff measure the wound on a weekly basis. Observation on 06/02/25 at 10:55 A.M., showed both residents buttocks were bright red/purple and non-blanching in areas. The resident had two small- eraser tip sized open areas with an estimated total circumference of a half dollar to his/her left buttock. The peri-wound was dry, peeling, red/purple in color with non-blanchable areas. During an interview on 06/04/25 at 3:23 P.M., The Assistant Director of Nursing (ADON) said the following: -Weekly skin assessments are not being completed as consistently as she should like, but she is not aware of any being missed; -The facility does not have a current wound care nurse, but the DON will be moving to that position soon and taking over those responsibilities. During an interview on 06/04/25, at 3:55 P.M., Licensed Practical Nurse (LPN) A said the following: -He/she performs skin assessments; -He/she is not sure if skin assessments are always getting completed, like they should; (continued on next page)

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	265253	A. Building B. Wing	04/15/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assessments should include all wounds and their descriptors; -The resident has a pressure wound to his/her left buttock. During an interview on 06/05/25, at 1:50 P.M., LPN B said the following: -The DON or LPN A is typically who completes skin assessments on a weekly basis; -Floor nurses do not measure wounds; -Wounds should be care planned; -He/she believed the resident's wound to be pressure related. During an interview on 06/05/25, at 2:30 P.M., Certified Nursing Assistant C said he/she does not work the resident's hall often but does know there is a patch on the resident's bottom. During an interview on 06/05/25, at 5:26 P.M., The DON said the following: -She expects skin assessments to be completed on a weekly basis and for all wound descriptors to be documented; -The resident's wound is documented as a pressure wound. -Wounds and wound care should be care planned. During an interview on 06/05/25, at 5:32 P.M., The MDS/Care Plan Coordinator said all wounds and wound care should be care planned. During an interview on 06/05/25, at 5:40 P.M., The Administrator said the following: -She expects skin assessments to be completed weekly; -Skin assessments should include all wound descriptors; -Wounds and wound care should be care planned. MO00255059

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services to meet the needs of each resident when Certified Medication Technician (CMT) D brought narcotic pain medication tablets into the facility and placed them into the bubble pack medication card for one resident (Resident #5) and a staff member subsequently administered one dose of the medication to the resident. The facility census was 98. 1. Review of Resident #5's face sheet showed: -admitted to the facility on [DATE]; -Diagnoses of chronic pain, low back pain, anxiety disorder, major depression, and stroke. Review of the resident's care plan revised on 05/25/25, showed: -Resident is at risk for increased pain and discomfort related to a diagnosis of chronic pain; -Follow up with the resident's physician and pain management as needed; -Medication provided as prescribed; -Monitor for effectiveness of medication; -Monitor for increased pain and discomfort; -Provide diversionary activities as needed; -Therapy to screen quarterly and as needed. Review of the resident's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 05/28/25, showed: -admitted to the facility on [DATE]; -Cognitively intact; -Independent with most activities of daily living (ADLs); -No behavioral symptoms; -Diagnoses of schizophrenia, anxiety, and depression; -Staff administered as needed (PRN) pain medication; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident expressed frequent complaints of pain and rated his/her pain at an '8' (on a numeric scale of 0-10, with 10 being the most severe pain). Review of the resident's active physician orders showed the following: -An order dated 05/16/25 for Hydrocodone-Acetaminophen (Norco) oral tablet 5/325 milligram (mg). Staff to administer one tablet by mouth every 6 hours as needed for pain. Review of the resident's medication administration record for May 2025 showed: -An order for Hydrocodone-Acetaminophen oral tablet 5/325 mg. Give one tablet by mouth every 6 hours as needed for pain; -On 05/19/25 at 8:20 A.M., staff administered a dose of the medication for a pain level of '8' with effective results; -On 05/19/25 at 7:47 P.M., staff documented administration of a dose of the pain medication for a pain level of '9' with effective results; -Staff did not document administration of any other doses of the pain medication on 05/19/25. -On 5/19/25, Certified medication technician (CMT) D did not document administration of either of the doses of the residents pain medication on the MAR. Review of the facility's-controlled drug count signature page showed the following: -On 05/19/25 at 2:00 P.M., CMT D signed as the incoming staff; -On 05/19/25 at 10:00 P.M., CMT D signed as the outgoing staff; -On 05/19/25 at 10:00 P.M., Registered Nurse (RN) E signed as the incoming staff. Review of the resident's progress notes showed: -No entries dated 05/19/25. Review of the resident's Medication Administration Record (MAR) for May 2025 showed: -An order for Hydrocodone-Acetaminophen oral tablet 5/325 mg. Give one tablet by mouth every 6 hours as needed for pain; -On 05/20/25 at 10:45 A.M., a nurse documented administration of one dose of the medication for a pain level of '8' with effective results. Review of the resident's-controlled medication count sheet showed the following information: -Drug name: Norco 5/325 mg; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Directions: one tablet by mouth every 6 hours as needed for pain (PRN); -On 05/20/25 at 10:45 A.M., LPN A signed out one tablet of the medication for administration; On 05/20/25 at 6:45 P.M., LPN A and the ADON destroyed one tablet of the medication and did a corrected count. Review of the resident's progress notes showed: -No entries dated 05/20/25. Review of the resident's progress notes showed: -One entry dated 05/21/25 as follows: At 4:57 P.M., a nurse documented Nurse Practitioner here for rounds, no new orders noted at this time. -Staff did not document the medication error, an assessment of the resident's condition, or notification of the resident's physician following the medication error in the resident's progress notes. During an interview on 06/04/25 at 1:43 P.M., Resident #5 said the following: -He/she had chronic back pain and staff administered as needed (PRN) pain medication to treat the resident's pain; -Staff administered the resident's pain medication accurately and on time; -The resident was not aware of any misappropriation of his/her property or medications; -The resident had not had a recent increase in sedation or pain. During an interview on 06/04/25 at 3:21 P.M., the Assistant Director of Nursing (ADON) said the following: -On 05/20/25, RN E reported that on the night of 05/19/25 at approximately 10:00 P.M., he/she was counting the narcotics with Certified Medication Technician (CMT) and Resident #5's Norco was short tablets when compared to the narcotic count sheet. The nurse refused to accept the cart because of the missing pills. The CMT told the nurse, he/she had a prescription for the exact same medication in his/her vehicle and went out to his/her vehicle and came back in with two loose pills. The CMT then taped the pills into the resident's medication card. The ADON checked the resident's Norco card and found Licensed Practical Nurse (LPN) A administered one of the taped in pills earlier on 05/20/25 and the ADON and another nurse destroyed the other taped in pill. During a phone interview on 06/05/25 at 11:38 A.M., Pharmacist H, a representative of the facility's local pharmacy said the following: -It is not acceptable practice for an employee to take their personal prescription medication and place that medication in a resident medication card to administer to a resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/25 at 12:40 P.M., the ADON said the following: -CMTs administer routine and as needed (PRN) pain medication to residents in the facility; -If a resident expressed pain and had a PRN order for pain medication, the nurse should first assess the resident's pain and then either the CMT or the nurse would administer the PRN medication. The nurse must sign administration of the PRN pain medication in the Medication Administration Record (MAR) along with the resident's numeric pain level, whether the medication it is given by the nurse or the CMT. The nurse of CMT administering the medication would sign the doses off on the narcotic count sheet. During a phone interview on 06/05/25 at 1:21 P.M., Registered Nurse (RN) E said the following: -He/she worked full time at the facility 3:00 P.M. to 3:00 A.M., or sometimes until 7:00 A.M.; -On the night of 05/19/25 at around 11:00 P.M., CMT D was preparing to leave for the night (at the end of the CMT's shift); -RN E counted the controlled medications with CMT D and found Resident #6's Norco card contained 2 pills less than what the controlled medication count showed he/she should have in the card; -The CMT was unsure what happened to the medications; -RN E refused to take over responsibility for the cart with 2 missing pills; -The CMT went outside to his/her car and returned and said he/she was now ready to count; -The RN thought the CMT might have brought the pills inside from his/her car, but replaced pills matched the exact appearance and number as the pills already in the card; -The CMT taped the 2 pills into the card and the nurse assumed responsibility for the cart and the CMT went home; -On 05/20/25 at approximately 5:00 P.M., RN E notified the ADON and the Administrator that CMT D taped two pills into Resident #5's Norco card on 05/19/25; -The ADON immediately audited the entire cart and removed the remaining taped in pill; -RN E said he/she did not think about the potential danger of the medication; -RN E said he/she assumed maybe the CMT had stolen and then returned the medications due to the count being short; RN E did not think to notify management or the ADON, DON at the time of the occurrence, but thought about it the next day and decided he/she needed to report the incident; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-In training, the facility had told him/her to immediately report to the RN on-call, the DON, of the Administrator of any allegation of misappropriation of resident property or medications, but he/she failed to do so; -RN E said he sat in on a meeting with CMT D on 05/20/25 along with the DON, ADON, and Administrator; -During the meeting, CMT D said he/she had a personal prescription for Norco and on the night of 05/19/25, when he/she could not locate 2 of Resident #5's Norco, he/she went to his/her own car and pulled 2 pills from his/her prescription bottle to replace the missing resident Norco. He/she then taped the pills into the resident's medication card; -CMT D denied taking any of the resident's pain medications, but said was unsure where the two resident Norco tablets were; -In the meeting, the ADON said the nurse was supposed to sign with the CMT when administering PRN pain medications, but he/she was not aware of that before the meeting; -The CMTs generally gave the PRN pain medication and signed them off on the controlled medication count sheet. The nurse would assess the resident's pain and document the administration of the PRN medications on the resident's MAR, as well as the resident's pain level. During a phone interview on 06/05/25 at 4:08 P.M., CMT D said the following: -On the night of 05/19/25, he/she counted the cart by him/herself, and the controlled medication count was correct; -CMT D then gave his/her medication cart keys to RN E and finished his/her charting; -Approximately one hour later, he/she returned to count the controlled medications RN E and at that time Resident #5's Norco card was 2 pills short according to the count sheet; -The CMT said he/she freaked out and went to his/her car and obtained 2 of his/her own personal Norco which were the same exact strength and taped his/her personal medication into the resident's Norco card, so the count would be correct; -When he/she returned to work, he/she was told by the DON and ADON to go to the front office and he/she told the DON, ADON, Administrator what he/she had done; -He/she had never taken any resident medications out of the facility or for personal use; -RN E was aware CMT went to his/her car and obtained the 2 pills and RN E did not say anything about not doing it at the time; The CMT said he/she had never misappropriated any resident medication, but was unsure what happened to the resident's two Norco; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CMT D said he/she should not have replaced the resident's missing medication with his/her own personal medication and that it was, The dumbest thing I've ever done in my life. During an interview on 06/05/25 at 4:00 P.M., LPN A said the following: -He/she worked on the morning of 05/20/25 and assisted with the administration of pain medication; -He/she gave Resident #5 one Hydrocodone/APAP for complaint of pain; -He/she was in a hurry and did not notice until after administration that the pill was taped into the bubble card. During an interview on 06/05/25 at 5:02 P.M., the Director of Nursing (DON) said the following: -If a resident complained of pain, the nurse would assess the resident's pain, the nurse would then go to the CMT's medication cart, sign for the medication in the controlled medication log and have the CMT unlock the narcotic box, and the nurse would remove and administer the medication; -The nurse would then document the resident's pain level and the administration of the PRN pain medication in the resident's medication administration record (MAR) on the computer; -He/she had heard from staff that the CMTs were giving PRN pain medications to residents at times; -The facility discussed getting new nurse medication carts that contain the resident PRN narcotics so that only the nurses would have access to the PRN controlled medications; -The DON said it was a gray area as to whether CMTs should give as needed pain medications. During an interview on 06/05/25 at 5:40 P.M., the Administrator said the following: -Two staff (nurses or CMTs) should count the controlled resident medications at the beginning and end of each shift; -If the count is off, staff should do another count with another nurse, if count still off, the staff should contact the Administration or the ADON, DON, or on call nurse to notify of the situation; -The CMT should not have used personal medications to replace missing resident medications; -The nurse should have reported immediately when this occur. MO00254563