

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Joplin Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2218 W 32nd Street Joplin, MO 64804	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40769</p> <p>Based on interviews and record review, the facility failed to protect all residents from misappropriation of resident property when belongings for one resident (Resident #1), including purse, wallet, debit cards, ID cards, and money, went missing while the resident resided at the facility. The facility census was 106.</p> <p>Review of the facility policy titled, Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown source, Exploitation, dated 10/15/22, showed the following:</p> <ul style="list-style-type: none"> -All of our resident have the right to be free from abuse, neglect, exploitation, and misappropriation of resident/guest property; -The facility's policy prohibits the misappropriation of resident's property; -This policy against abuse, neglect, exploitation and misappropriation of resident property includes abuse by any other person; - Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the residents consent. Acts that may constitute the misappropriation of resident property include, but are not limited to the theft or attempted theft of a resident money or personal property of any value or type, theft of a residents medication regardless of amount, or the use of residents funds including credit cards or checks and identity theft. <p>1. Review of Resident #1's face sheet (a snap shot of resident information) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included spinal stenosis (a chronic condition that occurs when the spinal canal narrows, putting pressure on the spinal cord and nerves), chronic pain syndrome, hypo-osmolality (condition where there are low levels of electrolytes, proteins, and nutrients) and hyponatremia (a condition where there are low levels of sodium in the blood). <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/02/24, showed the following:</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Moderate cognitive impairment;</p> <p>-Required moderate assistance for transfers and mobility.</p> <p>Review of the facility's Grievance/Complaint Form, dated 11/07/24, showed the following:</p> <p>-The resident discovered his/her purse was missing. He/She said it had items in it including a wallet and cash. The cash was in the amount of 140.00 dollars in 20 dollar bills and stack of [NAME] and ones of unknown amount;</p> <p>-The action taken to resolve the concern was replacing the missing money, purse, and wallet. The facility will take the resident to replace his/her photo ID. They will also take him/her to the bank to cancel out debit cards and get new ones. A lock box was placed and bolted in a drawer in the resident's room;</p> <p>-The grievance was resolved;</p> <p>-A request was made for a check to replace 140 dollars and for 20 dollars to replace the purse and wallet;</p> <p>-The resident was notified with a one-on-one discussion;</p> <p>-The form was completed on 11/21/24 by the Administrator.</p> <p>Review of the facility's investigation, dated 11/07/24, showed the following:</p> <p>-On 11/07/24, the resident found that his/her purse was missing with items in it including his/her, purse, wallet, and cash. He/She discovered it was missing after lunch when taken to the room by the housekeeping supervisor and assisting him/her to look for his/her purse to make a payment to the facility. His/Her purse was described to be a black clutch purse with two zippers on the outside, kept inside was his/her checkbook and cash with one check left, ID card, debit cards, and wallet. The resident said he/she had, 140 dollars in 20's and stack of dollar bills and five dollar bills,. He/She was uncertain how much;</p> <p>-On 11/07/24, the Administrator spoke to resident, with Housekeeping supervisor present, regarding report of missing purse with items in it. The resident verified he/she was going to make a payment to the facility and his/her purse with ID card, two debit cards, one check, insurance cards, and wallet were not in his/her room. The resident said he/she would hide it under his/her mattress at times and the Administrator checked with no purse found. The Administrator contacted the resident's family, to see if he/she took it home and he/she said he/she did not. Resident said he/she recalled having, 140 dollars in twenties and and one dollar bills in a stack with an unknown amount of the stack. Resident said the purse was approximately twenty dollars in value;</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 11/07/24, the resident's purse was discovered missing by the resident. The Housekeeping Supervisor assisted the resident in looking for his/her purse to make a payment to the facility, the purse was found to be missing. The Housekeeping Supervisor reported this to the Unit Coordinator/Registered Nurse (RN) on the resident's hall. The Unit Coordinator/RN and the Housekeeping Supervisor reported this to Financial Specialist. The Unit Coordinator and the Financial Specialist entered resident's room to talk with resident and with permission searched his/her room. The purse was not found. The Administrator was notified at 1:00 P.M. , and he/she spoke to resident. The police department was notified. Social services was notified and a grievance was filed. The Administrator followed up with family with resident's permission to check to see if the family had taken the resident's items home. The Financial Specialist, with resident's permission, called the resident's bank to stop active debit cards and check statements to make sure there was no recent activity. The bank confirmed there had been no recent activity. The last check payment was made on 10/23/24. The resident had his/her purse at that time. On 11/07/24, transportation was provided through the facility for resident to go to the bank to pick up new debit cards. The resident was encouraged to have them locked up and wanted the Financial Specialist, to lock them up in the front office. The resident had a date set next week with transportation from the facility to go to the driver's license bureau to get a new id. A plan was set to provide the resident a new purse of comparable cost. Financial Specialist was getting the resident new insurance cards. Facility will provide a lock box for resident to keep his/her valuable items. Resident was encouraged to keep money locked up.</p> <p>Review of the Police Report, dated 11/07/24, showed the following:</p> <p>-On 11/07/24, the officer responded to the facility in reference to a possible larceny. Information gathered and report completed;</p> <p>-The resident said that he/she went to get his/her purse today to write a check and he/she could not find it. The resident said he/she kept the purse in a drawer next to his/her bed and he/she last saw/used it on 10/23/24. The resident and multiple staff members have searched through his/her room and was unable to find his/her purse. The resident described his/her purse to be a black clutch bag that contained 140 dollars in cash or slightly more, two debit cards, driver's license (ID card), vehicle insurance cards, and a check book with one check left in it (unknown check number). The resident valued his/her purse at seven dollars. The resident wished to pursue charges if his/her purse was in fact stolen. The resident had since canceled the remaining check and the two debit cards. There were no security cameras around the facility.</p> <p>-On 11/08/24, the officer contacted the resident by phone. The resident confirmed he/she had notified his/her bank and canceled the debit cards/check. The resident was not aware of any other thefts within the facility.</p> <p>-The resident was asked to contact the police department if his/her bank notified his/hr that his/her debit card got used/declined as well as the stolen check. There were currently no leads or suspects.</p> <p>During an interview on 11/21/24, at 9:19 A.M., the resident said the following:</p> <p>-He/she asked the Admission Coordinator to help her get the purse out of his/her drawer so he/she could pay his/her bill to the facility about a week and a half ago;</p> <p>(continued on next page)</p>		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00245443, MO00244807		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40769</p> <p>Based on interview and record review, the facility failed to provide care per standards of practice when facility staff failed to update orders and continue medications upon one resident's (Resident #1) return to the facility from the hospital, resulting in the resident not receiving any medication for one day. The facility census was 114.</p> <p>Review of the facility policy titled, Admission of a Resident, effective October 2010, showed the following:</p> <ul style="list-style-type: none"> -The admission process was intended to obtain all the information as possible about the resident for the development of comprehensive plans of care and to assist the resident in becoming comfortable in the facility; -To obtain a complete document of the physician's plan of care at the time of admission the resident's medical record should include treatments and medications; -The admitting licensed nurse should transcribe all physicians' orders from the transfer sheet (if transferred from another health care institution), or from the physician directly (if admitted from home) and double check for accuracy when transcribing orders onto the facility admission's order sheet; -If the transfer sheet or orders are not signed by the attending physician, a telephone order should be executed to verify the physician's approval. Add any verbal orders for changes in medications or treatments to the admission order sheet. All orders should be signed by the licensed nurse with the full name, acronym, date, and time of day; -Notify appropriate personnel and departments of admission. Notify pharmacy of new admission, medication and treatment orders, and any allergies. <p>Review of the facility policy titled, General Dose Preparation and Medication Administration, effective December 12/01/07, showed the following:</p> <ul style="list-style-type: none"> -This policy set forth the procedures relating to general dose preparation and medication administration; -Facility staff should also refer to facility policy regarding medication administration and should comply with applicable law and the State Operations Manual when administering medications. <p>1. Review of Resident #1's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Readmitted [DATE]; <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included Parkinson's disease and dyskinesia with fluctuations (a chronic brain disorder that causes movement problems, mental health issues, and other health concerns), metabolic encephalopathy (a series of neurological disorders not caused by primary structural abnormalities), unspecified protein-calorie malnutrition, and dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, memory, and reasoning, that interferes with daily life).</p> <p>Review of the resident's hospital after visit summary, dated 08/29/24, showed the resident was hospitalized from 08/29/24, at 12:30 P.M., to 09/04/24, at 10:45 P.M. The resident's medication at discharge included the following:</p> <ul style="list-style-type: none"> -Ondansetron (used to treat nausea) 4 milligrams (mg), take one tablet by mouth every 8 hours as needed for nausea/emesis. Dissolve tablet on top of tongue and then swallow with saliva; -Apixaban (anticoagulant) 2.5 mg tablet, take one tablet by mouth two times daily; -Bisacodyl 10 mg suppository (stool softener), insert one suppository by rectum daily; -Dronabinol 5 mg capsule (used to treat nausea and vomiting caused by cancer chemotherapy), take 1 capsule by mouth two times daily with meals; -Acetaminophen (pain reliever) 325 mg tablet, take 2 tablets by mouth every six hours as needed; -Amlodipine (treats high blood pressure and chest pain) 5 mg tablet, take five mg by mouth daily; -Ascorbic acid (vitamin C) 500 mg tablet, take 1 tablet by mouth 2 times daily; -Buspirone HCL (used to treat anxiety) 5 mg tablet, take three times daily orally; -Carbidopa-levodopa (used to treat Parkinson's disease) 25-100 mg, take one tablet by mouth four times daily; -Cyanocobalamin (vitamin B-12), take one 1,000 microgram (mcg) tablet by mouth daily; -Famotidine (acid reducer) 20 mg tablet two times daily; -Folic acid, five mg tablet one time per day; -Mirtazapine (treats depression) 15 mg tablet, rapid dissolve, place inside cheek daily at bedtime; -Rivastigmine tartrate (treats Parkinson's disease) 1.5 mg capsule, take one capsule by mouth two times daily with meals; -Sucralfate (used to treat ulcers) 100 mg/milliliter (ml) oral every six hours. <p>Review of the resident's progress note dated 09/05/24, at 2:31 A.M., showed Licensed Practical Nurse (LPN) A noted the following:</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident arrived from the hospital on a stretcher with no paperwork or orders. The resident was alert and oriented to self only. The resident's speech was unclear and he/she found it hard to verbalize needs in an understanding manner. The resident was incontinent of bowel and bladder and will require to be checked and changed. The resident was diagnosed with failure to thrive. The resident was on a regular mechanical soft diet and thin liquids. The resident refused a mechanical soft diet while at the hospital. Bilateral sacral (triangular bone located at the base of the spine) spine deep tissue pressure injury (Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) and unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured) wound on heel. Resident had no signs of pain or discomfort currently. Staff placed call light and cell phone within reach.</p> <p>Review of the resident's September 2024 Physician Order Sheet showed staff did not document any new medication orders, as listed on the hospital discharge summary, for 09/04/24 or 09/05/24.</p> <p>Review of the resident's September 2024 Medication Administration Record (MAR) showed staff did not document administering medications on 09/04/24, 09/05/24, or 09/06/24.</p> <p>Review of the resident's progress note dated 09/06/24, at 4:25 A.M., showed the following:</p> <p>-The resident was sent out to the hospital at approximately 12:42 A.M. in an ambulance. The resident's vitals were stable and there were no signs of acute distress at the time he/she was sent out. The resident's family visited the resident and said that he/she was different than he/she had been at the hospital. The nurse told them that the resident's condition had not changed since admission the night before. The resident's family requested he/she be sent to hospital. The on-call physician notified and order received to send out to hospital.</p> <p>During an interview on 10/03/24, at 2:20 P.M., LPN A said the following:</p> <p>-He/she was working on the over night shift when the resident returned to the facility;</p> <p>-The hospital did not call to give report and he/she did not call the hospital to get report. The resident came from the hospital with no orders or discharge paperwork;</p> <p>-He/she did not know what the policy was and did not know if there was a procedure for admitting a new resident if they did not have orders;</p> <p>-He/she did not know who was responsible for putting in new orders when a resident is readmitted ;</p> <p>-He/She did not call the physician, on-call manager, or the hospital to attempt to get orders;</p> <p>-He/she thought maybe he/she should have called the physician or the Director of Nursing (DON). but the resident was not in distress;</p> <p>-He/She said he/she let a nurse know in the morning, but he/she did not remember who that was;</p> <p>-He/she did not administer any medications to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/03/24, at 2:33 P.M., LPN B said the following:</p> <ul style="list-style-type: none"> -He/she worked at the facility on 09/05/24. He/she remembered caring for the resident. He/she was not aware that the resident did not have any medication orders entered; -If he/she would have been made aware, he/she would have called the hospital or physician to get orders. He/she would have entered them, requested them STAT from the pharmacy, and gotten any available medication out of the emergency kit if needed; -The admitting nurse was responsible for entering medication orders and contacting the physician if there was an issue; -He/she sent the resident to the hospital later that evening. <p>During an interview on 10/03/24, at 2:10 P.M., Certified Medication Technician (CMT) D said the following:</p> <ul style="list-style-type: none"> -He/she remembered working on 09/05/24. They did not have medication orders for the resident after he/she had returned from the hospital; -He/she let the nurse know that he/she could not administer any medications to the resident due to there not being orders; -He/she could not remember who the nurse was; -He/she believes that the hospital did not send discharge orders with the resident when he/she readmitted to the facility; -He/she did not know if the physician was called, but he/she would assume they would be contacted; -He/she believed the nurse can also pull medications from there emergency kit if they do not have them on hand; -The resident may not get their first dose of their medication, or it may be delayed but they should not go all day without getting their medications after they readmit. <p>During an interview on 10/03/24, at 1:25 P.M., Registered Nurse (RN) C said the following:</p> <ul style="list-style-type: none"> -If a resident was admitted /readmitted , the admitting nurse puts in the orders. If there are no orders, then the physician or hospital should be contacted to get orders. If they still cannot get orders, then the Director of Nursing (DON) should be contacted; -A resident should not go a day without medication. Staff can order important medication stat from the pharmacy. If there is a delay in getting the medication from the pharmacy, they can pull medication from the e-kit or contact the physician for an alternative; -He/she remembered the resident readmitting to the facility, but was not sure why the orders were not put in. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Joplin Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2218 W 32nd Street Joplin, MO 64804	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/03/24, at 2:45 P.M. the DON said the following:</p> <ul style="list-style-type: none"> -The admitting nurse was responsible for making sure they have medication orders and entering the orders into the computer; -The admitting nurse should contact the hospital or physician if the resident does not have orders. He/she would expect the nurse to call and get report on a new admit/readmitted resident; -It is not appropriate for a resident to go a day without any medication if the medications were necessary. The physician should be notified if this occurs. The computer system gives the nurse the option to reactivate orders if it is a readmission; -He/she was made aware of the incident, but it was after it had happened; -The facility had an emergency supply of many medications if they don't have them on hand. <p>During an interview on 10/03/24, at 3:41 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> -The admitting nurse was responsible for entering medication orders for the resident; -If a resident arrives to the facility from the hospital without orders that should be communicated and the hospital should be contacted or staff should contact their provider as soon as possible; -It is not appropriate for a resident to go all day without medication; <p>MO00243037</p>