STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265312	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Nursing	77 Medical Drive Gainesville, MO 65655

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect all residents from misappropriation of resident property when staff could not account for 19 missing narcotics tablets for 10 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9 and Resident #10). The facility census was 43. Review of the facility policy titled Abuse, Prevention and Prohibition Policy, revised 10/22, showed the following information:-Should a specific employee be suspected of or have allegations made of misappropriation, the facility will follow the investigation protocol set forth in this policy;-The facility will educate staff on the policy and procedure for prevention of misappropriation of resident property and of investigation reporting and staff responsibility.Review of the facility policy titled, Medication Administration-General Guidelines, dated 01/01/18, showed the following information:-If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted, or medication removed from the night box/emergency kit (I-STAT - an automated dispensing cabinet used to securely store and track medications);-When medications are administered, the mobile medication cart is taken to the resident's location (room, dining area, etc).Review of the facility policy titled Controlled Substance Policy, revised 10/22, showed the following information:-Controlled substances are subject to special handling, storage, disposal, and record-keeping requirement. The facility will maintain compliance with these special provisions;-The Director of Nursing (DON) is responsible for the control of such drugs;-Controlled drugs are to be stored under double-lock conditions;-The key must remain in the possession of the licensed nurse or certified medication technician (CMT) that completed the count at all times during their shift;-Should it be necessary to give the keys to another licensed practical nurse (LPN) or CMT, a count will be done to verify the inventory;-All controlled substances are to be counted every shift;-Any discrepancy in the inventory of controlled substance is to be reported to the DON immediately. 1. Review of the facility's investigation report, undated, showed the following information:-On 02/26/26, at 7:00 A.M., Registered Nurse (RN) B gave off going shift report to oncoming RN A;-RN B then saw RN A standing in the medication room in front of the I-STAT logging into the machine to dispense medication;-RN B asked CMT C if he/she asked RN A to withdraw any medication from the I-STAT. CMT C said that he/she did not;-RN B then saw RN A walking from the bathroom. RN A said to RN B Well, I feel alive again. RN B said I didn't know you were dead. RN A said, You know, just not ready for the day.;-RN B immediately went to his/her car and notified the DON of the behavior;-The DON immediately notified the Administrator;-The DON and Administrator pulled up the I-STAT records and discovered that on 02/26/27, at 6:57 A.M., RN A had signed out an oxycodone (opiate used to treat moderate to severe pain) IR (immediate release) 10 milligram (mg) tablet under Resident #1's name;-On 02/26/27, at 8:00 A.M., the Administrator interviewed Resident #1. The resident could not remember the last time he/she received a pain pill. He/she thought it had been about three hours prior. The resident did remember that it was a female that gave him/her the medication;-The DON and Administrator interviewed RN A;-RN A said that he/she had not assessed (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1. RN A pulled the oxycodone IR 10 mg tablet for Resident #1 because he/she knew the resident would need the medication;-RN A said that he/she went to the bathroom immediately after pulling the medication from the I-STAT because he/she had diarrhea;-The DON told RN A that his/her behavior was very suspicious due to the fact that the medication had not been documented, the CMT covering the hall had not asked RN A to pull the medication, the resident had not been assessed nor asked for the medication, the Medication Administration Record (MAR) had not been checked to confirm when the last pain medication was given, and RN A had not looked for the medication in the medication cart. RN A went straight to the I-STAT and there was no proof that the medication was given;-RN A told the DON and the Administrator that he/she had not taken the medication;-The DON and Administrator told RN A that he/she was suspended pending an investigation;-RN A tossed his/her keys on the DON's desk and left the building;-On 02/26/26, at 9:17 A.M., the Administrator reported the incident to the Department of Health and Senior Services (DHSS);-On 02/26/26, at 9:29 A.M., the Administrator reported the incident to the Sheriff's office;-The Medical Director and Nurse Practitioner were also notified;-The DON printed a report of all the narcotics RN A had pulled from the I-STAT machine for the past six months. The report showed that on sixteen separate occasions, RN A pulled narcotics from the I-STAT without documenting on the MAR;-The DON asked CMT D, CMT E, and CMT F if they had ever asked a nurse to pull medication for them from the I-STAT machine. CMT D, CMT E, and CMT F said that they had never asked a nurse to pull a narcotic from the I-STAT;-Medication cards for the above narcotics were available in the medication carts.2. Review of Resident #1's face sheet (a brief resident profile sheet) showed the following information:-admission date of 03/16/17;-Diagnoses included multiple sclerosis (a chronic autoimmune disease disrupting communication between the brain and body), chronic obstructive pulmonary disease (COPD - lung disease), atrial fibrillation (irregular heart rate and rhythm) and dementia.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/06/26, showed the following information:-Moderately impaired cognitive skills;-Reported moderate pain intensity;-Pain frequently was constantly.Review of the resident's current care plan, last updated 01/22/26, showed staff to ensure the resident was assessed for pain.Review of the resident's current Physician Order Sheet (POS) showed an order, dated 12/01/25, for oxycodone IR 10 mg, one tablet every four hours as needed for pain.Review of the I-STAT documentation of medications that were removed by RN A showed on 12/25/25, at 8:18 A.M., RN A withdrew oxycodone IR 10 mg tablet for the resident. Review of the resident's electronic medical record (EHR) and MAR showed RN A did not document administration of the oxycodone IR removed from the I-STAT on 12/25/25. Review of the I-STAT documentation of medications that were removed by RN A showed on 12/29/25, at 3:59 P.M., RN A withdrew oxycodone IR 10 mg tablet for the resident. Review of the resident's EHR and MAR showed RN A did not document administration of the oxycodone IR removed from the I-STAT on 12/29/25.Review of the I-STAT documentation of medications that were removed by RN A showed on 01/12/26, at 3:04 P.M., RN A withdrew oxycodone IR 10 mg tablet for the resident. Review of the I-STAT documentation of medications that were removed by RN A showed on 01/12/26, at 7:23 P.M., RN A withdrew oxycodone IR 10 mg tablet for the resident. Review of the resident's EHR and MAR showed RN A did not document administration of the oxycodone IR removed from the I-STAT on 01/12/26.Review of the I-STAT documentation of medications that were removed by RN A showed on 01/26/26, at 3:03 P.M., RN A withdrew oxycodone IR 10 mg tablet for the resident. Review of the resident's EHR and MAR showed RN A did not document administration of the oxycodone IR removed from the I-STAT on 01/26/26.Review of the I-STAT documentation of medications that were removed by RN A showed on 02/26/26, at 6:57 A.M., RN A withdrew oxycodone IR 10 mg tablet for the resident. Review of the resident's EHR and MAR showed RN A did not document administration of the oxycodone IR removed from the I-STAT on 02/26/26.3. Review of Resident #2's face sheet showed the following information:-admission date of 08/21/25;-Diagnoses included brain cancer, COPD, and Type 2 Diabetes.Review of the resident's (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P.M., RN A withdrew hydrocodone-APAP 5/325 mg tablet for the resident. Review of the resident's EHR and MAR showed RN A did not document administration of the hydrocodone-APAP removed from the I-STAT on 01/12/26.8. Review of Resident #7's face sheet showed the following information:-admission date of 09/30/18;-Diagnoses included Alzheimer's disease, dementia, morbid obesity, and high blood pressure. Review of the resident's quarterly MDS, dated [DATE], showed the following information:-Severely impaired cognition;-Reported occasional pain frequency.Review of the resident's care plan, last updated on 06/12/25, showed staff to ensure the resident was assessed for pain.Review of the resident's current POS showed an order, dated 12/20/25, for hydrocodone-APAP 5-325 mg, one tablet every four hours as needed for pain.Review of the I-STAT documentation of medications that were removed by RN A showed on 01/12/26, at 7:24 P.M., RN A withdrew hydrocodone-APAP 5/325 mg tablet for the resident. Review of the resident's EHR and MAR showed RN A did not document administration of the hydrocodone-APAP removed from the I-STAT on 01/12/26.9. Review of Resident #8's face sheet showed the following information:-admission date of 07/29/24;-Diagnoses included high blood pressure, encopresis (leaking of stool from the rectum), and cachexia (severe weight and muscle loss).Review of the resident's quarterly MDS, dated [DATE], showed the following information:-Normal cognition;-Reported frequently having pain.Review of the resident's care plan, last updated on 08/12/25, showed staff to ensure the resident is assessed for pain.Review of the resident's current POS showed an order, dated 12/23/25, for hydrocodone-APAP 5-325 mg, one tablet every six hours as needed for pain.Review of the I-STAT documentation of medications that were removed by RN A showed on 01/12/26, at 7:24 P.M., RN A withdrew hydrocodone-APAP 5/325 mg tablet for the resident. Review of the resident's EHR and MAR showed RN A did not document administration of the hydrocodone-APAP removed from the I-STAT on 01/12/26.Review of the resident's EHR and MAR showed RN A did not document administration of the hydrocodone-APAP removed from the I-STAT on 01/12/26.10. Review of Resident #9's face sheet showed the following information:-admission date of 07/21/24;-Diagnoses included heart failure, atrial fibrillation (irregular heart rate and rhythm), dementia, anxiety, and stroke.Review of the resident's quarterly MDS, dated [DATE], showed the following information:-Severely impaired cognition;-Reported frequently having pain.Review of the resident's care plan, last updated on 06/12/25, showed staff to ensure the resident is assessed for pain.Review of the resident's current POS showed an order, dated 01/30/26, for tramadol 50 mg, one tablet every six hours for pain.Review of the I-STAT documentation of medications that were removed by RN A on 02/02/26, at 9:57 P.M., RN A withdrew tramadol 50 mg tablet for the resident. Review of the resident's EHR and MAR showed RN A did not document administration of the tramadol removed from the I-STAT on 02/02/26.10. Review of Resident #10's face sheet showed the following information:-admission date of 02/07/26;-Diagnoses included congestive heart failure, right lower extremity amputation, high blood sugar and peripheral vascular disease (narrowing blood vessels).Review of the resident's admission MDS, dated [DATE], showed the following information:-Normal cognition;-Reported frequently having pain.Review of the resident's care plan, last updated on 02/09/26, showed staff to ensure the resident was assessed for pain.Review of the resident's current POS showed an order, dated 02/07/26, for tramadol 50 mg, two tablets every six hours as needed for pain.Review of the I-STAT documentation of medications that were removed by RN A showed on 02/15/26, at 12:10 P.M., RN A withdrew tramadol 50 mg tablet for the resident. Review of the resident's EHR and MAR showed RN A did not document administration of the tramadol removed from the I-STAT on 02/15/26.11. During an interview on 03/12/26, at 9:47 A.M., CMT C said the following:-He/she counted the narcotics with the oncoming and off going CMT every shift;-Staff should notify the DON immediately if the narcotic count was off;-He/she signed out the narcotic in the narcotic book log and on the MAR;-He/she would only pull medications from the I-STAT if the medication was not in the medication cart;-He/she has never had to pull a narcotic from the I-STAT;-Misappropriation means stealing resident medications. During an interview on 03/12/26, at 11:06 A.M., RN G said the following:-He/she did a narcotic count with (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the off going nurse every shift;-Notify the DON of any discrepancy immediately;-Any missing narcotics is considered misappropriation;-All scheduled and PRN narcotics are located in the medication carts under double locks;-Narcotics should be signed out on the narcotic log and the MAR;-I-STAT is available to override any medication that is needed;-Each nurse has a personalized long in and passcode to get into the I-STAT machine;-If pulling medications from the I-STAT, staff must sign off as administering the medication on the MAR.During an interview on 03/12/26, at 11:25 A.M, CMT D said the following:-He/she did a narcotic count with the off going nurse every shift;-He/she signed out all narcotics in the narcotic log and on the MAR;-All narcotics were double locked;-He/she never gives his/her keys to anyone at any time during his/her shift;-He/she would notify the DON immediately with any narcotic discrepancy;-He/she considered missing medications misappropriation.During an interview on 03/12/26, at 11:39 A.M., the Pharmacist Consultant said the following:-Medications are delivered daily from the pharmacy to the facility;-The pharmacy runs a report of controlled medications daily;-The I-STAT does not account for the medication being administered, only how many narcotics are in the I-STAT machine, so if the count is correct, it will not create a discrepancy.During an interview on 03/12/26, at 11:46 A.M., the DON said the following:-He/she knew that RN A had a history of medication diversion in the past;-RN A was told not to administer any narcotics to residents. RN A was told that CMT's administer all medications;-It was discovered that RN A was pulling medication from the I-STAT;-The DON was running a discrepancy report weekly on the I-STAT and was doing a monthly narcotic count with the Pharmacist Consultant, however, what the RN A was doing, did not create a discrepancy;-The DON ran a report by each nurse's name, that showed every medication that the nurse pulled from the I-STAT. That list was then compared against the EHR MAR and the narcotic log;-RN A had been pulling medications and not administering them to the residents;-The DON is now completing a weekly audit of narcotics, comparing the medications pulled from the I-STAT against the medications administered in the EHR MAR;-The DON said he/she should have been completing the weekly audit and comparing the medications against the EHR MAR every week then he/she would had known immediately that RN A was diverting medications.During an interview on 03/12/26, at 4:30 P.M., the Administrator said the following:-On 02/26/26, the DON notified him/her of a potential medication diversion;-The DON and the Administrator immediately started an investigation and discovered that RN A had been removing narcotics from the I-STAT machine and not administering the medications to residents;-The DON and the Administrator have been monitoring and auditing weekly since the diversion;-The Administrator expected staff to administer medication to the residents and document the medication administration appropriately;-The Administrator expected the DON to monitor medication administration and documentation of administration weekly;-The Administrator said that missing narcotics is considered misappropriation of property.Complaint #2789239