

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Waynesville		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Birch Lane Waynesville, MO 65583	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43024</p> <p>Based on record review and interviews, facility staff failed to report allegations of misappropriation to the Department of Health and Senior Services (DHSS) within the twenty four hour required time frame for two residents (Resident #1, and Resident #2). The facility census was 81.</p> <p>1. Review of the facility's policy, Incident and Reportable Event Management, reviewed 12/1/23, showed staff are directed to report all alleged violations involving abuse. Neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long-term care facilities) in accordance with state law through established procedures.</p> <p>2. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 2/23/24, showed staff assessed the resident as cognitively intact.</p> <p>Review of the facility's misappropriation investigation, dated 3/26/24, showed staff documented the resident reported ten dollars missing on 3/23/24 to the Business Office Manager. Review showed the resident had kept his/her wallet with cash in his/her room and was not found when searched. Review showed the investigation did not contain documentation staff notified DHSS of the allegation of misappropriation of the residents money.</p> <p>During an interview on 3/26/24 at 10:27 A.M., the resident said he/she had ten dollars stolen and the office is aware. The resident said he/she saw the money in his/her wallet on 3/20/24. He/She said he/she did not access his/her wallet on 3/21/24 and noticed his/her money missing on 3/22/24. The resident said he/she did tell a nurse on 3/22/24 but can not remember which one, he/she also told the social worker and the business office manager.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/24 at 10:48 A.M., the administrator said he/she was notified on either 3/22/24 or 3/23/24, the resident had money missing. He/She said he/she instructed staff to search the resident's room because he/she has been out of the office, but nothing formal was started until 3/25/24. The administrator said he/she was not aware the Director of Nursing (DON) was not in the building and thought he/she would start the investigation. The administrator said he/she did not report the allegation to the state survey agency and did not have a designee report to state.</p> <p>During an interview on 3/26/24 at 11:51 the Business office manager said the resident told him/her about the missing money on 3/23/24 and he/she let the administrator know. He/She was not instructed to contact the state survey agency.</p> <p>During an interview on 3/26/24 at 12:02 P.M., the DON said he/she was not made aware of the allegation in a timely manner to follow the regulation of reporting.</p> <p>3. Review of Resident #2's medical record showed he/she admitted on [DATE] and did not have an MDS on file.</p> <p>Review of the facility's misappropriation investigation, dated 3/11/24, showed staff documented the resident was discharged to the hospital on 3/11/24. Review showed the resident had kept his wallet with cash in it tucked into his/her pillowcase. Review showed the residents family member called and asked where his/her wallet was, the resident's bed had already been stripped, staff searched the linens in the dirty laundry and found the resident's wallet there. Review showed Registered Nurse (RN) A turned the wallet into the SSD without checking contents. Review showed staffed documented they kept the wallet in his/her office in an unlocked tray and did not verify the contents of the wallet. Review showed the resident's member picked the wallet up after hours on 3/11/24 and called on 3/12/24 at approximately 11:30 A.M. to report \$260.00 missing out of the wallet.</p> <p>Review of the DHSS online confirmation report, dated 3/15/24, showed the administrator notified DHSS of the allegation of misappropriation on 3/15/24 at 4:42 P.M., 3 days after the alleged misappropriation.</p> <p>4. During an interview on 3/26/24 at 12:02 P.M., the DON said his/her expectation is to follow the policy and procedure and report to state immediately or within twenty four hours, he/she is an interim DON at the facility and was not here to report the allegation in a timely manner.</p> <p>During an interview on 3/26/24 at 12:15 AP.M., the administrator said he/she expects the facility policy and procedure to be followed but is behind, he/she did not realize it was such a short time frame for reporting because it's not a high severity.</p> <p>MO00233252</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43024</p> <p>Based on interview and record review, facility staff failed to start an investigation in a timely manner when one resident (Resident #1) reported missing money from his/her wallet. Facility staff failed to complete a thorough investigation when a family member reported one resident (Resident #2's) money missing from his/her wallet. The facility census was 81.</p> <p>1. Review of the facility's Abuse Conducting an Investigation policy, reviewed 7/18/23, showed allegations of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. Review showed when an incident of misappropriation of resident property is reported, the administrator or designees will investigate the occurrence, if the investigation is being conducted by the designee, the administrator will be consulted daily concerning the progress of the investigation. Review showed it is expected that the investigation would include, but is not limited to:</p> <ul style="list-style-type: none"> -Conducting interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses, practitioners, and hospital and emergency room staff. -The written summary of the investigation should include, but is not limited to: -Interviews with any witnesses to the incident; -Interviews with the resident's roommate, family, and/or visitors who may have information regarding the incident; -Interviews with other residents. <p>2. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 2/23/24, showed staff assessed the resident as cognitively intact.</p> <p>Review of the facility's misappropriation investigation, dated 3/26/24, showed staff documented the resident reported ten dollars missing on 3/23/24 to the Business Office Manager. Review showed the resident had kept his wallet with cash in his/her room and was not found when searched. Review showed the ten dollars was replaced by the facility to the resident.</p> <p>During an interview on 3/26/24 at 10:27 A.M., the resident said he/she had ten dollars stolen and the office is aware. He/She said he/she saw the money in his/her wallet on 3/20/24, he/she did not access his/her wallet on 3/21/24 and noticed his/her money missing on 3/22/24. He/She said he/she did tell a nurse on 3/22/24 but can not remember which one, he/she also told the social worker and the business office manager.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/24 at 10:48 A.M., the administrator said he/she was notified on either 3/22/24 or 3/23/24 the resident had money missing. The administrator said he/she instructed staff to search the resident's room because he/she has been out of the office but nothing formal was started until 3/25/24. The administrator said he/she was not aware the Director of Nursing (DON) was not in the building and thought he/she would start the investigation. The administrator said he/she never instructed the DON to start an investigation.</p> <p>During an interview on 3/26/24 at 10:55 A.M., the DON said he/she just found out the resident reported his/her money missing three minutes ago.</p> <p>During an interview on 3/26/24 at 10:58 the Social Services Director (SSD) said he/she found out the resident was missing money yesterday 3/25/24 and it was discussed in morning meeting that the facility would replace his/her money.</p> <p>During an interview on 3/26/24 at 11:51 the Business Office Manager said the resident told him/her about the missing money on 3/23/24 and he/she let the administrator know. He/She was not instructed to start an investigation.</p> <p>During an interview on 3/26/24 at 12:02 P.M., the DON said he/she just started the investigation into the resident's missing money. The DON said his/her expectation is to follow the policy and procedure and start the investigation promptly. He/She said, I was not made aware of the allegation in a timely manner to be able to start the investigation.</p> <p>During an interview on 3/26/24 at 12:15 AP.M., the administrator said he/she expects the facility policy and procedure to be followed and did not realize and investigation needed to be started so quickly in terms of severity.</p> <p>3. Review of Resident #2's medical record showed he/she admitted to the facility on [DATE] and did not have an MDS on file.</p> <p>Review of the facility's misappropriation investigation, dated 3/11/24, showed staff documented the resident discharged to the hospital on 3/11/24. Review showed the resident had kept his/her wallet with cash in it tucked into his/her pillowcase. Review showed the residents family member called and asked where his/her wallet was. The residents bed had been stripped, staff searched the linens in the dirty laundry, and found the resident's wallet. Review showed Registered Nurse (RN) A turned the wallet into the SSD without checking contents. Review showed staffed documented they kept the wallet in his/her office in an unlocked tray and did not verify the contents of the wallet. Review showed the resident's family member picked the wallet up after hours on 3/11/24 and called on 3/12/24 at approximately 11:30 A.M. to report \$260.00 missing out of the wallet. Review showed the investigation did not contain documentation of resident interviews with the resident's roommate, visitors, and other possible witnesses.</p> <p>During an interview on 3/26/24 at 10:48 A.M., the administrator said no other residents were interviewed for the investigation.</p> <p>During an interview on 3/26/24 at 10:55 A.M., the DON said he/she is unsure if any other residents, visitors, or possible witnesses were interviewed, he/she expects the SSD would oversee that.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/24 at 10:58 the SSD said he/she did not interview any other resident's for the investigation, the DON was supposed to provider him/her with questions but never did.</p> <p>During an interview on 3/26/24 at 12:02 P.M., the DON said he/she expects staff to follow policy and procedure and to always interview other residents and possible witnesses.</p> <p>During an interview on 3/26/24 at 12:15 P.M., the administrator said he/she is not aware of what their facility policy says on investigations but expects it to be followed and he/she will read the policy to have a better understanding.</p> <p>MO00233252</p>		