STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265456	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abode Health and Wellness Center	17451 Medical Center Parkway Independence, MO 64057

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 - 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 interview and record review, the facility failed to protect three sampled residents (Resident #1, #6, and #9) from misappropriation of property out of nine sampled residents. The facility census was 48 residents.A facility policy for Theft and Misappropriation of Resident Property was requested and not provided. A facility policy for Controlled Substances was requested and not provided. A facility policy for Discarding and Destroying Medication was requested and not provided. A facility policy for Medication Administration and Documentation was requested and not provided. 1.Review of Resident #1's admission Record showed the resident admitted to the facility on [DATE] and was re admitted to the facility on [DATE] with a diagnosis of chronic pain. Review of the resident's Brief Interview for Mental Status (BIMS) dated 7/15/25 showed the resident was moderately impaired. Review of the resident's care plan revised 7/16/25, showed:-The resident was on pain medication related to chronic pain.--Staff was to administer analgesic medications as ordered by physician.--Staff was to monitor and document side effects and effectiveness every shift. Review of the resident's Physicians Order Sheet (POS) dated 7/1/25-12/19/25 showed:-Percocet (Oxycodone w/Acetaminophen- Opioid, narcotic analgesic) Oral Tablet 5-325 milligram (mg). Give 1 tablet by mouth every 6 hours as needed for pain was started on 7/31/25 and discontinued on 8/19/25.-Percocet Oral Tablet 5-325 mg. Give 2 tablet by mouth every 6 hours as needed for pain was started on 7/31/25 and discontinued on 8/19/25.- Percocet Oral Tablet 5-325 mg. Give 1 tablet by mouth every 4 hours as needed for pain was started on 8/19/25 and discontinued on 9/24/25.-Percocet Oral Tablet 5-325 mg. Give 2 tablet by mouth every 4 hours as needed for pain was started on 8/19/25 and discontinued on 9/24/25.-Hydrocodone-Acetaminophen Tablet 5-325 mg (Norco - Opioid, analgesic narcotic). Give 1 tablet by mouth three times a day for pain was started on 9/24/25. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 8/26/25 showed one 30 count pack of Percocet Oral Tablet 5-325 mg was delivered to the facility. Review of the resident's Controlled Substance Accountability Sheet 1 of 1 dated 8/26/25 showed Licensed Practical Nurse (LPN) A removed 22 Percocet 5-325 mg tablets for the resident from 9/1/25 to 9/5/25.Note: On 9/2/25 at 11:15 A.M., LPN A signed out 4 Percocet 5-325 mg tablets and documented on the accountability form that 2 of the 4 tablets dropped on the floor. There is no documentation the tablets were wasted by a second staff member. Review of the resident's MAR dated 9/1/25-9/30/25 showed he/she was administered 4 tablets Percocet 5-325 mg tablets 9/1/25 to 9/5/25.Note: From 9/1/25 to 9/5/25 there were 18 unaccounted for oxycodone/acetaminophen 5-325 mg tablets signed out of the accountability sheet by LPN A that were not documented as being given to the resident on the resident's MAR. Review of the POS dated 7/1/25-12/19/25 showed:- Percocet Oral Tablet 5-325 mg. Give 1 tablet by mouth every 4 hours as needed for pain was discontinued on 9/24/25. -Percocet Oral Tablet 5-325 mg. Give 2 tablet by mouth every 4 hours as needed for pain was discontinued on 9/24/25. -Norco Tablet 5-325 mg. Give 1 tablet by mouth three times a day for pain was started on 9/24/25. Review of the pharmacy's Controlled (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed LPN A removed 25 Norco 5-325 mg tablets between 10/27/25 - 11/30/25. Review of the resident's Controlled Substance Accountability Sheet dated 10/27/25 showed LPN A documented the removal of 13 Norco between 10/27/25-11/23/25. Note: The facility only provided the accountability sheet up to 11/26/25. 12 Norco 5-325 mg tablets were unaccounted for. Review of the resident's MAR dated 11/1/25-11/30/25 showed he/she was administered 11 tablets of Norco 5-325 mg between 10/27/25 to 11/30/25.-NOTE: 14 Norco 5-325 mg tablets were unaccounted for. Review of the pharmacy's Controlled Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed LPN A removed 15 Norco 5-325 mg tablets between 12/2/25 - 12/14/25. Review of the resident's MAR dated 12/1/25-12/31/25 showed:-He/She was administered 7 tablets of Norco 5-325 mg between 12/2/25 to 12/7/25.-Note: The provided the resident's MAR documentation up to 12/7/25 with no documentation of Norco administration after that date. -NOTE: 14 Norco 5-325 mg tablets were unaccounted for. During an interview on 12/19/25 at 10:00 A.M., Pharmacist and Operational Manager said:-2 packs of 30 (60 total) Percocet pills were delivered to the facility on 7/31/25.-1 pack of 30 Percocet pills were delivered to the facility on 8/26/25.-1 pack of 30 Percocet pills were delivered to the facility on 9/5/25.-1 pack of 30 Percocet pills were delivered to the facility on 9/11/25.-1 pack of 30 Percocet pills were delivered to the facility on 9/19/25.-1 pack of 30 Percocet pills were delivered to the facility on 9/23/25.-3 packs of 30 (90 total) Norco 5-325 mg pills were delivered to the facility on 9/26/25.-Each 30 pack would have had its own accountability sheet.-If an accountability sheet can't be accounted for, then neither can the narcotic pills that the sheet was holding accountable. -If the only accountability sheet that the facility could provide for Percocet that was delivered on 7/31/25 was 2 of 2, that meant sheet 1 of 2 (30 pills) were unaccounted for. -If the facility could not provide the accountability sheet for the Percocet (30 pills) delivered on 9/5/25, the pills were unaccounted for.-If the facility could not provide the accountability sheet for the Percocet 30 pills) delivered on 9/11/25, the pills were unaccounted for.-If the only accountability sheet that the facility could provide for Norco that was delivered on 9/26/25 was 2 of 3, that meant sheet 1 of 3 (30 pills) and sheet 3 of 3 (30 pills) were unaccounted for, for a total of 60 pills. -The resident's narcotic medication began to get dispensed from the medication dispensary (pyxis) on 10/27/25, due to the physician changing the medication order from as needed to schedule and no further narcotic packs were delivered to the facility. During an interview on 12/19/25 at 2:44 P.M. LPN B said on 8/10/25, a urine sample was taken for the resident and tested for opioids at the lab and the resident's urine test came back negative for opioids, despite LPN A consistently signing the opioids out on the resident's narcotic accountability log. 2. Review of Resident #6's admission Record showed the resident admitted to the facility on [DATE] and was re admitted to the facility on [DATE], with a diagnosis of pain in the right knee. Review of the resident's BIMS dated 12/17/25 showed the resident was cognitively intact. Review of the resident's POS dated 7/1/25-10/31/25 showed:-Percocet Oral Tablet 5-325 mg. Give one tablet by mouth every 6 hours as needed for pain was started on 8/19/25 and discontinued on 9/12/25.-Percocet Oral Tablet 5-325 mg. Give one tablet by mouth at bedtime started on 9/12/25 and discontinued on 10/15/25. Review of the residents MAR dated 10/1/25 -10/31/25 showed from 10/1/25-10/11/25 there was 1 unaccounted for Percocet 5-325 mg tablets. Review of the pharmacy's Controlled Substance Dispense log on 12/19/25 at 9:00 A.M., showed LPN A removed 2 Percocet on 11/30/25. Review of the resident's MAR dated 11/1/25-11/31/25 showed, 1 Percocet was administered by LPN A.NOTE: 1 Percocet tablet was unaccounted for. Review of the pharmacy's Controlled Substance Dispense log on 12/19/25 at 9:00 A.M., showed LPN A removed 10 Percocet between 12/2/25- 12/14/25. Review of the resident's MAR dated 12/1/25-12/31/25 showed he/she was administered 5 tablets of hydrocodone (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/2/25 to 12/14/25.NOTE: 5 Percocet tablet was unaccounted for. During an interview on 12/19/25 at 11:54 A.M. the resident said:-He/She only received pain medication at night.-He/She never asked for pain medication during the day when the medication was ordered as needed. -He/She did not receive the signed-out pain medication that was on the accountability logs unless they were given at night.-He/She did not receive pain medication from LPN A on 8/29/25 at 7:25 A.M, 9/1/25 at 6:40 A.M., or 9/5/25 at 7:20 A.M. because he/she was never awake that early.-The physician recently changed his/her medication order to get it scheduled.-He/She heard it was changed because some of his/her pain medication was missing. 3. Review of Resident #9's admission Record showed the resident admitted to the facility on [DATE] and was re admitted to the facility on [DATE], with a diagnosis of chronic pain. Review of the resident's BIMS dated 12/10/25 showed the resident was cognitively intact. Review of the resident's POS dated 7/1/25-12/19/25 showed:-Oxycodone tablet 5 mg. Give one tablet by mouth every 6 hours as needed for pain was started on 7/18/25 and discontinued on 9/10/25.-Oxycodone tablet 5 mg. Give one tablet by mouth every 4 hours as needed for pain was started on 9/10/25 and discontinued on 10/1/25.-Norco Tablet 5-325 mg. Give 1 tablet by mouth two times a day for pain was started on 10/1/25. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 7/12/25 showed one 28 count pack of Oxycodone was delivered to the facility. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 9/10/25 showed one 30 count pack of Oxycodone was delivered to the facility. Review of the resident's Controlled Substance Accountability Sheet 1 of 1 dated 9/10/25 showed: -LPN A removed 30 oxycodone tablets. -LPN A was the only staff member who signed out on the accountability log. Review of the resident's MAR dated 9/1/25-9/31/25 showed:-He/She was administered 5 tablets of oxycodone 9/18/25 to 9/30/25.-Note: From 9/18/25-9/30/25 there were 24 unaccounted for oxycodone signed out of the accountability sheet by LPN A that were not documented as being given to the resident on the resident's MAR.-Note: LPN A was the only nurse who signed out any of the oxycodone on this narcotic accountability log. Review of the pharmacy's Controlled Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed LPN A removed 2 Norco on 10/27/25 from the automatic dispenser. Review of the resident's Controlled Substance Accountability Sheet dated 10/1/25 showed LPN A removed 1 Norco tablet from the medication cart supply on 10/27/25. Review of the resident's MAR dated 10/1/25-10/31/25 showed 1 Norco was documented as administered to the resident. -NOTE: 2 Norco tablets were unaccounted for. Review of the resident's Controlled Substance Accountability Sheet dated 10/20/25 showed the accountability sheet provided by the facility only went to 11/15/25. Review of the pharmacy's Controlled Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed LPN A removed 14 Norco tablets between 11/9/25 - 11/30/25. Review of the resident's MAR dated 11/1/25-11/30/25 showed: he/she was administered 8 hydrocodone tablets 11/8/25 to 11/30/25. -Note: 6 Norco were unaccounted for. Review of the pharmacy's Controlled Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed LPN A removed 10 Norco tablets between 12/2/25 - 12/14/25. Review of the resident's MAR dated 12/1/25-12/31/25 showed he/she was administered 5 hydrocodone tablets 12/2/25 -12/7/25. -Note: 5 Norco were unaccounted for. During an interview on 12/19/25 at 12:15 P.M. the resident said:-He/She did not ask for pain medication much when it was ordered as needed.-He/She was unsure why the physician changed the order to get pain medication twice a day. -He/She did not receive all of the oxycodone that was signed out for him/her on the narcotic countability logs. 4. During an interview on 12/19/25 at 10:20 A.M., Registered Nurse (RN) A said:-He/She was the Director of Nursing (DON) in training. -The as needed pain medications was administered from the medication cart, from a bubble pack.-The scheduled pain medication was administered from the pixus style dispense machine in the medication room. -When a nurse or Certified Medication Technician (CMT) gave (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a resident a pain medication, the order should have been looked up in the resident's MAR to ensure accuracy and documented in the resident's MAR that the medication was administered. -If a nurse or CMT gave a resident a pain medication that was a narcotic, in addition to signing the resident's MAR, the nurse or CMT should have signed the narcotic out on the resident's narcotic accountability sheet. -The Assistant Director of Nursing (ADON) was LPN A.-LPN A was the one who was responsible for monitoring the facility's narcotic logs. -When a label on a narcotic accountability sheet stated, 1 of 2, this meant that 2, 30 count packs of that narcotic and 2 narcotic accountability sheets were delivered from the pharmacy to the facility. During an interview on 12/19/25 at 12:28 P.M., the Physician said:-He/She changed the resident's as needed oxycodone orders to scheduled hydrocodone orders because he/she knew that oxycodone was not being administered to the resident's as they were being signed out.-He/She suspected narcotic diversion at the facility.-Changing the pain medication orders to scheduled forced more accountability with the pain medication as scheduled pain medication was dispensed from the machine and not from the medication cart. -He/She was upset because the narcotics unaccounted for at the facility fell under his/her medical license.-All pain medication should be documented by staff per the professional standards and guidelines. -If a resident's medication was not documented on the residents MAR, then it could not be proven that a medication was given to the resident. During an interview on 12/19/25 2:13 P.M., CMT A said:-The CMT's administered the scheduled pain medication to the residents.-The nurses administered the as needed pain medications to the residents.-All administered pain medication was supposed to be documented as given in the resident's MAR and on the resident's narcotic accountability sheets.-If a resident's medication was not documented on the residents MAR, then the medication was not given to the resident. -There was missing narcotics in the facility.-The missing narcotics were reported to the previous Administrator and the regional nurse consultant.-He/She was one of the staff members who reported the missing narcotic to the Administrator and regional nurse back in September. -He/She was unsure of the exact date that he/she reported the missing narcotics to the Administrator and the regional nurse. -Other staff members have also reported missing narcotic to the Administrator and the regional nurse, which included, LPN B and CMT B. During an interview on 12/19/25 at 2:44 P.M., LPN B said:-He/She noticed that LPN A was the only staff member to consistently give as needed pain medication to the residents. -LPN A signed out narcotics on accountability sheets but was not documenting that he/she administered them to the residents.-He/She knew that to be true because he/she would ask the residents if they received their pain medication right after LPN A signed them out and the residents would say no and he/she reported to prior ownership. -He/She reported missing narcotics in March to the previous administration under the previous owners. -He/She reported that there were narcotics missing in September again to the current regional nurse who was the interim Administrator at the time for the new company. -He/She reported the missing narcotics to the regional nurse who was acting as the Administrator at that time. -LPN A was not signing the residents MARs after he/she signed narcotics out on the accountability logs.-LPN A was suspended in September 2025 under the previous ownership for drug diversion. - September is when the missing narcotics were reported again due to them continuing to be unaccounted for.-The reporting in September was to the regional nurse who was the interim Administrator at the time of reporting. -LPN A was allowed to come back with the rule that he/she could no longer work the medication carts or have access to the narcotics.-When the new company bought the old company out, the new company was not made aware of the agreement and the drug diversion investigation involving LPN A, and gave LPN A the narcotic keys back. -LPN A was pulled from the floor from the previous company and since the new company has allowed him/her back on the floor, narcotics started disappearing (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	again. -He/She witnessed entire cards of narcotics disappear after LPN A worked. During an interview on 12/19/25 at 3:23 P.M., CMT B said:-He/She has worked at the facility for 3 years.-He/She believed that drug diversion has been occurring at the facility.-Drug diversion occurred with the previous owners that involved LPN A and has been occurring again since LPN A started working back on the floor. -He/She asked Resident #1 why the resident started asking for an increased amount of pain medication a few months back and Resident #1 informed him/her that LPN A instructed the resident to do so. -He/She reported the missing narcotics to the previous administration under the previous ownership in March. -He/She asked Resident #6 and Resident #9 on several occasions if they received pain medication after LPN A signed the medications out on the narcotic accountability log, and both residents have denied receiving the medication that was signed out by LPN A on numerous occasions. -He/She worked on a weekend with LPN A when he/she witnessed an entire pill card full of oxycodone disappear. -At the time of the missing narcotics being gone, him/her and LPN A were the only staff members with access to the medication cart. -The missing medication card and accountability sheet belonged to Resident #1 and was delivered on 7/31/25.-He/She reported the missing medication to the previous interim Administrator. During an interview on 12/19/25 at 3:44 P.M. LPN A said: -He/She was the Assistant Director of Nurses (ADON). -When someone is giving a narcotic, it should be charted in the MAR and charted on the narcotic accountability log. -He/She would have expected nurses and CMT's to chart narcotic administration in the MAR under all circumstances.-When narcotic accountability logs are completed, staff placed the logs in his/her box to file.-He/She was unsure why there were missing narcotic logs and unaccounted for narcotics.-He/She was unsure who was responsible for auditing narcotic logs and narcotic administration. -There has been issues in the past with possible narcotic diversion at the facility and he/she was investigated for diversion. -He/She knew there were narcotics reported missing from the facility in July and August.-There was another narcotic diversion in the facility when the previous owners owned the facility back in March 2025.-All staff members in the facility back in March had to give a urine sample.-He/She did divert narcotics from Resident #6 to Resident #1 on 9/10/25. -He/She was written up for the diversion.-He/She had his/her family member sign as the second nurse on the accountability log when the diversion occurred.-His/Her family member was not on the clock or working at the facility when he/she had him/her sign on the accountability log.-He/She has made some mistakes when it came to narcotic accountability.-He/She understood that when a medication was not documented as being administered, it could not be proven that it was administered to the resident.-He/She understood that professional standards of practice required nurses to document in a resident's medical record and MAR when a nurse administered a narcotic or any other medication to the resident. -He/She refused to answer when asked why he/she was documenting the administration of non-narcotic medications but did not document the administration of the narcotics. During an interview on 12/19/25 at 4:40 P.M., Administrator and Regional Nurse Consultant said:-They would expect narcotic to be documented in the resident's MAR any time a narcotic is signed out on the resident's narcotic accountability log.-They would have expected a residents narcotic accountability log and a resident's MAR to reflect the same administration patterns. - The pharmacy was responsible for the pixus narcotic auditing.-The ADON was responsible for the narcotic accountability logs and as needed narcotics in the medication cart. -LPN A was under investigation in 9/2025 for drug diversion and it was reported to the state agency at that time.-LPN A was also under investigation from the previous company for drug diversion.-The previous company failed to divulge the diversion investigation results to the new owners and LPN A was placed back on the floor and given access to narcotics. -Only assigned nursers and CMT's should be administering medications to the resident's-There were (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	occasions where LPN A accessed the narcotics and signed narcotics out on the accountability logs when he/she was not the assigned nurse for the residents.-LPN A got upset with the Administrator when he/she pulled LPN A from the floor as a nurse and instructed LPN A to only perform ADON duties.-LPN A was written up in 09/25 for diverting narcotics from Resident #6 to Resident #1. -The Pharmacy reported that they suspected a pattern of diversion due to LPN A being the nurse that always called to get the residents narcotics refilled and delivered to the facility. Complaint # 2679032

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately account for narcotic medication reconciliation for three sampled residents (Resident #1. #6 and #9) out of nine sampled residents. The facility census was 48 residents.A facility policy for Medication Administration and Documentation was requested and not provided. 1.Review of Resident #1's admission Record showed the resident admitted to the facility on [DATE] and was re admitted to the facility on [DATE], with a diagnosis of chronic pain. Review of the resident's Brief Interview for Mental Status (BIMS) dated 7/15/25 showed the resident was moderately impaired. Review of the resident's Physicians Order Sheet (POS) dated 7/1/25-12/19/25 showed:-Percocet (Oxycodone w/Acetaminophen- Opioid, narcotic analgesic) Oral Tablet 5-325 Milligram (MG). Give 1 tablet by mouth every 6 hours as needed for pain was started on 7/31/25 and discontinued on 8/19/25.-Percocet Oral Tablet 5-325 mg (Oxycodone w/ Acetaminophen). Give 2 tablet by mouth every 6 hours as needed for pain was started on 7/31/25 and discontinued on 8/19/25.- Percocet Oral Tablet 5-325 mg. Give 1 tablet by mouth every 4 hours as needed for pain was started on 8/19/25 and discontinued on 9/24/25.-Percocet Oral Tablet 5-325 mg. Give 2 tablet by mouth every 4 hours as needed for pain was started on 8/19/25 and discontinued on 9/24/25.-Hydrocodone-Acetaminophen Tablet 5-325 MG (Norco - Opioid, analgesic narcotic). Give 1 tablet by mouth three times a day for pain was started on 9/24/25. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 7/31/25 showed two 30 count packs of Percocet Oral Tablet 5-325 mg were delivered to the facility for a total of 60 tablets.Note: Accountability sheet 1 of 2 for 30 Percocet Oral Tablets 5-325 mg was unaccounted for and could not be provided by the facility. Review of the resident's Controlled Substance Accountability Sheet 2 of 2 dated 7/31/25 showed 26 Percocet 5-325 mg tablets were removed for the resident from 8/8/25 to 8/25/25.Note: There was no documentation 8/26/25 to 8/29/25. Review of the resident's Medication Administration Record (MAR) dated 8/1/25-8/31/25 showed he/she was administered 6 tablets of Percocet 5-325 mg tablets between 8/8/25 to 8/25/25.NOTE: 20 tablets of Percocet 5-325 mg tablets were unaccounted for. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 8/26/25 showed one 30 count pack of Percocet Oral Tablet 5-325 mg was delivered to the facility. Review of the resident's Controlled Substance Accountability Sheet 1 of 1 dated 8/26/25 showed 22 Percocet 5-325 mg tablets were removed for the resident from 9/1/25 to 9/5/25.Note: On 9/2/25 at 11:15 A.M., Licensed Practical Nurse (LPN) A signed out 4 oxycodone/acetaminophen 5-325 mg tablets and documented on the accountability form that 2 of the 4 tablets dropped on the floor. There is no documentation the tablets were wasted by a second staff member. Review of the resident's MAR dated 9/1/25-9/30/25 showed he/she was administered 4 tablets of Percocet 5-325 mg tablets 9/1,25 to 9/5/25.Note: From 9/1/25 to 9/5/25 there were 18 unaccounted for Percocet 5-325 mg tablets. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 9/5/25 showed one 30 count pack of Percocet Oral Tablet 5-325 mg was delivered to the facility.-Note: The accountability sheet for 30 Percocet Oral Tablets 5-325 mg was unaccounted for and could not be provided by the facility. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 9/11/25 showed one 30 count pack of Percocet Oral Tablet 5-325 mg was delivered to the facility.-Note: The accountability sheet for 30 Percocet Oral Tablets 5-325 mg was unaccounted for and could not be provided by the facility. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 9/19/25 showed one 30 count pack of Percocet Oral Tablet 5-325 mg was delivered to the facility. Review of the resident's Controlled Substance Accountability Sheet 1 of 1 dated 9/19/25 showed 19 Percocet 5-325 mg tablets were removed for the resident from 9/21/25 to 9/23/25. Review of the resident's MAR dated (continued on next page)

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	265456	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abode Health and Wellness Center	17451 Medical Center Parkway Independence, MO 64057

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/1/25-9/30/25 showed he/she was administered 10 tablets of oxycodone/acetaminophen 5-325 mg tablets 9/21/25 to 9/23/25.-Note: From 9/21/25-9/23/25 there were 10 unaccounted for Percocet 5-325 mg tablets. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 9/26/25 showed:-Three 30 count packs (90 total) of Norco Tablet 5-325 mg were delivered to the facility.-Note: Accountability sheet 1 of 3 and 3 of 3 for 30 Norco Tablet 5-325 mg was unaccounted for and could not be provided by the facility. 60 total hydrocodone delivered were unaccounted for. Review of the pharmacy's Controlled Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed 25 Norco 5-325 mg tablets were removed from the medication dispensing machine. Review of the resident's Controlled Substance Accountability Sheet dated 10/27/25 showed nine Norco 5-325 mg tablets removed from the medication dispense machine were not logged as available on the accounting sheet.Note: The facility only provided the accountability sheet up to 11/26/25. Review of the resident's MAR dated 11/1/25-11/30/25 showed:-He/she was administered 7 tablets of hydrocodone 10/27/25 to 11/30/25.-14 Norco 5-325 mg tablets were unaccounted for. Review of the pharmacy's Controlled Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed 15 Norco 5-325 mg tablets were removed from the medication dispensing machine. Review of the resident's MAR dated 12/1/25-12/31/25 showed:-He/she was administered 7 tablets of hydrocodone 12/2/25 to 12/7/25.-Note: Was provided MAR documentation up to 12/7/25.-Eight Norco 5-325 mg tablets were unaccounted for. During an interview on 12/19/25 at 10:00 A.M., Pharmacist and Operational Manager said:-2 packs of 30 (60 total) Percocet pills were delivered to the facility on 7/31/25.-1 pack of 30 Percocet pills were delivered to the facility on 8/26/25., 9/5/25, 9/11/25, 9/19/25, and 9/23/25.-3 packs of 30 (90 total) Norco Tablet 5-325 mg pills were delivered to the facility on 9/26/25.-Each 30 pack would have had its own accountability sheet.-If an accountability sheet can't be accounted for, then neither can the narcotic pills that the sheet was holding accountable.-The resident's narcotic medication began to get dispensed from the medication dispensary on 10/27/25, due to the physician changing the medication order from as needed to schedule and no further narcotic packs were delivered to the facility. 2. Review of Resident #6's admission Record showed the resident admitted to the facility on [DATE] and was re admitted to the facility on [DATE], with a diagnosis of pain in the right knee. Review of the resident's BIMS dated 12/17/25 showed the resident was cognitively intact. Review of the resident's POS dated 7/1/25-10/31/25 showed:-Percocet Oral Tablet 5-325 mg. Give one tablet by mouth every 6 hours as needed for pain was started on 8/19/25 and discontinued on 9/12/25.-Percocet Oral Tablet 5-325 mg. Give one tablet by mouth at bedtime started on 9/12/25 and discontinued on 10/15/25. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 8/23/25 showed two 30 count packs of Percocet Oral Tablet 5-325 mg was delivered to the facility.-Note: The accountability sheet for 30 Percocet Oral Tablets 5-325 mg was unaccounted for and could not be provided by the facility. Review of the resident's Controlled Substance Accountability Sheet 2 of 2 dated 8/23/25 showed:-Two Percocet 5-325 mg tablets were removed from 8/29/25 - 8/31/25.-LPN A documented that 1 of the 2 medications pulled was dropped with no destruction log to support. Review of the resident's MAR dated 8/1/25-8/31/25 showed no documentation of administration.-NOTE: Two Percocet 5-325 mg tablets were unaccounted for. Review of the resident's Controlled Substance Accountability Sheet 2 of 2 dated 8/23/25 showed:-11 Percocet 5-325 mg tablets were removed from 9/1/25 to 9/30/25. -Two tablets were documented as being removed from this resident's supply to administer to another resident. Review of the resident's MAR dated 9/1/25-9/30/25 showed he/she was administered two tablets of Percocet 9/1/25 to 9/30/25.-NOTE: Nine Percocet 5-325 mg tablets were unaccounted for. Review of the resident's Controlled Substance Accountability Sheet 2 of 2 dated 8/23/25 showed two Percocet 5-325 mg tablets were removed from 10/1/25 to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/11/25.Note: On 10/11/25 at 8:00 P.M. LPN A documented a remaining quantity of 1 oxycodone on the accountability sheet. There was no further documentation of where that 1 oxycodone went. Review of the resident's MAR dated 10/1/25- 10/11/25 showed he/she was administered two tablets of Percocet 9/1/25 to 9/30/25.-NOTE: One Percocet 5-325 mg tablets were unaccounted for. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 9/11/25 showed two 30 count packs of Percocet Oral Tablet 5-325 mg were delivered to the facility.-Note: The 2 of 2 accountability sheet for 30 Percocet Oral Tablets 5-325 mg was unaccounted for and could not be provided by the facility. Review of the pharmacy's Controlled Substance Dispense log on 12/19/25 at 9:00 A.M., showed two Percocet tablets were removed on 11/30/25. Review of the resident's MAR dated 11/1/25-11/31/25 showed one Percocet 5-325 mg tablet was administered. -NOTE: One Percocet 5-325 mg tablet was unaccounted for. Review of the pharmacy's Controlled Substance Dispense log on 12/19/25 at 9:00 A.M., showed 10 Percocet tablets were removed from 12/2/25 - 12/14/25. Review of the resident's MAR dated 12/1/25-12/31/25 showed he/she was administered 5 tablets of Percocet 12/2/25 to 12/14/25.-NOTE: Five Percocet 5-325 mg tablets were unaccounted for. During an interview on 12/19/25 at 11:54 A.M. the resident said:-He/She only received pain medication at night.-He/She never asked for pain medication during the day when the medication was ordered as needed.-He/She did not receive the signed-out pain medication that was on the accountability logs unless they were given at night.-He/She did not receive pain medication from LPN A on 8/29/25 at 7:25 A.M, 9/1/25 at 6:40 A.M., or 9/5/25 at 7:20 A.M. because he/she was never awake that early. 3. Review of Resident #9's admission Record showed the resident admitted to the facility on [DATE] and was re admitted to the facility on [DATE], with the diagnoses of congestive heart failure and chronic pain. Review of the resident's BIMS dated 12/10/25 showed the resident was cognitively intact. Review of the resident's POS dated 7/1/25-12/19/25 showed:-Oxycodone tablet 5 mg. Give one tablet by mouth every 6 hours as needed for pain was started on 7/18/25 and discontinued on 9/10/25.-Oxycodone tablet 5 mg. Give one tablet by mouth every 4 hours as needed for pain was started on 9/10/25 and discontinued on 10/1/25.-Norco Tablet 5-325 mg. Give 1 tablet by mouth two times a day for pain was started on 10/1/25. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 7/12/25 showed one 28 count pack of Oxycodone was delivered to the facility. Review of the resident's Controlled Substance Accountability Sheet 1 of 1 dated 7/12/25 showed five tablets of oxycodone were removed for the resident from 7/20/25 to 7/31/25. Review of the resident's MAR dated 7/1/25-7/31/25 showed he/she was administered one oxycodone tablet.-NOTE: Four Oxycodone 5 mg tablets were unaccounted for. Review of the resident's Controlled Substance Accountability Sheet 1 of 1 dated 7/12/25 showed 15 tablets of oxycodone were removed for the resident from 8/8/25 to 8/29/25. Review of the resident's MAR dated 8/1/25-8/31/25 showed he/she was administered five tablets of oxycodone 8/8/25 to 8/29/25.-NOTE: 10 Oxycodone 5 mg tablets were unaccounted for. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 8/30/25 showed one 28 count pack of Oxycodone was delivered to the facility.Note: Accountability sheet 1 of 1 for Oxycodone 5 mg was unaccounted for and could not be provided by the facility. 28 total oxycodone delivered were unaccounted for. Review of the pharmacy's-controlled substance delivery confirmation packing slip dated 9/10/25 showed one 30 count pack of Oxycodone was delivered to the facility. Review of the resident's Controlled Substance Accountability Sheet 1 of 1 dated 9/10/25 showed 29 oxycodone tablets were removed for the resident from 9/10/25 - 9/30/25. Review of the resident's MAR dated 9/1/25-9/31/25 showed he/she was administered 5 tablets of oxycodone 9/18/25 to 9/30/25.-NOTE: 24 Oxycodone 5 mg tablets were unaccounted for. Review of the pharmacy's Controlled Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed two Norco 5-325 tablets were removed from the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication dispensing machine on 10/27/25. Review of the resident's Controlled Substance Accountability Sheet dated 10/1/25 showed LPN A removed one Norco 5-325 mg tablet. Review of the resident's MAR dated 10/1/25-10/31/25 showed one Norco 5-325 mg tablet was administered.-NOTE: Two Norco 5-325 mg tablets were unaccounted for. Review of the pharmacy's Controlled Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed 14 Norco 5-325 mg tablets were removed from the medication dispensing machine between 11/8/25 - 11/30/25. Review of the resident's Controlled Substance Accountability Sheet dated 10/20/25 showed:-Note: The accountability sheet provided by the facility only went to 11/15/25.-Note: 14 Norco tablets were unaccounted for. Review of the resident's MAR dated 11/1/25-11/30/25 showed he/she was administered 8 hydrocodone tablets 11/8/25 to 11/30/25.-Note: Six Norco tablets were unaccounted for. Review of the pharmacy's Controlled Substance Dispense log printed on 12/19/25 at 9:00 A.M., showed 10 Norco tablets were removed from 12/2/25 - 12/14/25.-2 hydrocodone on 12/2/25 at 1:24 P.M.-2 hydrocodone on 12/3/25 at 11:02 A.M.-2 hydrocodone on 12/6/25 at 12:38 P.M.-2 hydrocodone on 12/7/25 at 7:21 P.M.-2 hydrocodone on 12/14/25 at 11:30 A.M. Review of the resident's MAR dated 12/1/25-12/31/25 showed he/she was administered 5 hydrocodone tablets 12/2/25 -12/7/25.-Note: Five Norco tablets were unaccounted for. During an interview on 12/19/25 at 12:15 P.M. the resident said:-He/She did not ask for pain medication very much when it was ordered as needed.-He/She was unsure why the physician changed the order to get pain medication twice a day.-He/She did not receive all of the oxycodone that was signed out for him/her on the narcotic countability logs. 4. During an interview on 12/19/25 at 10:20 A.M., Registered Nurse (RN) A said:-He/She was the Director of Nursing (DON) in training.-The nurses were responsible for administering the as needed pain medication to the residents.-The Certified Medication Technicians (CMT's) were responsible for administering the scheduled pain medication to the residents.-The as needed pain medications was administered from the medication cart and from a bubble pack.-The scheduled pain medication was administered from the pixus style dispense machine in the medication room. -When a nurse or CMT gave a resident a pain medication, the order should have been looked up in the resident's MAR to ensure accuracy and documented in the resident's MAR that the medication was administered.-If a nurse or CMT gave a resident a pain medication that was a narcotic, in addition to signing the resident's MAR, the nurse or CMT should have signed the narcotic out on the resident's narcotic accountability sheet.-The Assistant Director of Nursing (ADON) was LPN A.-LPN A was the one who was responsible for monitoring the facility's narcotic logs.-When a label on a narcotic accountability sheet stated, 1 of 2, this meant that 2, 30 count packs of that narcotic and 2 narcotic accountability sheets were delivered from the pharmacy to the facility. During an interview on 12/19/25 at, the Physician said:-All pain medication should be documented by staff per the professional standards and guidelines.-If a resident's medication was not documented on the residents MAR, then it could not be proven that a medication was given to the resident. During an interview on 12/19/25 2:13 P.M., CMT A said:-The CMT's administered the scheduled pain medication to the residents.-The nurses administered the as needed pain medications to the residents.-All administered pain medication was supposed to be documented as given in the resident's MAR and on the resident's narcotic accountability sheets.-If a resident's medication was not documented on the residents MAR, then the medication was not given to the resident. During an interview on 12/19/25 at 3:44 P.M., ADON/ LPN A said:-When someone is giving a narcotic, it should be charted in the MAR and charted on the narcotic accountability log.-He/She would have expected nurses and CMT's to chart narcotic administration in the MAR under all circumstances.-When narcotic accountability logs are completed, staff placed the logs in his/her box to file.-He/She was unsure why there were missing narcotic logs and unaccounted for narcotics.-He/She was unsure who was responsible for (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	auditing narcotic logs and narcotic administration.-He/She understood that when a medication was not documented as being administered, it could not be proven that it was administered to the resident.-He/She understood that professional standards of practice required nurses to document in a resident's medical record and MAR when a nurse administered a narcotic or any other medication to the resident. During an interview on 12/19/25 at 4:40 P.M., Administrator and Regional Nurse Consultant said:-They would expect narcotic to be documented in the resident's MAR any time a narcotic is signed out on the resident's narcotic accountability log.-They would have expected a residents narcotic accountability log and a resident's MAR to reflect the same administration patterns.- The pharmacy was responsible for the pixus narcotic auditing.-The ADON was responsible for the narcotic accountability logs and as needed narcotics in the medication cart. Complaint # 2679032