STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265468	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granby House	301 South Main Granby, MO 64844

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on observation, record review, and interview, the facility failed to protect all residents from misappropriation of property, including medications, when one resident's (Resident #1) fentanyl patch (a schedule IV controlled substance used for adults who have chronic pain) went missing from the resident while in the facility. The facility census was 42. On 05/26/24, the Administrator was notified of the Past Non-Compliance that occurred on 05/26/24. The Administrator and the charge nurse conducted an audit to ensure all other fentanyl patches were intact as placed on residents per documentation and accounted for in storage behind two locks. The Administrator notified the physician, hospice agency, police department, and the resident's family. The Administrator interviewed staff and residents and reviewed the camera surveillance. The maintenance department changed the access code on the back door utilized by the staff. Administration completed in-service education with all staff regarding controlled substances and monitoring for placement of pain patches. The facility ordered a replacement patch at their expense. The noncompliance was corrected on 05/28/24. Review of a facility policy entitled Controlled Substances, revised November 2022, showed the following: -The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976); -Only authorized licensed nursing and/or pharmacy personnel have access to Schedule II controlled substances maintained on premises. 1. Review of Resident #1's face sheet (gives basic profile information) showed the following: -admitted [DATE]; -Diagnoses included atrial fibrillation (a-fib - irregular heart function) with implanted pacemaker (helps maintain regular heart beat), congestive heart failure (CHF - heart's capacity to pump blood cannot keep up with the body's need), shoulder disorder, depression, and convulsions. Review of the resident's care plan, last updated 04/23/24, showed the following: (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: 265468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER: Granby House		STREET ADDRESS, CITY, STATE, ZIP CODE: 301 South Main, Granby, MO 64844	

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Coordinate with physician to manage pain medication for optimum control of pain; -Observe for non-verbal signs of pain; -Observe for factors that increase/decrease pain; -Provide resident with comfort measures as needed, such as back rubs, lotion to body, sponge baths, and repositioning; -Observe for intolerable pain and notify physician if not relieved; -Give scheduled pain medicine as ordered. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 05/02/24, showed the following information: -Severely cognitively impaired; -Resident on scheduled pain medication regimen within the last five days; -Resident received as needed pain medication within the last five days; -Resident had frequent pain that affected sleep and day to day activities frequently; -Pain intensity at level five (rating of worst pain over the last five days on a zero to ten scale, with zero being no pain and ten as the worst pain you imagine). Review of the resident's May 2024 Physician Order Sheet (POS) showed the following: -An order, dated 11/16/23, to check and record placement of fentanyl patch every shift (every 6 A.M. and 6 P. M. shift); -An order, dated 12/07/23, to record pain level every shift, every day (every 12 hours); -An order, dated 04/23/24, for fentanyl 75 microgram (mcg) transdermal (through the skin) patch. Apply to the skin every 72 hours and remove old patch. Review and record administration site. Review of the resident's May 2024 electronic Treatment Administration Record (eTAR) showed on 05/26/24, at 7:00 A.M., Licensed Practical Nurse (LPN) A documented placement of a fentanyl 75 mcg patch to the resident's left upper arm. Observation and interview on 06/06/24, at 10:20 A.M., showed camera footage of the 100 hall dated 05/26/24, at 4:30 P.M. The camera footage showed an individual identified by the Administrator as former employee CNA E entered the back door of the facility wearing a hoodie over his/her hair and turned the corner toward the resident's hall. The Administrator said the footage showed the same person in the same hoodie in the building on the previous day when they came in to pick up their last paycheck. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Licensed Practical Nurse (LPN) A's written statement, dated 05/26/24, showed the following: -While passing medication, he/she saw someone run out of the resident's room and out the back door; -LPN A ran to a room on the 200 hall for a direct view of the employee parking lot and called out to Certified Nurse Aide (CNA) B, who came into the room and agreed that the person getting into a vehicle was former CNA E; -LPN A and CNA B quickly went to the resident's room to assess him/her. The resident lay in bed. They noted the left gown sleeve was pulled down at the shoulder; and the fentanyl patch the LPN placed that morning was not in place. There was a slight red outline where the patch had been. During an interview on 06/06/24, at 11:00 A.M., LPN A verified his/her written statement. The nursing staff checks placement of fentanyl patches every shift and documents the body location of the patch. Review of a CNA B 's written statement, dated 05/26/24, showed the following: -He/she was passing dinner trays on the long hall (200 hall). LPN A called out to him/her and asked him/her to identify the person getting into the a vehicle. CNA B said it was former CNA E. The driver of the vehicle drove through the grass and away; -The CNA went with LPN A to the resident's room. The resident's gown was pulled off the shoulder and no patch was there. They noted redness where LPN A said he/she had place a patch that morning. During an interview on 06/07/24, at 9:02 A.M., CNA B said on 05/26/24, around 4:30 P.M., he/she was passing dinner trays on the 200 hall. LPN A called out to him/her to come into a room and look out the window. LPN A asked him/her who was getting into a vehicle in the lot. CNA B told the LPN the individual was former CNA E. CNA B said he/she could not see if CNA E was holding anything. The CNA went with LPN A to the resident's room. The resident's gown was pulled off the shoulder and no patch was there. They noted redness where LPN A said he/she had place a patch that morning. During an interview on 06/06/24, at 3:04 P.M., LPN D said staff is supposed to check the placement of all pain patches every shift (day shift and night shift). Fentanyl patches are placed every three days and staff documents where the patch is applied. All narcotics and controlled medications are counted each shift change. LPN D said the resident usually refuses to change positions in bed and stays on his/her back most of the time. The resident's pain patches do not come off easily. During an interview on 06/06/24, at 10:20 A.M., the Administrator said the following: -LPN A called the Administrator to report seeing a former employee coming out of the resident's room and going out the back door of the facility. The identity of the individual was also confirmed at the time by CNA B; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A and CNA B went to the resident's room to assess him/her and noted the resident's left gown sleeve was pulled down from the shoulder, and the fentanyl patch placed that morning by LPN A was not in place. There was a slight red outline on the resident's skin where the patch had been previously; -The Administrator came into the facility to start an investigation and make notifications; -NA B stated he/she was in the dining room at that time and did see a vehicle matching the description to that of former CNA E's drive past the dining room window toward the employee parking lot, but did not see the driver; -The Administrator notified the physician, the hospice agency, the resident's family, the police department, and the State Agency of the incident and missing pain patch; -The facility had the pharmacy replace the missing fentanyl patch at facility expense. MO00236731