Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265481	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pin Oaks Living Center	1525 West Monroe Mexico, MO 65265

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** 36185 Based on interview and record review, the facility failed to protect residents from misappropriation of property when 40 tablets of oxycodone/acetaminophen (narcotic pain medication used to treat moderate to severe pain) and five tablets of gabapentin (used to treat nerve pain) were determined missing for one resident (Resident #1), when in the possession of facility staff. A sample of seven residents was selected for review. The facility census was 68. Review of the facility's Abuse Prohibition Protocol, undated, showed the following: -It is the policy of this facility that reports of misappropriation of property are promptly investigated; -Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent; -The staff will complete an active search of missing items including documentation of the investigation, and interview with staff members having contact with the resident during the relevant periods of the alleged incident. Review of the facility policy, Medications Scheduled II-V (drugs, substances, and certain chemicals used to manufacture have been classified into categories based upon the drugs acceptable use and drug's abuse or dependency potential), undated, showed the following: -To provide medication for residents as prescribed by facility medication personnel and to comply with State and Federal guidelines regarding these medications; -All Schedule II, III, IV or V medications must be counted (comparing pills and disposition record) at every change of shift by two certified medication technicians (CMT), or one CMT and one licensed nurse. Both personnel must sign verification of correct count for schedule II, III, IV and V medications; -If, at any time the count is incorrect, the CMT must notify licensed nursing staff, who will call the Director of Nursing (DON) or designee for instruction. 1. Review of Resident #1's undated face sheet 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: 265481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pin Oaks Living Center	1525 West Monroe Mexico, MO 65265

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

-The resident admitted to the facility on [DATE] at 3:15 P.M.

-Diagnoses included chronic inflammatory demyelinating polyneuritis (a disorder that involves nerve swelling and irritation that leads to a loss of strength and sensation), polymyalgia rheumatica (an inflammatory disorder causing muscle pain and stiffness around the shoulders and hips), and unspecified pain.

Review of the resident's nursing note, dated 9/19/24 at 3:33 P.M., showed the resident admitted to the facility via personal vehicle accompanied by his/her family member.

Review of the resident's Physician Order Sheet (POS), dated September 2024, showed the following:

-Oxycodone/acetaminophen 5 milligrams (mg) /325 mg one tablet every six hours as needed (PRN) for pain;

-Gabapentin 600 mg one tablet every six hours at 6:00 A.M., 12:00 P.M., 6:00 P.M. and 12:00 A.M. for chronic inflammatory demyelinating polyneuritis.

Review of the resident's Medication Administration Record (MAR), dated September 2024, showed the following:

-On 9/19/24 at 7:48 P.M., CMT C documented he/she administered one tablet of oxycodone 5 mg/acetaminophen 325 mg and gabapentin 600 mg;

-On 9/20/24 at 12:00 A.M., Registered Nurse (RN) D documented he/she administered gabapentin 600 mg;

-On 9/20/24 at 10:43 A.M. CMT B documented he/she administered one tablet of oxycodone 5 mg/acetaminophen 325 mg.

Review of the resident's Controlled Drug Receipt/Record/Disposition Form for September 2024 showed CMT C signed out one tablet, the form did not include the name of the medication, but showed the original amount was 338 tablets. CMT C signed out one tablet on 9/19/24 at 8:00 P.M., making the amount left 337 tablets .

Review of the resident's Controlled Drug Receipt/Record/Disposition Form for September 2024 showed on 9/19/24 at 11:30 P.M. RN D signed out gabapentin 300 mg, two capsules making the amount left 184 tablets.

Review of the facility investigation, dated 9/20/24 at 1:00 P.M., showed the following:

-Allegation type: Suspected crime and misappropriation of resident property;

-Allegation details: RN A and CMT B reported they counted the resident's bottle of oxycodone/acetaminophen 7.5 mg/ 325 mg bottle that was brought in from home and there were 338 tablets in the bottle and there were 85 gabapentin in one bottle and 186 gabapentin in another bottle. The two staff reported they passed it off to CMT C to count;

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pin Oaks Living Center	1525 West Monroe Mexico, MO 65265

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

-The following morning (9/20/24), the count was not done between shifts. CMT B counted all the resident's narcotics and there were only 296 oxycodone/acetaminophen tablets in the bottle. The resident had received two oxycodone/acetaminophen in the night. The Director of Nursing (DON) counted the oxycodone/acetaminophen and gabapentin with RN A and there were 40 missing oxycodone/acetaminophen tablets, along with five missing gabapentin tablets.

During an interview on 10/1/24 at 2:30 P.M. the resident's family member said the following:

-He/She was asked to bring the resident's medications from home to the facility on [DATE] when the resident was admitted . The facility said they were going to use the resident's medications until the resident's medications arrived from the pharmacy;

-Originally, the bottle of oxycodone/acetaminophen contained 450 tablets. He/She was not sure of the amount of oxycodone/acetaminophen in the bottle at the time the resident admitted to the facility. The resident would combine his/her oxycodone/acetaminophen into one bottle when it arrived in the mail when he/she was at home. The resident had a couple bottles of gabapentin, but he/she was not sure of the amount.

-He/She gave all the resident's medications to RN A. The staff at the facility were to count the medications and document the amount.

During interview on 10/1/24 at 9:25 A.M. CMT B said the following:

-On 9/19/24 the resident was admitted to the facility from home. The resident's family member brought in medications that could be used until the resident's medications came in from the pharmacy. It was common practice for the facility to use medications from home;

-CMT B and RN A counted the oxycodone/acetaminophen and gabapentin multiple times until they agreed on the same amount. There were 338 oxycodone/acetaminophen tablets and two bottles of gabapentin. One bottle contained 186 tablets and the second bottle contained 85 tablets;

-The following day (9/20/24) at 6:30 A.M. at the start of CMT B's shift, he/she found multiple clear bags of gabapentin unlabeled, and stapled shut inside the narcotic drawer of the medication cart. Five of the gabapentin tablets and 40 of the oxycodone/acetaminophen tablets were missing.

During an interview on 9/30/24 at 5:00 P.M. CMT C said the following:

-On 9/19/24 at 2:00 P.M., he/she counted narcotics and gabapentin at the start of his/her shift with CMT B. Resident #1 had just been admitted to the facility from home so his/her medications were not a part of the count at shift change;

-CMT C was to count with RN D when he/she arrived at 6:00 P.M., but he/she did not because RN D didn't normally count narcotics at shift change;

-CMT C administered one tablet of gabapentin 300 mg (he/she was to administer two but misread the order) and one tablet of oxycodone/acetaminophen on his/her shift to the resident. The narcotic count sheets didn't have the name of medications on them. CMT C was not sure if he/she signed the medications out on the correct narcotic sheet;

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Pin Oaks Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 West Monroe Mexico, MO 65265	

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	-There were so many gabapentin tablets, CMT C divided them up into clear bags of ten tablets and stapled them shut. RN D said not to divide them into bags so CMT C stopped after dividing up one bottle of the gabapentin. He/She did not label the bags of gabapentin and placed them in the narcotics drawer, located in the medication cart; -It was routine to use medications that were brought in by family from home, once those medications were used up, medications were ordered from pharmacy; -CMT C did not count with RN D when RN D took over the medication cart at 10:00 P.M. During an interview on 10/1/24 at 8:30 A.M. RN A said the following: -On 9/19/24, at approximately 2:30 P.M., the resident was admitted to the facility directly from home. The resident's family brought in medications from home for the facility to use until the resident's medications arrived from pharmacy. The DON directed staff to count the resident's oxycodone/acetaminophen and gabapentin, as there had been an issue with missing gabapentin in the past; -There were two bottles of gabapentin and a large bottle of oxycodone/acetaminophen; -RN A and CMT B counted the oxycodone/acetaminophen several times to ensure the amount was accurate and counted 338 tablets total; -CMT B filled out the narcotic count sheets and gave the medications to CMT C to recount with RN D when he/she came on duty at 6:00 P.M.; -RN D (the oncoming charge nurse for 6:00 P.M. to 6:00 A.M.) refused to count narcotics when he/she came on to start his/her shift. RN D routinely refused to count the narcotics when he/she worked, RN D would leave the facility before staff had a chance to count or said it would take too much time; -On 9/20/24 (the following morning) at 6:00 A.M., RN A worked the day shift (6:00 A.M. to 6:00 P.M.) and RN D refused to count the narcotics at the end of his/her shift; -CMT B started his/her shift at 6:30 A.M. and was scheduled to pass medications for the resident's hall. CMT B found eight clear bags containing capsules, 10 per pack, stapled shut in the narcotic drawer of the medication cart. The bags were unlabeled. CMT B identified the clear bags to contain gabapentin, as one bottle of the resident's gabapentin was missing. Staff counted the gabapentin and five tablets were unaccounted for from the previous count the evening before; - RN A and CMT B counted the resident's oxycodone/acetaminophen and there were 40 tablets missing from the previous count the evening before. Staff re-counted the medication and they came up with the same number. The missing oxycodone/acetaminophen and gabapentin were reported to the Administrator. During an interview on 9/30/24 at 5:40 P.M. RN D said the following: -On 9/19/24, he/she worked 6:00 P.M. to 6:00 A.M. CMT C left at 10:00 P.M. and RN D took over the medication cart. RN D and CMT C did not complete a narcotic count when RN D took over the cart. It was common for staff not to count narcotics at shift change; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Pin Oaks Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 West Monroe Mexico, MO 65265	

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	-RN D only administered gabapentin 600 mg (two 300 mg capsules) to the resident on his/her shift. During an interview on 9/30/24 3:15 P.M. the DON said the following: -She would expect staff to follow the facility policies, regarding medication count verification; -She questioned whether RN A and CMT B counted the resident's medications on 9/19/24 when the resident arrived at the facility as the count was not documented; -Staff did not document count verification at 10:00 P.M. on 9/19/24 at shift change or at 6:00 A.M. the morning of 9/20/24 at shift change; -CMT C documented he/she administered one oxycodone/acetaminophen on 9/19/24 at 7:48 P.M., and signed out one tablet on the Controlled Drug Receipt/Record Disposition Form. The form did not indicate the medication, but showed an original count of 338; - CMT B administered one oxycodone/acetaminophen the morning of 9/20/24, but didn't sign it out on the Controlled Drug Receipt/Record Disposition Form; -The DON counted 298 oxycodone/acetaminophen on 9/20/24 during the investigation into the missing narcotics. There were 40 missing oxycodone/acetaminophen tablets if the previous count was correct; -The DON counted the gabapentin, one bottle contained 184 capsules. RN D administered two capsules from this bottle on his/her shift. There were eight bags of gabapentin, each contained 10 tablets of gabapentin, 80 tablets total. CMT C documented on the MAR he/she administered gabapentin, one 300 mg tablet, but didn't document this on the Controlled Drug Receipt/Record Disposition Form. The DON determined there were five missing gabapentin tablets if the count was correct upon admission. During an interview on 10/1/24 the Administrator said the following: -She would expect staff to follow the facility policies regarding medication count verification at shift change; -The facility could not determine if staff miscounted the resident's narcotics and other medication upon admission or if staff misappropriated the medications. MO242410

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Pin Oaks Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 West Monroe Mexico, MO 65265	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36185 Based on interview, and record review, the facility failed to ensure narcotic counts were completed to ensure any missing doses could be readily detected, failed to label medications, and failed to store medications in a safe and effective manner. Licensed staff failed to complete on-coming and off-going controlled drug counts to verify the correct count of narcotics for one resident (Resident #1). Licensed staff also failed to follow the facility policy when accepting medications that were brought from home for the resident to ensure the medications were examined and positively identified by the pharmacist and approved for the resident's use. The facility census was 68. Review of the facility policy, Medications Scheduled II-V (drugs, substances, and certain chemicals used to manufacture them have been classified into categories based upon the drugs acceptable use and abuse or dependency potential), undated, showed the following: -To provide medication for residents as prescribed by facility medication personnel and to comply with State and Federal guidelines regarding these medications; -All Schedule II, III, IV or V medications must be counted (comparing pills and disposition record) at every change of shift by two Certified Medication Technicians (CMT), or one CMT and one licensed nurse. Both personnel must sign verification of correct count for schedule II, III, IV and V medications. Review of the facility's policy, Medication, Acceptance on Admission, undated, showed the following: -Medications, including drugs, sedatives, narcotics, medicated lotions, and ointments, brought by or with the resident upon admission to the facility may not be used unless the contents of the container have been examined and positively identified by the pharmacist or the resident's attending physician; -Medications examined and approved for resident's use must be properly labeled in accordance with the established facility policies governing the labeling of medications; -Medications that are accepted, but do not meet facility labeling requirements, must be forwarded to the pharmacy for proper labeling prior to administration of the medication; -The staff/charge nurse was responsible for documenting the results of the facility's decision to accept or reject medications brought by the resident during the admission process; -If the medication is accepted, the name, strength, and quantity of the medication must be included; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Pin Oaks Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 West Monroe Mexico, MO 65265	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff must also document if the medications had to be identified or relabeled, the name and title of the person identifying the medications or authorizing the acceptance of them and any other information deemed appropriate and necessary and the name and title of person recording the data. 1. Review of Resident #1's nursing note, dated 9/19/24 at 3:33 P.M., showed the resident admitted to the facility via personal vehicle accompanied by his/her family member. Review of the resident's physician order sheet (POS), dated September 2024, showed the following: -Oxycodone/acetaminophen 5 milligrams (mg) /325 mg one tablet every six hours as needed (PRN) for pain; -Gabapentin 600 mg one tablet every six hours at 6:00 A.M., 12:00 P.M., 6:00 P.M. and 12:00 A.M. for chronic inflammatory demyelinating polyneuritis. Review of the Narcotic Card Inventory (for all residents) dated September 2024 showed the following: -On 9/19/24 (6:00 A.M. to 2:00 P.M. shift) there was no evidence the off-going staff verified the controlled drug count was correct with the on-coming staff; -On 9/19/24 (2:00 P.M. to 10 P.M. shift) there was no evidence the on-coming staff verified the controlled drug count was correct with the off-going staff; -On 9/19/24 (10 P.M. to 6:00 A.M. shift) there was no evidence the on-coming staff verified the controlled drug count was correct with the off-going staff; On 9/20/24 (6:00 A.M. to 2:00 P.M. shift) there was no evidence the off-going staff verified the controlled drug count was correct with the on-coming staff. During an interview on 10/1/24 at 2:30 P.M. the resident's family member said the following: -Facility staff asked him/her to bring the resident's medications from home to the facility on [DATE] when the resident was admitted . Staff said they were going to use the resident's medications until medications arrived from the pharmacy; -He/She gave all the resident's medications to Registered Nurse (RN) A. The staff at the facility were to count the medications and document the amount. Review of the resident's medical record showed staff did not document the staff member who authorized the acceptance of the medications from home upon admission. Also, staff did not document the name, strength and quantity of medications accepted. There was no evidence the medications were examined and positively identified by the pharmacist or physician. During an interview on 10/1/24 at 9:25 A.M. CMT B said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Pin Oaks Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 West Monroe Mexico, MO 65265	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 9/19/24 the resident was admitted to the facility from home. The resident's family member brought in medications that could be used until the resident's medications came in from the pharmacy. It was common practice for the facility to use medications from home. He/She was not aware medications brought in from home needed to be verified by the pharmacist or the physician; -CMT B and RN A counted the oxycodone/acetaminophen and gabapentin multiple times until CMT B and RN A agreed on the same amount. There were 338 oxycodone/acetaminophen tablets and two bottles of gabapentin. One bottle contained 186 capsules and the second bottle contained 85 capsules; -The following day, 9/20/24 at 6:30 A.M. at the start of the shift, CMT B found multiple clear bags of gabapentin unlabeled, and stapled shut inside the narcotic drawer of the medication cart. Five of the gabapentin and 40 of the oxycodone/acetaminophen tablets were missing. During an interview on 9/30/24 at 5:00 P.M. CMT C said the following: -On 9/19/24 at 2:00 P.M., he/she counted narcotics and gabapentin at the start of his/her shift with CMT B. Resident #1 had just been admitted to the facility from home, so his/her medications were not a part of the count at shift change; -CMT C was to count with RN D when he/she arrived at 6:00 P.M., but CMT C did not because RN D didn't normally count narcotics at shift change; -CMT C administered one gabapentin 300 mg capsule (he/she was to administer two but misread the order), and one oxycodone/acetaminophen tablet on his/her shift to the resident. The narcotic sheets didn't have the name of medications on them. CMT C was not sure if he/she signed the medications out on the correct narcotic count sheet; -There were so many gabapentin capsules CMT C decided to divide them up into clear bags of ten and stapled them shut. RN D said not to divide them into bags so CMT C stopped after dividing up one bottle of the gabapentin. CMT C did not label the bags of gabapentin and placed them in the narcotics drawer, located in the medication cart; -It was routine to use medications that were brought in by family from home. Once those medications were used up, medications were ordered from the pharmacy; -CMT C did not count with RN D when RN D took over the cart at 10:00 P.M. He/She should have counted, but just didn't get it done. During an interview on 10/1/24 at 8:30 A.M. RN A said the following: -On 9/19/24, at approximately 2:30 P.M., the resident was admitted to the facility directly from home. The resident's family brought in medications from home for the facility to use until the resident's medications arrived from pharmacy. The Director of Nursing (DON) directed staff to only count the resident's oxycodone/acetaminophen and gabapentin because there had been an issue with missing gabapentin in the past; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265481	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pin Oaks Living Center	1525 West Monroe Mexico, MO 65265

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There were two bottles of gabapentin, a large bottle of oxycodone/acetaminophen, various over the counter medications along with medications that the resident did not have a physician's order for. The medications were not verified with the pharmacist or the physician. RN A was not aware that needed to be done; -CMT B started his/her shift at 6:30 A.M. and was scheduled to pass medications for the resident's hall. CMT B found eight clear bags containing capsules (10 per pack) stapled shut in the narcotic drawer of the medication cart. The bags were unlabeled. CMT B identified the clear bags to contain gabapentin, because one bottle of the resident's gabapentin was missing. During an interview on 9/30/24 at 5:40 P.M. RN D said on 9/19/24, he/she worked 6:00 P.M. to 6:00 A.M. CMT C left at 10:00 P.M. and RN D took over the medication cart. RN D and CMT C did not complete a narcotic count when RN D took over the cart. It was common for staff not to count narcotics at shift change. During an interview on 9/30/24 3:15 P.M. the DON said the following: -She would expect staff to follow the facility policies regarding acceptance of medications, verification of the medications, storage and count verification of narcotics at change of shift or when a different staff member took over the medication cart; -The DON was not aware the facility policy directed staff to verify medications with a pharmacist or the physician when medications were brought in by a resident;. -The resident's orders were for oxycodone/acetaminophen 5 mg/325 mg, but the medication brought in from home for the resident was oxycodone/acetaminophen 7.5 mg/ 325 mg tablets. Also, the orders for gabapentin was for 600 mg one capsule, but the medication brought in from home was gabapentin 300 mg capsules. During an interview on 10/1/24 the Administrator said the following: -She would expect staff to follow the facility policies regarding acceptance and verification of medications, along with medication storage. Staff should also follow the policy for count verification of narcotics at shift change; -She would expect staff to notify the physician if a resident brought in his/her medications from home and obtain direction/orders if those medications/narcotics could be accepted at the facility and used for the resident. MO242410