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	06/16/2026

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. Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #1), in a review of five sampled residents, was free from misappropriation of medications when Registered Nurse (RN) A administered gabapentin (used to treat seizures and nerve pain) instead of the scheduled hydrocodone-acetaminophen (narcotic pain medication used for moderate to severe pain) to the resident. RN A documented he/she administered hydrocodone-acetaminophen on the resident's Medication Administration Record (MAR) and narcotic log, but RN A administered a gabapentin, not hydrocodone-acetaminophen as ordered. The facility census was 87. On 06/16/26 at 1:50 P.M., the Administrator was notified of the past noncompliance which occurred on 05/20/26. On 05/20/26, the Director of Nursing (DON) became aware RN A misappropriated Resident #1's hydrocodone-acetaminophen. Upon discovery, the DON and Licensed Practical Nurse (LPN) B interviewed RN A regarding administering gabapentin but documenting he/she administered hydrocodone-acetaminophen. The DON terminated RN A's employment, sent a self-report to the state survey agency, contacted the resident's physician regarding the incident, notified law enforcement, and notified the Missouri Board of Nursing. The DON and the Minimum Data Set (MDS) nurse counted all narcotic medications in all the medication carts to verify accuracy. The DON in-serviced all certified medication technicians (CMT) and licensed nurses on misappropriation of residents' belongings with emphasis on medication. The DON ran an as needed (PRN) medication report to see if RN A documented giving PRN medications to residents who no other staff had given or had given as frequently. Staff interviewed residents about concerns of missing medication with no further concerns identified. The facility replaced the resident's one tablet of hydrocodone-acetaminophen 10/325 mg. The deficiency was corrected on 05/21/26. Review of the facility's Tool: Abuse Prevention Policy and Procedure Checklist, undated, showed the following:-Each resident has the right to be free from misappropriation of property;-Misappropriation of resident property is defined as the deliberate misplacement, wrongful, temporary, or permanent use of a resident's belongings without the resident's consent. Review of Resident #1's undated face sheet showed the resident's diagnoses included low back pain, spinal stenosis (narrowing of the space surrounding the spinal cord, causing pressure and pain), fourth thoracic vertebra (break or collapse of the fourth bone down in the mid-back), first lumbar vertebra fracture (break in the bone at the very top of your lower back, where the mid-back meets the lower spine), second lumbar vertebra fracture, and third lumbar vertebra fracture. Review of the resident's Care Plan, updated 01/04/26, showed he/she received narcotic medication for treatment of chronic pain. Review of the resident's Physician Order Sheet (POS), dated May 2026, showed the following:-Gabapentin 600 mg, give one tablet twice a day between 6:00 A.M. and 10:00 A.M. and between 3:00 P.M. and 6:00 P.M. for fourth thoracic vertebra fracture (original order dated 1/21/26);-Hydrocodone-acetaminophen 10/325 mg, give on tablet every six hours at 06:00 A.M., 12:00 P.M., 06:00 P.M., and 12:00 A.M. for pain. Review of the resident's Medication Administration Record (MAR), dated 05/15/26 at 12:00 A.M., showed RN A documented he/she administered hydrocodone-acetaminophen 10/325 mg to the resident. During an interview on 06/16/26 at 11:45 A.M., the resident said the following:-On 05/15/26, he/she woke up at 3:00 A.M. in pain and realized the nurse had not brought his/her pain medication that was scheduled for 12:00 (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.M.;-He/She asked the staff for his/her scheduled pain medication;-RN A brought in a tablet and said it was the pain medication. He/She did not look at the tablet in the cup;-He/She did not have enough water to swallow the pill and noticed the tablet had a terrible taste. His/Her pain medication (hydrocodone-acetaminophen) did not have a terrible taste;-He/She was in pain throughout the next morning, which was not normal because the pain medication (hydrocodone-acetaminophen) kept his/her pain tolerable;-He/She requested staff to allow him/her to taste his/her medication the next morning. The gabapentin had the same terrible taste as the medication RN A administered on 5/15/26. Review of the resident's MAR, dated 05/20/26 at 12:00 A.M., showed RN A documented he/she administered hydrocodone-acetaminophen 10/325 mg to the resident. During an interview on 06/16/26 at 11:45 A.M., the resident said the following:-On 05/20/26, he/she woke up at 1:15 A.M. and realized staff had not brought his/her pain medication, so he/she turned on the call light;-He/She asked Certified Nurse Assistant (CNA) C for some water and to tell the nurse he/she needed the scheduled pain medication. He/She asked CNA C to stay in the room when the nurse brought the medication into his/her room;-RN A handed him/her a medication cup with a tablet inside;-While RN A turned his/her back to get a cup of water, he/she spit the tablet out onto the bed without RN A noticing;-He/She took pictures of the front and back of the tablet and asked CNA C if he/she knew what the tablet was. CNA C said he/she did not know but would take it to a different charge nurse to find out;-The staff (unknown name) told him/her the medication was a gabapentin and not his/her pain medication (hydrocodone-acetaminophen). During an interview on 06/18/26 at 07:31 A.M., CNA C said the following:-The resident asked him/her to stay in the room while RN A brought in the medication;-RN A gave the resident a tablet in a medication cup, the resident put the cup to his/her mouth and held it between his/her lips and teeth instead of swallowing it;-The resident put the tablet on his/her bed without RN A noticing;-The resident asked for an identification of the tablet, but CNA C did not know what it was;-CNA C took the tablet to LPN B to determine if the tablet was correct and wrote a statement. Review CNA C's undated written statement, provided by the facility, showed the following:-The resident activated the call light around 1:10 A.M. on 05/20/26 to ask for his/her pain medication that was due at midnight;-He/She notified RN A about the resident's request for pain medication and returned to the resident's room with more ice water;-The resident asked CNA C to stay to make sure he/she received the correct medication as the resident reported last week RN A gave him/her something else;-RN A brought the medication to the resident;-The resident took the tablet from his/her lips and laid it next to him/her until RN A left to go back up the hall;-The resident asked what the medication was and if CNA C could find out;-CNA C took a picture on the resident's phone of the front and back of the tablet, then took it to Licensed Practical Nurse (LPN) B who put it in a medication bag. Observation on 06/16/26 at 12:05 P.M., showed the following:-The facility provided two pictures from the resident's phone of the medication RN A administered to the resident on 5/20/26; -The tablet was oval and white;-One side of the tablet was scored (manufactured with a shallow indentation or groove across it's surface for safely splitting the tablet in half) with the letter D on the right side and the number 24 on the left side of the tablet;-The other side was also scored but did not have any markings. Review of the website drugs.com showed an image of gabapentin 600 mg with an imprint of D 24 on the tablet, white in color, and oval in shape. (The image of the gabapentin 600 mg matched the photos of the tablet provided by facility from the resident's phone.) During an interview on 06/16/26 at 12:45 P.M., the Director of Nursing (DON) said the following:-She arrived at the facility around 5:30 A.M. on 05/20/26 and LPN B requested to talk about an incident;-LPN B provided a statement from CNA C and a tablet in a medication pouch. LPN B said RN A gave the resident a gabapentin in place of the hydrocodone-acetaminophen;-She called RN A into her office, handed RN A the gabapentin that was in the pouch, and asked RN A to explain what happened;-RN A said he/she must have been confused with the medications;-When she asked RN A if the narcotic count for the hydrocodone-acetaminophen would be over by one. RN A said, no; -She terminated RN A's employment;-She contacted the resident's physician, law enforcement, and the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Missouri Board of Nursing regarding the incident;-The MDS nurse assisted with counting all narcotic medications in all the medication carts to verify accuracy;-She in-serviced all certified medication technicians (CMTs) and licensed nurses on misappropriation of residents' belongings with emphasis on medication;-She ran a PRN medication report to see if RN A documented giving PRN medication to residents who no other staff had given or had given as frequently;-The staff interviewed residents about concerns with missing medication with no further concerns identified;-The facility replaced the resident's of hydrocodone-acetaminophen 10/325 mg;-She expected staff to administer the correct medications when scheduled and not to divert any medications from a resident. During an interview on 06/16/26 at 1:50 P.M., the Administrator said she expected staff to administer medications per physician order and not divert the medication. 30193013020131