STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265536	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Health & Rehabilitation	1600 East Rollins St Moberly, MO 65270

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. 42594 Based on observation, interview and record review, the facility failed to prevent misappropriation of three residents' (Resident #1, #2 and #3) narcotic pain medication when certified medication technician (CMT) A removed one hydrocodone-acetaminophen (a combination medication used to relieve pain containing an opioid pain reliever and a non-opioid pain reliever) 5 milligrams (mg)/325 mg pill from Resident #1's and #3's narcotic medication card and removed two hydrocodone 10 mg/325 mg pills from Resident #2's narcotic medication card and admitted to ingesting them while on duty. The facility census was 81. The administrator was notified on 3/6/24 of the past non-compliance which occurred on 2/27/24. On 2/27/24 the consulting pharmacist was at the facility conducting a random spot check of medications. The pharmacist counted narcotics with CMT A and found medications that were missing from three residents' narcotic cards. The pharmacist asked what happened to them and CMT A admitted to ingesting the medications. Upon discovery, the administrator suspended CMT A, assessed all residents for pain and counted all narcotic medications. CMT A was terminated on 2/28/24. The facility conducted in-services on abuse, neglect, and misappropriation. Staff corrected the deficient practice on 2/28/24. Review of the facility policy, Abuse Prevention Program, dated December 2016, showed the following: -The residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation; -The administration will protect the residents from anyone including, but necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual; 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 2/3/24, showed the following: -The resident's cognition was moderately impaired; -The resident took scheduled and as needed pain medication; -The resident had occasional pain; (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 - Some	-The resident had diagnoses that included chronic kidney disease, hereditary lymphedema (a genetic condition characterized by chronic swelling of certain parts of the body), non-pressure chronic ulcer of unspecified part of left and right lower legs limited to breakdown of the skin (ulcers that are caused by poor circulation and can be painful), chronic venous hypertension with ulcer and inflammation of right lower extremity. Review of the resident's physician order sheet for February 2024 showed an order for hydrocodone-acetaminophen tablet 10 mg/325 mg; give one tablet by mouth three times a day for pain (start date 11/8/22). Review of the resident's medication administration record (MAR) for February 2024 showed hydrocodone-acetaminophen 10 mg/325 mg give one tablet three times a day at 8:00 A.M., 2:00 P.M. and 8:00 P.M. Review of the resident's controlled medication utilization record (narcotic count sheet) for hydrocodone-acetaminophen 10/325 mg, one tablet three times a day, dated 2/22/24, showed the following: -On 2/27/24 at 8:00 A.M., CMT A signed out one hydrocodone-acetaminophen 10 mg/325 mg leaving the count at 17 pills remaining; -On 2/27/24 at 2:00 P.M., CMT A signed out one hydrocodone-acetaminophen 10 mg/325 mg leaving the count at 16 pills remaining; -On 2/27/24 (no time noted) a master count was completed by the assistant director of nursing (ADON) and CMT I for a count of 15 pills remaining, leaving one pill unaccounted for. 2. Review of Resident #2's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 2/24/24, showed the following: -The resident's cognition was severely impaired; -The resident had frequent pain; -The resident's pain occasionally effected his/her sleep; -The resident had diagnoses that included apraxia (unable to make voluntary movements or gestures even though you have the physical ability), aphasia (unable to communicate effectively with others), cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of cognition), unspecified dementia with behavioral disturbances, cerebrovascular disease (a group of conditions that affect blood flow and blood vessels in the brain), history of traumatic brain injury and history of malignant neoplasm (cancerous tumor) of the brain. Review of the resident's physician order sheet for February 2024 showed an hydrocodone-acetaminophen tablet 5 mg/325 mg; give two tablets by mouth three times a day for pain (start date of 11/8/22). Review of the resident's MAR for February 2024 showed hydrocodone-acetaminophen 5 mg/325 mg give two tablets three times a day at 8:00 A.M., 2:00 P.M. and 8:00 P.M. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's controlled medication utilization record (narcotic count sheet) for hydrocodone-acetaminophen 5/325 mg, dated 2/22/24, showed the following: -On 2/27/24 at 8:00 A.M., CMT A signed out two hydrocodone-acetaminophen 5 mg/325 mg leaving the count at 11 pills remaining; -On 2/27/24 at 2:00 P.M., CMT A signed out two hydrocodone-acetaminophen 5 mg/325 mg leaving the count at 9 pills remaining; -On 2/27/24 (no time noted) a master count was completed by the ADON and CMT I for a count of 7 pills remaining, leaving two pills unaccounted for. 3. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 1/2/24, showed the following: -The resident's cognition was severely impaired; -The frequency of the resident's pain and the effect the resident's pain had on his/her sleep was left blank; -The resident had diagnoses that included osteoarthritis (pain and stiffness from the wearing down of the protective tissue at the ends of bones and worsens over time) of the right knee, heart failure and other heart-related complications, chronic pulmonary edema (a condition caused by too much fluid in the lungs), and chronic obstructive pulmonary disease (COPD - refers to a group of diseases that cause airflow blockage and breathing-related problems). Review of the resident's physician order sheet for February 2024 showed an order for hydrocodone-acetaminophen 5/325 mg; give one tablet four times a day for pain (start date of 11/8/22). Review of the resident's MAR for February 2024 showed hydrocodone-acetaminophen 5 mg/325 mg give one tablet four times a day at 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M. Review of the resident's controlled medication utilization record (narcotic count sheet) for hydrocodone-acetaminophen 5/325 mg give one tablet four times a day, dated 2/20/24, showed the following: -On 2/27/24 at 8:00 A.M., CMT A signed out one hydrocodone-acetaminophen 5 mg/325 mg leaving the count at 50 pills remaining; -On 2/27/24 at 2:00 P.M., CMT A signed out one hydrocodone-acetaminophen 5 mg/325 mg leaving the count at 49 pills remaining; -On 2/24/24 at 4:00 P.M., CMT A signed out one hydrocodone-acetaminophen 5 mg/325 mg leaving the count at 48 pills remaining; -On 2/27/24 (no time noted) a master count was completed by the ADON and CMT I for a count of 47 pills remaining, leaving one pill unaccounted for. 4. During an interview on 3/18/24 at 12:58 P.M., the pharmacy consultant said the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was at the facility to do a check of the facility medication counts for accuracy; -He/She began a count with CMT A; -The first card the pharmacy consultant pulled to count was for Resident #1; -When he/she counted the pills on the card for Resident #1 the number of actual pills in the card (15) did not match the ending number (17) on the resident's narcotic count sheet; -He/She told CMT A the count in the card was 15 and the count on the narcotic count sheet was 17; -CMT A said he/she forgot to sign out the 2:00 P.M. administration to Resident #1. CMT A then signed the narcotic count sheet in front of the pharmacy consultant. The ending count was then 16; -He/She again told CMT A the count did not match. CMT A began to act nervous and flipped through the narcotic count sheets; -CMT A then asked to speak to the pharmacy consultant in private; -They both went into the medication room where CMT A told the pharmacy consultant he/she had consumed the medication that was unaccounted for; -The pharmacy consultant asked CMT A if any of the other resident's counts would be inaccurate and CMT A said yes; -CMT A said counts would also be off for Residents #2 and #3; -At that point the pharmacy consultant took CMT A to the Director of Nursing (DON). CMT A told the DON that he/she had taken one hydrocodone-acetaminophen 5/325 mg from Resident #3, two hydrocodone-acetaminophen 5/325 mg from Resident #2 and one hydrocodone-acetaminophen 10/325 mg from Resident #1 and ingested them all. During an interview on 3/6/24 at 3:00 P.M. and 3/18/24 at 12:53 P.M., the DON said the following: -On 2/27/24 the pharmacy consultant and CMT A came to his office and CMT A told him he/she had taken narcotic medications from three residents; -CMT A said he/she ingested three hydrocodone-acetaminophen 5/325 mg and one hydrocodone-acetaminophen 10/325 mg; -The DON immediately took CMT A to the administrator's office; -CMT A was escorted from the building and was terminated on 2/28/24 for misappropriation of resident narcotic medications. During an interview on 3/6/24 at 3:00 P.M. the administrator said the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 2/27/24, the DON brought CMT A to her office and let her know there was a problem with CMT A diverting narcotics; -CMT A admitted to ingesting three residents' (Residents #1's, #2's and #3's) hydrocodone-acetaminophen pills (three hydrocodone-acetaminophen 5/325 mg and one hydrocodone-acetaminophen 10/325 mg); -The local police department was called and the incident was reported; -CMT A was escorted from the building at 3:15 P.M. on 2/27/24; -Staff completed a count of all narcotics on 2/27/24, after CMT A was escorted from the building. There were no further discrepancies found. MO232430