STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265664	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James River Nursing and Rehabilitation	3550 East Battlefield Springfield, MO 65809

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** 40769 Based on record review and interview, the facility failed to keep all residents free from misappropriation when the staff could not account of 17 doses of medication, affecting twelve residents (Resident #2, #4, #8, #9, #10, #1, #3, #5, #6, #11, #12 and #7), that were the possession of the facility. The facility census was 99. Review of the facility policy, Abuse, Neglect, Exploitation or Misappropriation Prevention Program, revised 04/2021, showed the residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Review of the facility policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 2022, showed the following information: -All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported lo local, state and federal guidance (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported; -All allegations are thoroughly investigated. The Administrator initiates investigations; -Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations; -Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement; -The Administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. 1. Review of the Follow-Up Investigation Report, undated, showed the following: -Licensed Practical Nurse (LPN) A was the alleged perpetrator; (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: 265664	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER James River Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3550 East Battlefield Springfield, MO 65809	

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Multiple pills were found in LPN A's pockets when taken out of the facility to a police car. Police brought the pills back into facility and all were identified and signed out of narcotic book. All medications were identified and accounted for. There were no missing medications. Upon notification of arrest, facility Assistant Director of Nursing (ADON) called into facility to cover shift and collect keys; - LPN A was interviewed on 02/05/24, at approximately 12:00 P.M. LPN A was asked why he/she pulled narcotics out of narcotic box without signing them out and if this was policy. LPN A said, No, I just usually sign out all medications at the end of shift. LPN A also said he/she had pulled the pills at the beginning of his/her shift, placed them in individual pill distribution cups, and placed them in his/her pocket for administration. -The ADON arrived to the facility at approximately 9:30 P.M. and LPN D was seated at the 400 hall nurses' station and gave him/her a brief overview of what he/she had witnessed and then reported back to his/her assigned hall; -He/she went to the 100/200 hall nurses' station to retrieve the 400 hall unit keys from LPN C. LPN C and the ADON then returned back to 400 hall nurses station to give report and count the medication log. LPN C said he/she and LPN D had already counted after LPN A had given the keys to LPN C. LPN C had flagged the medications with slips of paper in the medication book that were incorrect. He/she confirmed the inaccurate counts of medication. The medications were not yet signed out in the med log or on the electronic MAR/TAR. 2. During an interview on 02/14/24, at 9:30 A.M., the Narcotics Detective said the following: -Police officers were dispatched to the facility on [DATE] at 8:20 P.M. ; -The officers arrested LPN A and took him/her out of the facility. The officers found six white pills loose in two of LPN A's pockets; -The facility staff identified the pills as three oxycodone pills (a controlled substance used to treat moderate to several pain), one Lortab (a controlled substance used to treat moderate to several pain) pill, one Xanax (a controlled substance used to treat anxiety) and one Norco (a controlled substance used to treat moderate to several pain) pill; -The six pills were confiscated when the nurse was taken out of the facility by the police officers. 3. During an interview on 02/08/24 the Director of Nursing (DON) said the following: -The handwritten list of residents and medications is the list of medications that were missing from the count; -There were 17 pills total that were missing from the count; -He/she made the list based off of sticky notes that were left in the Narcotic book by LPN C and LPN D. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All of the pills were found in LPN A's pocket by the police officers and identified by LPN A and LPN B; -He/she thought all the pills were accounted for and not actually missing; -He/she was not aware that there were only six pills found in LPN A's pocket. 4. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included cellulitis (a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin) of the left leg, multiple sclerosis (a long-lasting (chronic) disease of the central nervous system), muscle wasting and atrophy (wasting away), and weakness. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/22/24, showed the following: -The resident was cognitively intact; -The resident required partial/moderate assistance for mobility and transfers; -The resident has pain occasionally and received as needed pain medication in the last five days; -Pain effects sleep. Review of the resident's care plan, dated 01/30/24, showed the following: -The resident was on pain medication therapy as needed; -Administer analgesic medications as ordered by physician. Monitor/ document side effects and effectiveness every shift; -The resident had an order for oxycodone 5 milligram (mg); -Evaluate the effectiveness of pain interventions. Review of the facility provided handwritten list, undated, showed one tablet of the resident's oxycodone could not be accounted for. Review of the resident's current Physicians Order Sheet (POS) showed an order, dated 01/19/24, for oxycodone HCL oral tablet 5 mg, give one tablet by mouth every four hours as needed for moderate to severe pain. Review of the resident's current Medication Administration Record (MAR)/Treatment Administration Record (TAR), dated 02/01/24, showed staff did not document administering oxycodone HCL in the evening or night. (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 Narcotic Record showed the following: -On 02/01/24, at 11:30 A.M., oxycodone 5 mg, one dose was given with balance forward of 51; -On 02/01/24, at 11:20 P.M., oxycodone 5 mg, one dose documented as given with a slash mark, balance forward showed 50 with another slash mark. The Narcotic Record was signed by LPN C and the ADON; -Attached to the narcotic record was a Medication Disposition Form, dated 02/01/24 at 11:30 P.M., that said medication identified and removed from the count, signed by the Director of Nursing (DON) and Registered Nurse (RN) I. 5. Review of Resident #4's face sheet showed the following: -admitted [DATE]; -Diagnoses included rhabdomyolysis (a rare muscle injury where muscles break down), muscle wasting and atrophy, chronic pain syndrome, and low back pain. Review of the resident's care plan, updated 02/01/24, showed the following: -The resident had chronic pain due to lower back, ankles, and right leg chronic pain syndrome; -The resident has an order for Norco oral tablet 7.5-325 mg; -Anticipate the resident's need for pain relief and respond immediately to any complaint of pain; -Evaluate the effectiveness of pain interventions Review of the resident's discharge MDS, dated [DATE], showed the following: -The resident was cognitively intact; -The resident required substantial/maximal assistance for mobility and transfers; -The resident had pain frequently and received as needed pain medication in the last five days; -Pain effects sleep frequently. Review of the facility provided handwritten list, undated, showed one tablet of the resident's Norco could not be accounted for. Review of the resident's current POS showed an order, dated 01/09/24, for Norco oral tablet 7.5-325 mg, give one tablet by mouth every 12 hours as needed for pain. Review of the resident's MAR/TAR, dated 02/01/24, showed staff did not document administering an evening does of the resident's event does of Norco oral tablet 7.5-325 mg. (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 nurses' notes, dated 02/01/24, showed staff did not document regarding the resident's Norco. Review of the resident's narcotic record showed the following: -On 02/01/24, at 5:00 A.M., staff documented administration of Norco 7.5 mg, one tablet, with balance forward of 49, -On 02/01/24, at 11:20 P.M., dose given had a slash mark balance forward and showed 48 amount. In received was another slash mark. The form was signed by LPN C and the ADON; -Attached to the narcotic record was a Medication Disposition Form, dated 01/01/24, with one tablet identified and removed from the count. The form was signed by the DON and RN I. 6. Review of Resident #8's face sheet showed an admitted [DATE]. Review of the resident's admission MDS, dated [DATE], showed the following: -The resident was cognitively intact; -The resident required supervision assistance for mobility and transfers; -The resident has pain occasionally and received as needed pain medication in the last five days; -Pain effects sleep occasionally. Review of the resident's care plan, dated 01/27/24, showed the following: -The resident has pain; -The resident will not have an interruption in normal activities due to pain through the review date; -The resident has an order for hydrocodone-acetaminophen (Norco) oral tablet 5-235 mg; -Administer Norco oral tablet 5-235 mg every six hours as needed per orders -Anticipate the resident's need for pain relief and respond immediately to any complaint of pain; -Evaluate the effectiveness of pain interventions; -The residents pain is alleviated/relieved by rest and pain medications. Review of the facility provided handwritten list, undated, showed one tablet of the resident's Norco could not be accounted for. Review of the resident's current POS showed 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	-An order, dated 01/24/24, for Norco (hydrocodone-acetaminophen) oral tablet 5-325 mg, give one tablet by mouth every six hours as needed for pain, not to exceed four tablets in one day. Review of the resident's MAR/TAR, dated 02/01/24, showed staff did not document administration of an evening dose off Norco. Review of the resident's narcotic record showed the following: -On 01/31/24, at 2:04 P.M., staff noted one dose of Norco 5-325 removed with balance forward of 78; -On, no date given, staff noted Norco 5-325 no dose was given, however balance forward showed 77, -On 02/01/24, at 11:20 P.M., staff noted a slash mark with balance forward of 76 of Norco 5-325. Staff noted amount received with another slash mark. The line was signed by LPN C and the ADON; -Attached to the narcotic record was a Medication Disposition Form, dated 02/01/24, with one tablet identified and removed from the count. The form was signed by the DON and RN I. 7. Review of Resident #9's face sheet showed the following: -admitted [DATE]; -Diagnoses included osteomyelitis (infection of the bone) of the vertebra, thoracic region, pain in right hip, and chronic pain syndrome. Review of the resident's care plan, dated 03/07/23, showed the following: -The resident is on pain medication therapy as needed; -The resident will be free of any discomfort or adverse side effects from pain medication through the review date. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Required partial/moderate assistance for mobility and transfers; -The resident has pain occasionally and received as needed pain medication in the last five days; -Pain effects sleep occasionally. Review of the facility provided handwritten list, undated, showed one tablet of the resident's pregabalin (Lyrica - used to treat nerve pain) 50 mg, could not be accounted for. Review of the resident's current POS showed an order, dated 02/25/23, for Lyrica oral capsule, 8 mcg, give one capsule by mouth three times a day related to chronic pain syndrome. (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 narcotic record showed the following: -On 02/01/24, at 1:00 P.M., staff administered pregablin (Lyrica) 50 mg with balance forward of 73; -On 02/01/24, at 11:20 P.M., pregablin 50 mg had a slash mark with balance forward showed that showed 72. The amount received marked another slash mark. The line was signed by LPN C and the ADON; -Attached to the narcotic record was a Medication Disposition Form, dated 02/01/24, that showed one tablet identified and removed from the count. The form was signed by the DON and RN I. 8. Review of Resident #10's face sheet showed the following: -admitted [DATE]; -Diagnoses included muscle wasting and atrophy. Review of the resident's admission MDS, dated [DATE], showed the following: -The resident was cognitively intact; -The resident required partial/moderate assistance for mobility and transfers; -The resident has pain occasionally and received as needed pain medication in the last five days; -Pain effects sleep occasionally. Review of the resident's care plan, dated 01/27/24 showed the following: -The resident has chronic pain due to general body pain; -Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Review of the facility provided handwritten list, undated, showed two of the resident's Lomotil (a controlled substance used to treat diarrhea) could not be accounted for. Review of the resident's current POS showed an order, dated 01/30/24, for Lomotil oral tablet 2 5-0.025 mg, give two tablets by mouth four times a day to treat malignant (cancer) neoplasm of overlapping sites of rectum, anus and anal canal. Review of the resident's February 2024 MAR/TAR showed staff did not document administration of Lomotil at the scheduled time of 9:00 P.M. on 02/01/24. Review of the resident's nurses' notes showed did not document regarding the missed dose of Lotomil on 02/01/24. Review of the resident's narcotic record showed 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 02/01/24, at 5:00 P.M., staff documented administration of Lomotil, two pills given, with balance forward forward of 74; -On 02/01/24, at 11:20 P.M., staff marked a slash mark and listed balance forward of 72. The amount received was marked with another slash mark. The line was signed by LPN C and the ADON; -Attached to the narcotic record was a Medication Disposition Form, dated 02/01/24, that identified two tablets removed from the count and signed by the DON and RN I. 9. Review of Resident #1's face sheet (resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included fracture of left lower leg. Review of resident's care plan, revised on 02/01/24, showed the following: -The resident is on sedative/hypnotic therapy related to insomnia; -Order for zolpidem tartrate (a controls substance, sedative/hypnotic) oral tablet 5 mg; -The staff should administer sedative/hypnotic medications as ordered by physician. -The resident has acute/chronic pain related to left ankle fracture; -The staff should administer analgesia (oxycodone 5 mg, two tabs every 8 hours as needed) as per orders, give half hour before treatments or care; -The staff should anticipate the resident's need for pain relief and respond immediately to any complain of pain. Review of the facility provided handwritten list, undated, showed the two of the resident's oxycodone, five mg, and one of the resident's zolpidem, five mg, could not be accounted for. Review of resident's February 2024 POS showed the following: -An order, dated 01/08/24, for zolpidem tartrate oral tablet, 5 mg, 1 tablet by mouth at bedtime related to insomnia; -An order, dated 01/23/24, for oxycodone HCI oral tablet 5 mg, give 2 tablets by mouth every 8 hours as needed for pain related to acute pain due to trauma. Review of the resident's February 2024 MAR/TAR showed the following: -On 02/01/24, at 9:00 P.M., staff did not document they administered zolpidem, 5 mg, to the resident; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 02/01/24, staff did not document they administered the evening dose of oxycodone 5 mg, to the resident. Review of the resident's nurse progress notes, dated 02/01/24, showed staff did not document regarding the zolpidem and oxycodone not being administered. Review of the resident's narcotic log for oxycodone showed the following: -On 02/01/24, at 3:00 A.M., staff administered two tabs to the resident, with remaining count of 54 tabs. -On 02/01/24. at 11:20 P.M., staff documented a line (-) as dose given with remaining count of 52 tabs; -On 02/01/24 staff identified two tabs as removed from count on the medication disposition page signed by the DON and RN I. 10. Review of Resident #3's face sheet showed the following: -admitted [DATE]; -Diagnoses included intertrochanteric fracture of right femur (hip fracture) and muscle wasting and atrophy. Review of resident's care plan, initiated on 01/18/24, showed the following: -The resident has acute pain related to right humerus fracture and right femur fracture; -The resident has an order for oxycodone HCL oral tablet 5 mg; -The staff will administer medications as ordered and monitor/document for side effects and effectiveness; -The resident is cognitively intact. Review of the facility provided handwritten list, undated, showed the two of the resident's oxycodone's could not be accounted for. Review of resident's February 2024 POS showed an order, dated 01/27/24, for oxycodone HCI capsule 5 mg, give one capsule by mouth every six hours a needed for moderate to severe pain. Review of the resident's February 2024 MAR/TAR showed on 02/01/24, at 9:00 P.M., staff did not document they administered oxycodone to the resident. Review of the resident's progress notes, dated 02/01/24, showed staff did not document regarding the resident's oxycodone. Review of the resident's narcotic log for oxycodone 5 mg tabs showed 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 02/01/24, at 9:40 A.M., staff administered one tab to the resident with remaining count of 39 tabs; -On 02/01/24, at 11:20 P.M., staff documented a line (-) as dose given with remaining count of 37 tabs; -On 02/01/24, staff identified two tabs as removed from count on the medication disposition page signed by the DON and RN I. 11. Review of Resident #5's face sheet showed the following: -admitted [DATE]; -Diagnoses included fracture of unspecified part of neck of right femur (hip fracture) and muscle wasting and atrophy. Review of resident's care plan, initiated on 01/12/24, showed the following: -The resident has acute pain related to right hip fracture; -The resident has an order for oxycodone HCL oral tablet 5 mg; -The staff should administer analgesics as ordered by the physician; -The staff should anticipate the resident's need for pain relief and respond immediately to a complaint of pain. Review of the facility provided handwritten list, undated, showed the one of he resident's oxycodone's could not be accounted for. Review of resident's February 2024 POS showed an order, dated 01/12/24, for oxycodone HCL oral tablet 5 mg, give one tablet by mouth every four hours as needed for pain related to fracture or unspecified part of neck of right femur, initial encounter for closed fracture. Review of the resident's February 2024 MAR/TAR showed on 02/01/24, staff did not document they administered the evening dose of oxycodone to the resident. Review of the resident's progress notes, dated 02/01/24, showed staff did not document regarding the oxycodone. residents Oxycodone. Review of the resident's narcotic log for oxycodone 5 mg tabs, showed the following: -On 02/01/24. at 1:00 A.M., staff administered one tab to the resident with remaining count of 48 tabs. -On 02/01/24, at 11:20 P.M., staff documented a line (-) as dose given with remaining count of 47 tab; (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 narcotic log for hydrocodone-acetaminophen 10/325 mg tabs, showed the following: -On 02/01/24, staff documented receiving 90 tabs from the pharmacy; -On 02/01/24. at 11:20 P.M., staff documented a line (-) as dose given with remaining count of 89 tabs; -On 02/01/24 staff identified one tab as removed from count on the medication disposition page signed by the DON and RN I. Review of resident's narcotic log for Xanax. 25 mg tabs, showed the following: -On 02/01/24. at 11:20 P.M., staff documented one dose administered with remaining count of seven; -On 02/01/24, staff identified one tab as removed from count on the medication disposition page signed by the DON and RN I. 13. Review of Resident #11's face sheet showed the following: -admitted [DATE]; -Diagnoses included pathological fracture (a broken bone caused by disease, often by the spread of cancer to the bone), Review of resident's care plan .initiated on 01/31/24, showed the following: -The resident has an order for Percocet (oxycodone) oral tablet 10-325 mg; -The staff should administer analgesics (percocet oral tablet 10-325 mg) as ordered by the physician. The staff should monitor for side effects and effectiveness. Review of the facility provided handwritten list, undated, showed one of the resident's Percocets could not be accounted for. Review of resident's February 2024 POS showed an order, dated 01/31/24, for Percocet oral tablet 10-325 mg, give one tablet by mouth three times a day for pain. Review of the resident's February 2024 MAR/TAR showed the following: -On 02/01/24, at 8:00 P.M., staff did not document they administered Percocet mg to the resident. Review of the resident's nurses' progress notes, dated 02/01/24, showed staff did not document regarding the Percocet. Review of the resident's narcotic log for Percocet 10/325, showed the following: -On 02/01/24, at 1:00 P.M. , staff documented balance forward of five tablets ; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER James River Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3550 East Battlefield Springfield, MO 65809	

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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	-On 02/01/24. at 11:20 P.M., staff documented a line one dose given with remaining count of 4 tablets; -On 02/01/24, staff identified one tab as removed from count on the medication disposition page signed by the DON and RN I. 13. Review of Resident #12's face sheet showed the following: -admitted [DATE]; -Diagnoses included muscle wasting and atrophy and fracture of right femur (broken thighbone). Review of resident's care plan, revised on 02/01/24, showed the following: -The resident had acute pain related to right hip fracture; -The resident had an order for oxycodone oral tablet 5 mg. Review of resident's February 2024 POS showed an order, dated 01/29/24, for oxycodone oral tablet 5 mg, give one tablet by mouth every four hours as needed for moderate to severe pain related to fracture of right hip. Review of the resident's February 2024 MAR/TAR showed on 02/01/24, staff did not document they administered the evening dose of oxycodone 5 mg to the resident. Review of the resident's nurses' progress notes, dated 02/1/24, showed staff did not related to the oxycodone. Review of the resident's narcotic log for oxycodone 5 mg tabs, showed the following: -On 02/01/24, staff documented receiving 174 tabs from the pharmacy; -On 02/01/24, at 11:20 P.M., staff documented a line (-) as dose given with remaining count of 173 tabs; -On 02/01/24, staff identified one tab as removed from count on the medication disposition page signed by the DON and RN I. 14. Review of Resident #7's face sheet showed the following: -admitted [DATE]; -Diagnoses included unspecified fracture of fifth lumbar vertebra (fracture to the lower spine), and muscle wasting and atrophy. Review of resident's care plan, initiated on 01/26/24, showed the following: -The resident is on pain medication therapy PRN; (continued on next page)

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F 0602

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-Order for oxycodone-acetaminophen tablet 5-325 mg;

-The staff should administer analgesic medications as ordered by physician;

-The staff should monitor/document side effects and effectiveness every shift.

Review of resident's February 2024 POS showed an order, dated 01/25/24, for oxycodone-acetaminophen tablet 5-325 mg, give one tablet by mouth every four hours as needed for pain, not to exceed six tabs in 24 hours.

Review of the resident's February 2024 MAR/TAR showed on 02/01/24, staff did not document they administered the evening dose of oxycodone-acetaminophen 5-325 mg, to the resident.

Review of the resident's nurse progress notes, dated 02/01/24, showed staff did not document regarding the resident's oxycodone.

Review of the resident's narcotic log for Percocet 5/325 mg tabs showed the following:

-On 02/01/24, at 4:30 P.M., staff administered one tab to the resident with remaining count of 22 tabs;

-On 02/01/24, at 11:20 P.M., staff documented a line (-) as dose given with remaining count of 21 tabs;

-On 02/01/2024 staff identified one tab as removed from count on the medication disposition page signed by the DON and RN I.

15. During an interview on 02/08/24, at 12:48 P.M., the ADON said the following:

-He/she got a call from LPN C that police officers were in the building and taking LPN A;

-He/she arrived at the facility between 9:00 A.M. and 9:30 P.M. He/she took report from LPN C;

-The police had already left the building with LPN A. He/she counted the medications from the lock box;

-The medications that were missing from the count had been identified by LPN C and LPN D and been confiscated and taken out of the building by the police;

-He/she pulled up the MAR/TAR and started doing rounds on the residents;

-He/she put slash marks (-) on the narcotics record to show the medications were not administered and show that the medications were not accounted for and could be taken out of the count.

During an interview on 02/08/24, at 1:12 P.M., Certified Nurse Aide (CNA) B said it is not appropriate to take a resident's medication. The staff are educated about misappropriation and taking a resident's medication.

(continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/08/24, at 2:00 P.M., LPN C said the following: -On 02/01/24, at around 8:45 P.M., a CNA came to get him/her due to there being police in the facility; -He/she went to the hall where the officers were and saw they had put LPN A in handcuffs; -He/she called the ADON who was the manager on call; -The police officer said LPN A was under arrest and took her outside. They then returned with a clear Ziploc bag with six to eight pills in it that they said had been found in LPN As pockets; -It is not appropriate to put resident medications in staff's pockets; -He/she worked with LPN D to identify the medications. He/she believes there was two pills of Norco, one Percocet, one Xanax, and one oxycodone. He/she believes there were more duplicates, but could not remember; -He/she did a complete narcotics count with LPN D and there were 17 total pills missing from the count; -The amount of pills that were in LPN A's pocket did not account for all of the missing medication. The count had been correct prior to the LPN A's shift; -He/she and the ADON signed the narcotic sheets of the missing medication; -He/she let the ADON and DON know that there were missing medications. During an interview on 02/08/24, at 3:33 P.M., LPN D said the following: -On 02/01/24, at around 9:00 P.M., CNA E came and told him/her that their were police officers in the building; -The police officers arrested LPN A and took him/her outside; -They brought back in clear plastic bag without about seven pills in it and said they had found it in LPN A's pockets. They asked for LPN C and LPN D to identify the medication and they did; -He/she does not know why LPN A had medication in his/her pockets. It is not appropriate to put resident medication loose in their pockets or to pop multiple residents' medication at the same time; -He/she does not remember what the pills were; -The police officers then took the pills with them; -He/she helped LPN C complete the narcotic count and found there to be more missing medication than what was in LPN A's pocket; (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 marked all of the missing medication with a sticky note on the pages were the count was off. During an interview on 02/08/24, at 4:04 P.M., CMT F said the following: -He/She had been on break with CNA E and came back in the building at 8:30 P.M., -CMT F said that there were three police officers at the vending machines and the officers asked to be taken to LPN A; -CMT F took the officers to the 400 hall where LPN A was working; -CMT F said the police officers went into room [ROOM NUMBER] and arrested LPN A; -CMT F said that LPN A gave the keys to the med cart to LPN C; -CMT F said that two police offers came back in the building and had a clear Ziploc bag with 6 to 7 pills in it; -CMT F said that LPN C and LPN D identified the pills for the police; -LPN C and LPN D went through the narcotic book and identified medications that were missing; -CMT F said that it is not appropriate for staff to have medications belonging to residents in their pockets; -CMT F said that it is not appropriate to take a resident's medication to a room that the resident did not reside in. During an interview on 02/08/24, at 1 [TRUNCATED]

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40769 Based on interview and record review, the facility failed to ensure effective pain management was provided to all residents, consistent with professional standards of practice, when staff failed to administer one resident's (Resident #8) as needed pain medication when the resident requested the mediation due to pain and showed physical signs of pain. The census was 99. Review of the facility policy, Administering Oral Medications, revised 10/2010, showed the following: -For tablets or capsules from a bottle. pour the desired number into the bottle cap and transfer to the medication cup. Do not touch the medication with hands. Return extra capsules/tablets to the bottle. All medications to be given at the same time can be placed in the same cup except those that require assessment (e.g., vital signs) prior to administration; -For unit dose tablets and capsules, place packaged medications directly into the medication cup; -Confirm the identity of the resident; -Explain the procedure to the resident; -Place medications on the bedside table or tray; -Offer water to assist the resident in swallowing medications; -Allow the resident to swallow oral tablets or capsules at his or her comfortable pace; -If a medication falls to the floor, discard and document per facility protocol. Repeat the preparation; -Remain with the resident until all medications have been taken. 1. Review of Resident #8's face sheet showed the following: -admitted [DATE]; -Diagnoses included severe sepsis with septic shock (condition that happens when one's blood pressure drops to a dangerously low level after an infection), type 2 diabetes mellitus (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) with diabetic chronic kidney disease, and bacteremia (viable bacteria in the blood). Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required supervision assistance for mobility and transfers; -Resident had pain occasionally and received as needed pain medication in the last five days; -Pain effects sleep occasionally. Review of the resident's care plan, dated 01/27/24, showed the following: -The resident had pain; -The resident will not have an interruption in normal activities due to pain through the review date; -The resident has an order for hydrocodone-acetaminophen (Norco - used to treat moderate to severe pain) oral tablet 5-235 milligram (mg); -Administer Norco oral tablet 5-235 mg every six hours as needed per orders; -Anticipate the resident's need for pain relief and respond immediately to any complaint of pain; -Evaluate the effectiveness of pain interventions; -The resident's pain is alleviated/relieved by rest and pain medications. Review of the resident's current POS showed the following: -An order, dated 01/24/24, for Norco oral tablet 5-325 mg, give one tablet by mouth every six hours as needed for pain, not to exceed four tablets in one day. Review of the resident's February 20234 MAR/TAR showed staff did not document administration of Norco oral tablet to the resident. Review of the resident's narcotic record showed the following: -On 01/31/24, at 2:04 P.M., staff noted one dose of Norco 5-325 mg administered with a balance forward of 78 pills; -On unknown date, staff noted one does of Norco 5-325 mg administered with a balance forward of 77 pills; -On 02/01/24, at 11:20 P.M., staff placed a slash mark thru dose given a balance forward of 76 pills; -Attached to the narcotic record was a Medication Disposition Form, dated 02/01/24 that showed one tablet identified and removed from the count. The form was signed by the Director of Nursing (DON) and Registered Nurse (RN) I. During an interview on 02/08/24, at 9:32 A.M., the resident said the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did not receive his/her Norco on the night of 02/01/24. He/she was in a lot of pain in his/her wound site and felt like it was 10 on a scale of one to 10. He/she asked for his/her pain medication multiple times from the certified nurse aide (CNA). The staff never brought the medication; -He/she was also in pain the following morning, but he/she did receive pain medication. During an interview on 02/08/24, at 1:12 P.M., the CNA B said the following: -The resident said he/she did not receive his/her pain medication on the night of 02/01/24. The resident requested it three times between around 8:00 P.M. and 9:00 P.M.; -The resident was wincing and moving around like he/she could not get comfortable; -He/she reported to the nurse three times that the resident had requested pain medication. During interviews on 02/08/24, at 12:48 P.M., and 02/09/24, at 11:40 P.M., the Assistant Director of Nursing (ADON) said the following: -He/she arrived at the facility between 9:00 and 9:30 P.M. on 02/01/24 to cover for a nurse who had to leave. He/she took report from Licensed Practical Nurse (LPN) C; -The nurse the ADON replaced had already left the building when he/she arrived; -He/she pulled up the MAR/TAR and started doing rounds on the residents; -Medications should be administered as ordered by the physician and then documented on the MAR/TAR and Narcotics records if it is a controlled medication; -The MAR/TAR and the narcotics records should match, however, the narcotics log is not used as an administration record; -He/she was not aware of any residents being in pain on the night of 02/01/2024 as the result of not getting their pain medication. During an interview on 02/08/24, at 12:13 P.M., the Director of Nursing said generally, medications should be administered as ordered by the physician. MO0000231298

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40769 Based on interview and record review, the facility failed to ensure all residents' medical records were complete and accurate when faciltiy staff failed to document if treatments were completed for four residents (Resident #2, #4, #9, and #10) and failed to follow-up with the residents regarding potentally missed treatments. The census was 99. 1. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included cellulitis (a bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin) of the left leg, multiple sclerosis (a long-lasting (chronic) disease of the central nervous system), muscle wasting and atrophy (waste away), hypotension (low blood pressure), weakness, severe sepsis with septic shock (when a person's body responds improperly to an infection and causes your organs to malfunction). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/22/24, showed the following: -The resident was cognitively intact; -The resident required partial/moderate assistance for mobility and transfers. Review of the resident's care plan, dated 01/30/24, showed the following: -Potential for pressure ulcer (localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences) development due to limited mobility and weakness; -The resident will have intact skin, free of redness, blisters or discoloration by/through the review date; -Administer treatments as ordered and monitor for effectiveness; -Actual impairment with excoriation to peri, groin, and buttock due to moisture associated skin damage (MASD); -The resident skin injury will be healed by review; -Keep skin clean and dry. Review of the resident's current Physicians' Order Sheet (POS) showed the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 01/24/24, for mineral cream to left lower leg two times daily to promote skin integrity every day and evening shift; -A current order for Nystatin External Powder 100000 Unit/GM (gram) (Nyastatin Topical - treats fungal or yeast infections of the skin), apply to bilateral breast, pannus, and groin topically every shift for MASD/yeast; -Micatin Cream 2% (miconazole nitrate), apply to buttock topically every shift for MASD/yeast. Review of the resident's Medication Administration Record (MAR)/Treatement Administration Record (TAR), dated February 2024, showed the following: -On 02/01/24, staff document the evening does of mineral cream was not adminitered. The Assistant Director of Nursing (ADON) entered code nine, indicating to see nurses' notes; -On 02/01/24, staff docmented the evening does of Nystatin External Powder, was not administered. The ADON entered code nine, indicating to see nurses' notes; -On 02/01/24, staff dcumented the evening does of Micatin Cream 2% was not administered. The ADON entered code nine, which indicated to see nurses' notes. Review of the resident's nurses' notes showed the following: -On 02/02/24 at 12:49 A.M., the ADON documented adminitration of Nystatin External Powder was not documented on the previous shift; -On 02/02/24, at 12:49 A.M., the ADON documented administration of mineral cream was not documented on the previous shift; - On 02/01/24, at 12:49 A.M., the ADON documented administation of Micatin Cream was not documented on the previous shift. 2. Review of Resident #4's face sheet showed the following: -admitted [DATE]; -Diagnoses included rhabdomyolysis (s a rare muscle injury where muscles break down), cognitive communication deficit, muscle wasting and atrophy, chronic pain syndrome, and low back pain. Review of the resident's care plan, updated 02/01/24, showed the following: -Had potential for pressure ulcer development due to limited mobility; -The resident will have intact skin, free of redness, blisters or discoloration by/through the review date; -Administer treatments as ordered and monitor for effectiveness; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Potential/actual impairment to skin integrity due to MASD to pannus, groin, and under the breasts; -The resident will maintain or develop clean and intact skin by the review date; -Keep skin clean and dry. Review of the resident's discharge MDS, dated [DATE], showed the following: -Cognitively intact; -Required substantial/maximal assistance for mobility and transfers; -Had pain frequently and received as needed pain medication in the last five days; -Pain effected sleep frequently. Review of the resident's current POS showed the following: -An order, dated 01/09/24, for Nystatin External Powder, apply to bilateral breast, pannus, and groin topically every day and evening shift for MASD/yeast; -An order, dated 01/09/24, to complete accu-check (used to check blood sugar levels) before meals and at bedtime; -An order, dated 11/11/24, due to MASD to bilateral buttock. Staff to cleanse with soap and water or incontinent wipe, apply clamoseptine (uesd to treat and prevent minor skin irritations) every shift until resolved. Review of the resident's February 2024 MAR/TAR showed the following: -On 02/01/24, staff documented the administrastion of Nystatin External Powder was not administered. The ADON entered a code nine, indicating see nures's notes; -On 02/01/24, staff did not document accu-checks for the evening were not completed. Staff did not document a reason; -On 02/01/24, staff documented the administration of clamoseptine was not completed on the evening shift. Staff entered a code nine, indictating to see nurses' notes. Review of the resident's nurses' notes, dated 02/02/4, showed the following: -On 02/02/24, at 12:50 A.M., the ADON documented Nystatin External Powder was not documented as administered from the previous shift; -On 02/02/24 , at 12:50 A.M., the ADON documented clamoseptine was not documented as administered from the previous shift. (Staff did not document regarding the potentially missed accu-checks.) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #9's face sheet showed the following: -admitted [DATE]; -Diagnoses included type two diabetes mellitus with diabetic chronic kidney disease, osteomyelitis (infection of the bone) of the vertebra, pain in right hip, dementia, and chronic pain syndrome. Review of the resident's annual MDS, dated [DATE], showed the following: -The resident was cognitively intact; -The resident required partial/moderate assistance for mobility and transfers. Review of the resident's current POS showed the following: -An order, dated 11/27/23, for Premarin vaginal cream .625 mg/gram (gm), insert one gram vaginally every other evening related to urinary tract infections. Review of the resident's February 2024 MAR/TAR showed the following: -On 02/01/24, staff documented the Premarin vaginal cream .625 mg/gm, was not administered. The ADON entered a code nine, indicating see nurses' notes. 4. Review of Resident #10's face sheet showed the following: -admitted [DATE]; -Diagnoses included COVID-19, pneumonia, muscle wasting and atrophy, and cognitive communication deficit. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -The resident required partial/moderate assistance for mobility and transfers. Review of the resident's current POS showed the following: -An order, dated 01/10/24, to apply tubigrip (light compression stocking) to left arm due to edema (swelling) in the morning and remove at night every day and evening shift. Review of the resident's February 2024 MAR/TAR showed the following: -On 02/01/24, staff documented tubigrip order to left arm due was not addressed that evening. Staff entered a code nine, indicating see nurses' notes. Review of the resident's nurses notes showed the following: (continued on next page)

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James River Nursing and Rehabilitation	3550 East Battlefield Springfield, MO 65809

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 02/02/24, at 12:47 A.M., the ADON documented tubigrip order showed evening shift did not documented if the action occurred. 5. During interviews on 02/08/24, at 12:48 P.M., and on 02/09/24, at 11:40 P.M., the ADON said the following: -He/she got a call that a nurse had to leave the facility unexpectedly. The nurse had already left the building when the ADON arrived; -The ADON arrived at the facility between 9:00 P.M. and 9:30 P.M. He/she took report from another nurse on duty Licensed Practical Nurse (LPN) C; -He/she pulled up the MAR/TAR and started doing rounds on the residents; -If he/she documented a nine on the MAR/TAR, there should be a note in the nurses' notes as to why the treatment was not completed; -He/she documented Not documented from previous shift because she assumed the treatments had been completed by the nurse that left, before he/she got to the facility. The ADON did not ask the residents if they had recieved their treatments; -Treatments should be administered as ordered by the physician and then documented on the MAR/TAR. During an interview on 02/08/24, at 12:13 P.M., the Director of Nursing (DON) said the following: -He/she said to ask the ADON when asked about treatments not administered the night of 02/01/24; -Generally, treatments should be administered as ordered by the physican. 48534 MO0000231298