STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265787	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laverna Manor Health & Rehabilitation	904 Hall Avenue Savannah, MO 64485

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 assure one resident (Resident #2) was free from misappropriation of his/her property when the resident's narcotic medications were found missing from the facility. The facility census was 58. Review of the undated facility abuse policy included: Our residents have the right to be free from abuse, neglect, misappropriation or resident property and exploitation. Review of the Controlled Substances policy, revised April 2019, showed: - Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift; - Upon receipt: the nurse receiving the medication and the individual delivering the medication verify the name, dose and quantity of each controlled substance being delivered. Both individuals sign the controlled substance record of receipt. - At the end of each shift: Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse doing off duty determine the count together. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately; - The director of nursing (DON) investigates all discrepancies in controlled medication reconciliation to determine the cause and identify and responsible parties and reports the findings to the administrator; 1. Review of Resident #2's Face Sheet, dated 6/13/25, showed diagnoses of depression, dementia, heart disease, and low back pain; Review of the resident's Medication Administration Record (MAR), dated 6/13/25, showed the resident was taking Oxycodone 5mg tablets by mouth every 8 hours routinely; Review of the facility's investigation, dated 5/22/25, showed: - No allegation stated as to why investigation was prompted; - No alleged perpetrator was identified; (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	- The local police department was contacted; - A search of the facility and interviews with all nurses who had access to controlled substance Oxycodone was conducted with no outcomes; - Investigative interviews by the DON focused on failure to follow up on pharmacy orders not delivered, when in fact the Oxycodone order had been delivered and verified by facility staff. - The investigation did not address inventory procedures by staff prior to the missing medications or why the discovery of the missing medications happened in the middle of the shift instead of at shift change; - No clear identification of the process failures which led to the diversion of a controlled substance; - No explanation as to why the investigation was inconclusive, and the allegation could not be verified; - Corrective actions to be taken include narcotic count process strengthening and in-servicing with staff; During an interview on 6/13/25 at 10:45 A.M., LPN A said: - During the incident of the missing Oxycodone medication LPN A was not involved in the turnover of the medications or medication counts. His/her personal policy is to count all drugs including full cards when coming on and going off shift to ensure all drugs are accounted for. The old policy had changed and now everyone is required to count all narcotic medications as well as full cards in stock; - He/she said that if the medication counts were done correctly, the shift and amount of the missing drugs would have been identified and someone could have been held accountable. No one had been counting the full sheets of narcotics, so it was impossible to tell exactly when the medications went missing. During an interview on 6/13/25 at 3:30 P.M., the Administrator said: - The previous process which was in place at the time of the drug inventory discrepancy was for staff to count the in use sheets of pills but not count the full sheets in stock that had not had any pills administered from. The count sheets and the pills would be accessible to all the staff who had access to the controlled drugs. Inventories would be done at the end of each shift jointly by staff; - Now the process is that the count sheets are annotated on a inventory sheet and kept separate from the stock so they can not be removed from the inventory. All pills in use and in storage are counted at the end of each shift in order to catch any overall discrepancy in stock rather than a discrepancy from just the active pill sheet; - The previous DON who conducted the investigation of the missing controlled drugs was no longer employed by the facility; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The medication expectation by staff is all pill sheets that have not been issued and ones that are in use, are counted at the end of each shift; - She is not certain, but it looks like 60 pills of Oxycodone 5mg tablets are missing from the inventory as of 5/21/25 at 10:00 P.M and they were confirmed received into the facility on 5/4/25; - The resident's medications that are missing have been replaced with the emergency stock so that he/she never missed a required dose of Oxycodone medication; During an interview on 6/16/25 at 9:00 A.M., Police Officer A said: - The preliminary investigation through interviews indicated the facility did not have any inventory controls over the controlled medication to properly identify when and who was responsible for losing or taking the 5mg Oxycodone at the facility. - He/she said the evidence that was gathered had shown the drugs were most likely taken by a staff member. MO254681