STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265793	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Plata Nursing Home	100 Old Stagecoach Road LA Plata, MO 63549

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47246 Based on interview and record review, the facility failed to report an allegation of misappropriation of a resident's medications to the state survey agency, when the director of nurses (DON) received information an unnamed resident was hoarding his/her pain medications and giving them to a Certified Nursing Assistant (CNA) employed by the facility, who in turn was giving them to his/her spouse, also employed by the facility, in a review of four sampled residents. The facility census was 43. Review of the facility policy, Abuse Prevention Program, dated (revised) August 2006, showed the following: -The residents of the facility have the right to be free from abuse, exploitation or mistreatment, misappropriation of resident property, corporal punishment, and involuntary seclusion. Review of the facility policy, Reporting Abuse to Facility Management, dated (revised) April 2014, showed the following: -It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to immediately report any incident or suspected incident of neglect, resident abuse, including injuries of unknown source, mistreatment, exploitation, or misappropriation of resident property to facility management; -The facility prohibits resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals; -Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money with the resident's consent; - All personnel, residents, family members, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse to the supervisor on duty, the DON, or the administrator; (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy. Review of the facility's policy showed it did not include the responsibility to report and investigate allegations or occurrences of abuse, neglect, or misappropriation to the state agency within required time frames for reporting. During an interview on 08/15/24 at 3:20 P.M., the Director of Nurses (DON) said the following: -A former employee reported he/she witnessed a resident tell Certified Nurse Aide (CNA) A that he/she had saved some pain pills for CNA A to give to his/her spouse, CNA B, on Monday, 08/12/24; -The former employee gave a description of the resident's room and hall location, but could not recall the resident's name; -The administrator was gone that day, and the DON was in charge of overseeing the facility; -The DON did not report the allegation of misappropriation of medications to the administrator until Tuesday, 08/13/24, when the administrator returned to the facility; -She had only been in the position as the DON for about 10 months and did not know that she should have notified the administrator and state agency of the allegation of misappropriation immediately; she did not realize this was a reportable incident. During an interview on 08/15/24 at 5:50 P.M., the administrator said the following: -She was first made aware of an allegation of a resident hoarding pain pills and giving them to an employee on Tuesday, August 13, 2024, when she returned to the facility; -The DON oversaw the facility in the administrator's absence; -She would have expected to be contacted immediately regarding an allegation of misappropriation of a resident's medication; -The allegation of misappropriation of a resident's medications should have been reported to the state agency within the appropriate time frame (two hours for abuse that has resulted in bodily injury and 24 hours for all other allegations). MO00240488

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47246 Based on interview and record review, the facility failed to investigate an allegation of misappropriation of a resident's medications, when the Director of Nurses (DON) received information that an unnamed resident was hoarding his/her pain medications and giving them to a Certified Nursing Assistant (CNA) employed by the facility, who in turn was giving them to his/her spouse, also employed by the facility, in a review of four sampled residents. The facility census was 43. Review of the facility policy, Abuse Prevention Program, dated (revised) August 2006, showed residents of the facility have the right to be free from abuse, exploitation or mistreatment, misappropriation of resident property, corporal punishment, and involuntary seclusion. Review of the facility policy, Reporting Abuse to Facility Management, dated (revised) April 2014, showed the policy did did not include the responsibility to investigate allegations or occurrences of abuse, neglect, or misappropriation and to share the results of the investigation to the state agency. During an interview on 08/15/24 at 3:20 P.M., the Director of Nurses (DON) said the following: -A former employee told the DON that he/she witnessed a resident tell CNA A that he/she had saved some pain pills for CNA A to give to his/her spouse, CNA B, on Monday, 08/12/24; -The former employee gave a description of the resident's room and hall location but could not recall the resident's name; -The administrator was gone that day, and the DON was in charge of overseeing the facility; -The DON attempted to identify the unnamed resident but could not; -The DON spoke with the Assistant Director of Nurses (ADON) and one Licensed Practical Nurse (LPN) who had been primarily responsible for passing pain medications for two weeks prior to the incident, and both denied that medications were left with residents unattended; -The DON did not interview any other facility staff, including CNA A and CNA B, or residents regarding the reported incident; -The DON felt she had investigated the allegation to the best of her ability and said she had only been in the position as the DON for about 10 months and did not know that she should have started a thorough investigation of the allegation of misappropriation or that she should have reported it to the state agency. During an interview on 08/15/24 at 5:50 P.M., the administrator said the following: -She was first made aware of an unnamed resident hoarding pain pills and giving them to a former employee on Tuesday, August 13, 2024, by the DON; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The DON oversaw the facility in the administrator's absence; -The DON should have started an immediate, thorough investigation of the allegation of misappropriation of a resident's medication; -She did not perform an investigation of the incident upon her knowledge of the event. MO00240488

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47246 Based on interview and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice for three residents, (Resident #2, #1 and #3), when staff failed to remain with the resident when staff administered medications, and failed to ensure staff did not leave medications in the resident's room for one resident (Resident #1), when the resident did not have an order to keep medications at bedside or to self-administer, in a sample of four residents. The facility census was 43. Review of the facility policy, Administering Oral Medications, dated (revised) October 2010, showed the following: -The purpose of this procedure is to provide guidelines for the safe administration of oral medications; -Remain with the resident until all medications have been taken. The facility did not provide a policy for medications left at the resident's bedside. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/30/24, showed the resident was cognitively intact. During an interview on 08/15/24 at 12:40 and at 06:20 P.M., the resident said the following: -The nursing staff did not stay with residents when medications are given, that was often an omission here; -Staff would leave the resident's medications in a medication cup with the resident's name on it and would walk away before he/she took the medication; -Two weeks ago, he/she was in the dining room and the nurse left a pill (calcium with Vitamin D) for him/her to take in a med cup with a name on it and then walked away; -The resident thought the medication cup had his/her name on it, but the first letter was hard to read; -The resident asked two other residents at his/her table what name they thought was on the medication cup and they could not read it either; -The resident asked staff to get the medication nurse so the resident could make sure the medication was for him/her; -The nurse went back to the table and told the resident that it was the resident's name, that the nurse had been writing so many names he/she just messed up on the first letter; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident did not go to the medication room to ask the medication nurse about the medication cup and pill, he/she remained in the dining room; -The medication nurse came back to the dining room quickly when the resident asked staff to get him/her; -The resident did not take the pill until after he/she talked with the medication nurse about why his/her name looked different on the medication cup. During an interview on 08/15/24 at 5:30 P.M., the Assistant Director of Nurses (ADON) said the following: -She recalled the incident that occurred to Resident #2 a couple of weeks ago; -The resident was in the dining room and she gave the resident a pill in a medication cup marked with the resident's name; -She stayed with the resident until she thought the resident had swallowed the pill and then she went back to the nurses' medication room; -The resident came to the nurses' medication room and had spit the pill back into the medication cup because the resident did not think it was his/her name on the medication cup; -She told the resident that she had written the name of the resident on the medication cup, but was in a hurry so the first letter was a little messed up; -She assured the resident it was his/her medication, and it was okay for the resident to take it; -She did not leave medications for residents to take without staying with them. 3. Review of Resident #1's Continuity of Care Document (CCD) undated, showed diagnoses of cataracts and chronic obstructive pulmonary disease (COPD, a chronic condition that results in the decreased flow of air into and out of the lungs). Review of the resident's Physician Order Sheet (POS), undated, showed an order for albuterol sulfate (a medication used to open the airways of the lungs), hydrofluoroalkane (HFA, a propellant that helps to move the medication into the lungs), aerosol inhaler, 90 micrograms (mcg) per actuation (per spray), two puffs of inhalation four times a day, ordered 09/28/21, no stop date. Review of the resident's POS did not include an order for the resident to have medications left at bedside. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact. During an interview on 08/15/24 at 10:20 A.M., the resident said the following: -The nursing staff brought his/her medications in a cup, left them on his/her bedside table, then left the room before the resident took them; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-His/Her vision wasn't always good, but he/she thought he/she recognized most of the medications when he/she looked in the med cup; -Some of the med nurses left the resident's inhaler (albuterol sulfate inhaler) on the bedside table and he/she would use it when he/she needed it because it helped his/her breathing. 4. Review of Resident #3's CCD, undated, showed diagnoses of macular degeneration (an eye disease that can result in blurring and vision loss), and cataracts (clouding of the normally clear lens of the eye). Review of the resident's quarterly MDS, dated [DATE], completed by facility staff showed the following: -Cognitively intact; -Used corrective lenses for vision. During an interview on 08/15/24 at 12:40 P.M., the resident said the following: -Staff did not stay with him/her most of the time when they give him/her medications; -He/She could not see very well, so he/she would ask the staff what the medications were for before the staff left the room; -The resident would use his/her fingers to feel the medications because he/she thought he/she could tell what most of the medications were by feeling them. During an interview on 08/15/24 at 5:30 P.M., the Assistant Director of Nurses (ADON) said the following: -She knew that some of the staff had been leaving medications with residents and not watching them take their medications; -She recently reminded all the licensed staff and Certified Medication Technicians (CMT's) that they had to stay with a resident until all medications were taken. During an interview on 08/15/24 at 03:55 P.M., the Director of Nurses (DON) said the following: -It was not appropriate for staff to leave medications with a resident for a resident to take and not stay with them; -It was not appropriate for staff to leave a medication at bedside for a resident to take without a physician order to leave at bedside. During an interview on 08/15/24 at 05:50 P.M., the administrator said the following: -She would expect staff to remain with a resident until all medications were taken; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She would not expect staff to leave medications in a resident's room unless the resident had a physician order to do so; -She was not aware that the residents reported staff did not stay with them when staff administered medications; -She knew this had been an issue and she had provided monthly med tech meetings to discuss these issues; -She knew facility staff would leave the medication cart in the med room and take medications to each resident, instead of taking the cart down the hall to each resident's room, she thought this probably contributed to staff leaving medications unattended. #MO00240488