

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  Aurora Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1200 McCutchen Road Rolla, MO 65401	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43010</b></p> <p>Based on interview and record review, facility staff failed to prevent the misappropriation of seven resident's (Resident #2, #3, #4, #5, #6, #7, and #8) narcotic medications when Licensed Practical Nurse (LPN) A took the medication without authorization of the residents or the residents' responsible parties. The facility census was 78.</p> <ol style="list-style-type: none"> <li>Review of the facility's Abuse, Neglect, and Exploitation Policy, dated 8/22/22, showed misappropriation defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's permission.</li> <li>Review of the facility's investigation, dated 9/12/24, showed staff had suspicions the narcotics count were off when they identified LPN A had subtracted various pills inaccurately for multiple residents. Upon their investigation it was identified five residents had counts off or were given a narcotic outside of their normal scheduled timeframe. When LPN A was notified he/she did not cooperate and did not return to the facility. The Assistant Director of Nursing (ADON) was made aware on 9/20/24 LPN A had been arrested at another local facility and officers found empty narcotic cards in LPN A's car for Aurora Health and Rehabilitation. The Director of Nursing (DON) tried reaching out to police on 9/17/24 and 9/23/24 for more information.</li> <li>Review of the police reported, dated 9/20/24, showed officers arrested LPN A at another local facility for misappropriation of narcotics. The police report showed the officer documented seven different empty narcotic pill cards from the facility labeled with resident's names were found in LPN A's car.</li> <li>Review of Resident #2's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 9/10/24, showed staff assessed the resident as: <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Experienced occasional pain;</li> <li>-Received scheduled and as needed pain medications.</li> </ul> </li> </ol> <p>Review of the resident's Physician Order Sheets (POS), dated 10/2024, showed an order for Hydrocodone/APAP 5-325 mg (narcotic pain medication) administer one tablet by mouth every 4 hours.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the police report, dated 9/20/24, showed the officer documented he/she found one empty Hydrocodone/APAP 5-325 mg medication card with the resident's name in LPN A's car.</p> <p>5. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Experienced occasional pain;</li> <li>-Received scheduled and as needed pain medications.</li> </ul> <p>Review of the resident's POS, dated 10/2024, showed an order for Oxycodone (narcotic pain medication) five mg administer one talbet by mouth every six hours for severe pain and Oxycotin (narcotic pain medication) 20 mg administer one tablet by mouth two times a day for pain.</p> <p>Review of the residents narcotic log sheet, dated 9/5/24, for Oxycodone 5 mg, showed LPN A signed out that he/she administered one pill on 9/6/24 but he/she subtracted two pills from the narcotic count. Review showed LPN A administered one pill on 9/8/24 but he/she subtracted two pills from the narcotic count. Review showed LPN A wasted one pill on 9/9/24 without a witness.</p> <p>Review of the police report, dated 9/20/24, showed the officer documented he/she found one empty Oxycodone 5 mg and one empty Oxycotin 20 mg medication card with the resident's name in LPN A's car.</p> <p>6. Review of Resident #4's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Received scheduled pain medications.</li> </ul> <p>Review of the resident's POS, dated 10/2024, showed an order for Oxycodone/APAP 10-325 mg take one tablet by mouth every 12 hours, and Oxycodone/APAP 10-325 mg take one tablet by mouth every 24 hours as needed for pain.</p> <p>Review of the residents narcotic log sheet, dated 8/28/24, for Oxycodone 10-325 mg, showed LPN A signed out that he/she administered one Oxycodone 10-325 mg pill on 8/28/24 but he/she subtracted two pills from the narcotic count.</p> <p>Review of the police report, dated 9/20/24, showed the officer documented he/she found one empty Oxycodone 10-325 mg medication card with the resident's name in LPN A's car.</p> <p>7. Review of Resident #5's Quarterly MDS, dated [DATE] showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;-Experienced occasional pain;</li> <li>-Received scheduled pain medication.</li> </ul> <p>Review of the resident's POS, dated 10/2024, showed an order for Oxycodone 5 mg capsules five mg by mouth four times a day for pain.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the police report, dated 9/20/24, showed the officer documented he/she found one empty Oxycodone 5 mg medication card with the resident's name in LPN A's car.</p> <p>8. Review of Resident #6's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Experienced occasional pain;</li> <li>-Received as needed pain medications.</li> </ul> <p>Review of the resident's POS, dated 10/2024, showed an order for Hydrocodone/APAP 7.5-325 mg administer one tablet by mouth every 6 hours.</p> <p>Review of the police report, dated 9/20/24, showed the officer documented he/she found one one narcotic count sheet and two empty Hydrocodone/APAP 7.5-325 mg medication cards with the resident's name in LPN A's car.</p> <p>9. Review of Resident #7's Discharge MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Experienced occasional pain;</li> <li>-Received scheduled and as needed pain medication.</li> </ul> <p>Review of the residents POS, dated 10/2024, showed an order for Hydrocodone/APAP 10-325 mg take one tablet by mouth every six hours, at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6 P.M. for moderate to severe pain.</p> <p>Review of the resident's narcotic log sheet, dated 9/9/24, showed LPN A signed out that he/she administered Hydrocodone/APAP 10-325 mg one pill on 9/10/24 but he/she subtracted two pills from the narcotic count.</p> <p>Review of the police report, dated 9/20/24, showed the officer documented he/she found one empty Hydrocodone/APAP 10-325 mg medication card with the resident's name in LPN A's car.</p> <p>10. Review of Resident #8's Quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Experienced occasional pain;</li> <li>-Received scheduled and as needed pain medications.</li> </ul> <p>Review of the resident's POS, dated 10/2024, showed an order for Hydrocodone/APAP 10-325 mg take one tablet by mouth every six hours as needed for chronic pain.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the narcotic log sheet, dated 9/1/24, showed LPN A signed out that he/she administered one pill on 9/10/24 but he/she subtracted two pills from the narcotic count.</p> <p>11. During an interview on 10/8/24 at 9:50 A.M., the administrator said he/she was made aware of the allegation of misappropriation and they started an investigation. He/She said the investigation showed no one missed their medications but the subtraction was off in the narcotic book. He/She said corporate was contacted about the allegation for assistance. Their investigation showed no pills were misappropriated. LPN A was asked to come into the office to talk about the miscalculations but never showed back up to work. Even after being notified of the empty narcotic cards the count was not off so they concluded the investigation as unsubstantiated.</p> <p>During an interview on 10/8/24 at 10:00 A.M., the DON said upon starting the investigation and going through the carts the narcotic counts were correct. The investigation showed discrepancies with the subtraction and administration of some of the narcotics so they contacted LPN A who was responsible for the medications at that time. LPN A would not come back to the facility and did not show back up to work an interview.</p> <p>During an interview on 10/10/24 at 12:32 P.M., LPN A said he/she worked a lot of hours and picked up a lot of shifts at the facility. He/She does not know what happened to the additional pills and said he/she must have subtracted incorrectly. He/She said he/she never wasted a medication while working at the facility. He/She said she was arrested at another facility and knows there were some narcotic log sheets in her car from the facility that he/she had accidentally taken and never took back. LPN A said he/she did not take any medications from the facility. LPN A said he/she was not aware medications were given outside of prescribed timeframe's and gave medications as ordered. LPN A said there was nothing else besides the narcotic sheets found in his/her car from the police.</p> <p>MO00242392</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>43010</p> <p>Based on interview and record review, facility staff failed to report an allegation of misappropriation of narcotics to the State Survey Agency within the 24 hour time frame, in accordance with their policy, and state law for seven residents (Resident #2, #3, #4, #5, #6, #7, and #8) out of 10 sampled residents. The facility census was 78.</p> <p>1. Review of the facility's Abuse, Neglect, and Exploitation Policy, dated 8/2022, showed reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies within specified timeframe's. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>2. Review of the facility's investigation, dated 9/12/24, showed the Assistant Director of Nursing (ADON) documented their narcotic count had discrepancies and/or medications being given outside of scheduled timeframe by Licensed Practical Nurse (LPN) A. The ADON attempted to speak with LPN A but he/she never returned to the facility. Review showed the Director of Nursing (DON) contacted the police on 9/23/24 and left a message to call him/her back regarding the empty narcotic cards found in LPN A's car. Review showed the facility did not report the alleged misappropriation to the Department of Health and Senior Services within the required 24 hour timeframe.</p> <p>During an interview on 10/8/24 at 9:50 A.M., the administrator said they started an investigation because the narcotic count was off. He/She said their investigation showed no residents missed their medications and there was just an issue of the narcotic counts being subtracted incorrectly by LPN A. He/She said the DON and ADON tried to interview LPN A but he/she did not cooperate with them and never came back to the facility. He/She was made aware by the ADON and DON on 9/20/24 empty narcotic cared were found by an officer in LPN A's car at another local facility. He/She said the corporate office was called and said it was not reportable because the investigation did not show any pills had been misappropriated even though cards were found by an officer in LPN A's car at another local facility.</p> <p>During an interview on 10/8/24 at 10:00 A.M., DON said the counts in the narcotic book were correct but they still had speculation and concern of LPN A not counting the narcotics right. He/She said they were unable to interview LPN A about their concerns with the count not being subtracted correctly. The DON said he/she talked with corporate after being made aware on 9/20/24, by the ADON, empty narcotic cards were found at another local facility by police. He/She was told this was not a reportable incident since they were unable to substantiate their investigation even though narcotic cards were found in LPN A's car at another local facility. He/She said with allegations of misappropriation the state should be notified.</p> <p>During an interview on 10/8/24 at 12:35 P.M., the Assistant Director of Nursing (ADON) said he/she received a call from an administrator at another local facility on 9/20/24, stating they had found narcotic cards from their facility in LPN A's car. The ADON said he/she told corporate about the incident, but was told it was not a reportable incident because their counts were not off. The ADON said he/she followed what corporate said to do.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/8/24 at 1:06 P.M., the Regional Nurse Consultant said he/she was made aware of the allegation and of the missing narcotic cards and sheets found at the other local facility by the police by the ADON and DON. He/She said staff are trying to get into contact with the police for more information and who was affected. He/She said they did not have any names for the residents whose narcotic cards were supposedly taken. He/She said the nurse involved never came back to be interviewed and did not take a drug test. He/She said they report when they have a proven allegation of misappropriation and without reasonable cause it was not reportable to the state.</p> <p>MO00242392</p>		