STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265851	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverstone Place	2735 Eagleson Dr 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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 43010 Based on interview and record review facility staff failed to ensure one resident (Resident #1) remained free from significant medication errors when staff administered Resident #2's Fentanyl (an copied drug used in the treatment of severe pain) patch to Resident #1. The facility census was 85. The administrator was notified on 3/12/25 of past Non-Compliance, which occurred on 2/27/25 when staff administered the wrong medication to the incorrect resident. Staff assessed the resident, notified the residents physician, sent the resident to the hospital, and in-serviced nursing staff on medication administration. Staff corrected the deficient practice on 3/10/25. 1. Review of the facility's Medication administration general guidelines policy, undated, showed staff are to verify medication is correct three times before administering the medication. Residents are identified before medication is administered. Medications supplied for resident are never administered to another resident. Review of the facility's Medication error policy, undated, showed staff are to report the administration of the wrong medication being administered to a resident. Medications should be administered per physician's orders. When a medication error has occurred update the physician and responsible party immediately via telephone with the medication error. Follow all new physician orders in regards to the medication error. Obtain a set of vital signs immediately. Staff are to complete a medication error report and turn into the Director of Nursing (DON) office. Review of the facility's Performing the five rights policy, undated, showed staff are to, for safety, check the five rights three times. Take out the patient's medication drawer or bin and place it alongside the medication administration record (MAR) sheet containing the drug orders. Verify that the patient name on the drawer corresponds to the name on the MAR sheet. Count the number of medications to be administered at the particular time. The five rights for medication administration are right drug, right dose, right route, right time, and right patient. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 2/21/25, showed staff assessed the resident as follows: -Cognitively intact; -Diagnosis of Congestive Heart Failure; (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Received a scheduled pain regimen; -Had pain occasionally. Review of the residents care plan, dated March 2025, showed the resident was at risk for pain and utilized acetaminophen related to a history of pain. Staff are directed to give the medication as ordered. Review of the resident's Physician's Order Sheet (POS), dated March 2025, showed the POS did not contain an order for a Fentanyl patch. Review of the resident's nurses note, dated 2/27/25 at 12:17 P.M., showed staff documented they found Resident #2's fentanyl patch on the resident. Staff assessed the resident, removed the Fentanyl patch, and filled out a medication error report for placement of a Fentanyl patch to the incorrect resident. Staff contacted the physician and received orders to remove the Fentanyl patch and monitor the resident's vitals signs every 15 minutes for two hours. During an interview on 3/12/25 at 11:41 A.M. the DON said nurses are responsible for administering Fentanyl patches. If a nurse has a medication error they are expected to assess the resident and call the doctor. He/She said they are also responsible for contacting the resident's family. The nurse is expected to follow the doctors orders and make a nurses note. He/She said the nurse made a medication error by administering Resident #2's Fentanyl patch to Resident #1. The nurse noticed the error after about 30 minutes and removed the patch and reported to the him/her immediately. The DON said he/she contacted the doctor and was told to do 15 minutes checks with vital signs for two hours. He/She said LPN D filled out a medication error report and made a nurses note. He/She said LPN D was educated on the spot about medication administration and the five rights He/She said all staff were inserviced on 3/10/25. During an interview on 3/12/25 at 2:32 P.M., the physician said staff contacted his/her office and let them know about the medication error. During an interview on 3/18/25 at 7:50 A.M., LPN D said he/she normally works nights but worked a day shift that day. He/She said he/she was not used to the fast past of day shift and was trying to keep up. He/She said he/she made a to do list which included the fentanyl patch for Resident #2. He/She went to Resident #1's room and applied the patch and said he/she did not find the existing patch and though it may have fallen off. He/She said it wasn't until about 30 minutes later when he/she went to chart he/she realized the medication error. He/She said he/she immediately let the DON know and went down to remove the patch and assess the resident. He/She said the doctor was called and instructed to do 15 minute checks for two hours. He/She said he/she notified family of the error and made progress notes in the resident's chart. He/She was educated on the five rights of medication and medication administration. MO00250265