| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265851 | A. Building<br>B. Wing | 11/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Silverstone Place | 2735 Eagleson Dr<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview and record review, facility staff failed to ensure residents remained free of significant medication errors when staff administered Resident #2's medication to Resident #1 which resulted in Resident #1 glucose levels fall below the healthy range. The facility census was 86.The administrator was notified on 11/20/25 of past Non-Compliance, which occurred on 8/13/25 when staff administered the wrong medication to the incorrect resident. Staff assessed the resident, notified the residents physician, monitored the resident, and in-serviced nursing staff on medication administration. Staff corrected the deficient practice on 8/13/2025.1. Review of the facility Medication Administration General Guidelines Policy, revised 5/2022, showed medications are administered as prescribed in accordance with manufacturers specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after having familiarized themselves with the medication. Residents are identified before medication is administered. Explain to the resident the type of medication being administered and the procedure. Medications supplied for a resident are never administered to another resident.2. Review of the facility investigation, dated 8/13/25, showed Certified Medication Technician (CMT) B administered Resident #2's medication to Resident #1 because Resident #1 and Resident #2 have similar names. Staff documented CMT B is unfamiliar with residents. Review showed nursing staff in-serviced on proper medication administration on 8/13/25.3. Review of Resident #1's quarterly minimum data set (MDS), a federally mandated assessment tool, dated 11/5/25, showed staff assessed the resident as cognitively intact with a diagnosis of diabetes.Review of the resident's physician order sheet (POS), dated August 2025, did not contain a physician's order for Novolog insulin (a rapid-acting insulin to control blood sugar levels). Review of the resident's progress notes, dated 8/13/25 at 4:45 P.M., showed Registered Nurse (RN) A documented at 5:55 P.M., Certified Medication Technician (CMT) B administered Novolog insulin 24 units to the resident, and blood sugar was 153. Review showed the physician notified immediately, received orders to administer glucose gel, take vitals and blood glucose every hour for the next 10 hours, order for glucagon IM if resident to become unconscious. Physician declines need to send resident to ER at this time but with frequent monitoring as described. Resident has consumed 760mL of orange juice, two glucose gels, and 50% of dinner meal. Blood glucose at 160 at 17:27. Resident able to make needs known, speech clear and easily understood, reporting at this time he/she currently feels no different than normal.During an interview on 9/25/25 at 8:19 A.M., CMT B said he/she was responsible for a medication error on 08/13/25. He/She said he/she gave Resident #2's Novolog insulin 24 units to Resident #1. CMT B said he/she immediately reported the medication error to the Director of Nursing (DON). He/She said staff contacted the physician and was told to check the residents blood sugar every hour. He/She said the resident did not suffer any adverse effects from receiving the medication. CMT B said he/she did not know how he/she made the error. CMT B said he/she did not know if he/she was rushing or how the error occurred. He/She said staff are directed to check the Electronic Medical Administration Record verses the resident and the medication. He/She said he/she should have verified the resident's last name and date of birth prior to administering the insulin. CMT B said he/she did not ask the resident's last name and knew he/she should have asked. He/She said the two residents had just been admitted to the facility.During an interview on 11/20/24 at 8:28 A.M., Resident #1 said staff did give her the wrong medication, he/she said he/she does not know a lot of details, but staff scrambled to get him/her sugar because the insulin took his/her sugar too low. He/She said staff checked on him/her constantly. He/She said he/she is a diabetic, but he/she does not take insulin just metformin. He/She said the medication error was scary, but staff handled it well.During an interview on 11/20/25 at 8:55 A.M., the administrator said CMT B gave Resident #1 Resident #2's insulin, when resident #1 does not receive insulin for his/her diabetes diagnoses. He/She said the residents have the same first name and were admitted about the same time and across the hall from each other. He/She said CMT B states she verified the residents name, and the resident said yes. He/She said the resident refused to go to the hospital. He/She said the resident was given sugar and was place on one-on-one monitoring for over 24 hours. He/She said there was a full investigation into the medication error and staff were in serviced on insulin administration and the seven rights of medication administration.During an interview on 11/20/25 at 9:45 A.M., The DON said he/she expects all staff administering medication to follow the seven rights of medication administration, and if they have questions they need to verify further. He/She said the medication error was not intentional. Resident #1 and Resident #2 share the same first name and the CMT was |