STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on interview and record review, the facility failed to ensure two residents, (Resident #1 and Resident #2), in a review of eight sampled residents, were free from misappropriation of property, when Registered Nurse (RN) A/Former Assistant Director of Nursing (ADON) misappropriated the residents' narcotics. RN A/Former ADON signed as receiving the residents' narcotic medications from the pharmacy. There was no documentation the narcotic medications were administered or destroyed. The narcotic medications were not found in the facility after RN A/Former ADON received the narcotic medications from the pharmacy. The facility census was 39. On 09/09/24 at 4:05 P.M., the administrator was notified of the past noncompliance which began on 07/06/24. On 08/31/24, the Director of Nursing became aware of the violation of misappropriation of resident's narcotic medication. Upon discovery, the facility conducted an investigation, notified appropriate parties, suspended RN A/Former ADON and all facility staff were educated on the facility misappropriation policy. RN A/Former ADON was suspended on 09/02/24. The deficiency was corrected on 09/03/24 after all staff had been inserviced and RN A/Former ADON was no longer employed with the facility. Review of the facility policy titled, Controlled Substances, revised December 2012, showed the following: -Only authorized licensed nursing and/or pharmacy personnel shall have access to Schedule II controlled medications (medications with a high potential for abuse) maintained on premises; -Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record; -All keys to controlled substance containers shall be on a single key ring that is different from any other keys; -Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing. Review of the facility policy titled, Investigating Incidents of Theft and/or Misappropriation of Resident Property, revised April 2017, showed the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents have the right to be free from theft and/or misappropriation of personal property; -Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. 1. Review of Resident #1'sface sheett showed the following: -Re-admit to the facility on [DATE]; -Diagnoses included complete traumatic amputation at level between knee and ankle, right lower leg. Review of the resident's individual narcotic record, dated 07/03/24, showed the resident returned with 32 tablets oxycodone-acetaminophen (Schedule II narcotic pain medication) 5-325 milligrams (mg). Review of the resident's Physician's Order Sheet (POS), dated July 2024, showed an order for oxycodone-acetaminophen 5-325 mg, give one tablet by mouth every four hours as needed for pain. Review of the resident's Medication Administration Record (MAR) dated July 2024 (07/03/24 through 07/05/24) showed no documentation staff administered oxycodone-acetaminophen 5-325 mg for pain. (the resident should of had 32 tablets remaining). Review of the resident's Order Audit Report, dated 07/05/24, showed RN A/Former ADON re-ordered the resident's oxycodone-acetaminophen 5-325 mg. Review of a pharmacy delivery receipt, dated 07/06/24 at 3:14 A.M., showed the following: -The pharmacy delivered oxycodone-acetaminophen 5-325 mg, 60 tablets for Resident #1; -Signed by RN A/Former ADON as received. Review of the nurses' cart narcotic sign in log, dated 06/26/24-07/19/24, showed no documentation on 07/06/24, that RN A/Former ADON signed the resident's oxycodone-acetaminophen 60 tablets into the narcotic count/lock box. Review of the resident's Order Audit Report, dated 07/17/24, showed RN A/Former ADON re-ordered the resident's oxycodone-acetaminophen 5-325 mg. Review of the resident's MAR, dated July 2024 (07/05/24 through 07/17/24) showed no documentation staff administered oxycodone-acetaminophen 5-325 mg for pain. (the resident should of had 92 tablets remaining). Review of a pharmacy delivery receipt, dated 07/18/24 at 2:59 A.M., showed the following: -The pharmacy delivered oxycodone-acetaminophen 5-325 mg 60 tablets for Resident #1; -Signed by Licensed Practical Nurse (LPN) G as received. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurses' cart narcotic sign in log, dated 06/26/24-07/19/24, showed on 07/18/24 LPN G signed the resident'soxycodonee-acetaminophen 60 tablets into the narcotic count/lock box. Review of the resident's MAR, dated July 2024 (07/17/24 through 07/31/24), showed no documentation staff administered oxycodone-acetaminophen 5-325 mg for pain. (the resident should of had 152 tablets remaining). Review of the resident's POS, dated August 2024, showed an order for oxycodone-acetaminophen 5-325 mg, give one tablet by mouth every four hours as needed for pain. Review of the resident's MAR, dated August 2024, (08/01/24 through 08/14/24), showed no documentation staff administered oxycodone-acetaminophen 5-325 mg for pain. (the resident should of had 152 tablets remaining). Review of the resident's Order Audit Report, dated 08/14/24, showed RN A/Former ADON re-ordered the resident's oxycodone-acetaminophen 5-325 mg. Review of the pharmacy delivery receipt, dated 08/15/24 at 2:09 A.M., showed the following: -The pharmacy delivered oxycodone-acetaminophen 5-325 mg 60 tablets for Resident #1; -Signed by RN A/Former ADON as received. Review of the nurses' cart narcotic sign in log, dated 07/19/24-08/19/24, showed no documentation on 08/15/24 that RN A/Former ADON signed Resident #1's oxycodone-acetaminophen 60 tablets into the narcotic count/lock box. At that time, the resident should of had 212 tablets of oxycodone-acetaminophen at the facility. During an interview on 09/05/24 at 11:55 A.M., Resident #1 said the following: -He/She had occasional pain on the right side of his/her stump; -He/She does not complain of pain to staff, had not asked for, or received pain medication. 2. Review of Resident #2's POS, dated August 2024, showed an order for hydrocodone-acetaminophen (Schedule II narcotic pain medication) 5-325 mg, one tablet by mouth every 12 hours as needed for hand pain. Review of the resident's August 2024 MAR showed no documentation staff administered hydrocodone-acetaminophen 5-325 mg for pain. Review of the resident's Order Audit Report showed the following: -On 08/13/24, RN D/IP (Infection Preventionist) re-ordered the resident's hydrocodone-acetaminophen 5-325 mg; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/14/24, RN A/Former ADON discontinued the resident's hydrocodone-acetaminophen 5-325 mg order in the computer system. Review of a pharmacy delivery receipt, dated 08/15/24 at 2:09 A.M., showed the following: -The pharmacy delivered hydrocodone-acetaminophen 5-325 mg 14 tablets for Resident #2. -Signed by RN A/Former ADON as received. Review of the nurses' cart narcotic sign in log, dated 07/19/24 - 08/19/24, showed no documentation on 08/15/24 that RN A/Former ADON signed Resident #2's hydrocodone-acetaminophen 14 tablets into the narcotic count/lock box. During an interview on 09/05/24 at 9:53 A.M., Resident #2 said the following: -He/She does not have much pain; -He/She does not ask for or take anything for pain; -If he/she has pain, he/she doesn't complain about it or request medication for pain. 3. Review of the facility investigation dated 09/02/24 showed the following: -It was reported by RN D/IP and LPN E that there was a missing card of oxycodone-acetaminophen 5-325 for Resident #1; -It was reported that on the previous day there were two cards of oxycodone-acetaminophen 5-325 in the narcotic box and now there was only one card; -This narcotic (oxycodone-acetaminophen for Resident #1) was delivered on 05/20/24 (this card was still located in the narcotic box), 07/18/24, and 08/14/24, and documented into the building by LPN G; -The delivery sheets for these medications were missing from the manifest book along with the sign out sheets for the narcotic and resident daily flow sheets; -It was noted in Resident #1's MAR Resident #1 had not taken this medication in the last two months; -This medication supply had been exhausted three times and reordered three times by RN A/Former ADON; During this investigation two other incidents were noted to have occurred: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On the night shift of 08/14/24, RN A/Former ADON worked the night shift. He/She clocked in at 5:32 P.M. and left at 8:45 A.M. the next morning. RN A/Former ADON received a pharmacy delivery 08/15/24 at 2:09 A. M. and signed for this delivery. Two medications that were included in this delivery were not signed in on the narcotic count sheet. This included a card of Resident #1's oxycodone-acetaminophen 60 tablets and a card of Resident #2's hydrocodone-acetaminophen 14 tablets. The original paperwork showing this delivery had not been located at this time. Duplicates were obtained from the pharmacy; -On the night shift of 07/05/24, RN A/Former ADON clocked in at 5:51 P.M. and left the following morning at 8:16 A.M. RN A/Former ADON received a pharmacy delivery at 3:14 A.M. and signed for this delivery. One medication that was included in this delivery was not signed in for on the narcotic card count sheet. This included a card of Resident #1's oxycodone-acetaminophen 60 tablets. The original paperwork showing this delivery has not been located at this time. Duplicates were obtained from the pharmacy; -Upon investigation the residents involved had not taken any pain medication for several months. The missing narcotics had been ordered in the system only by RN A/Former ADON. Review of RN D/IP's written statement dated 09/05/24 at 3:23 P.M. showed the following: -On Saturday (morning) 08/31/24, he/she counted the nurse cart (held the narcotic medications) with RN A/Former ADON; -He/She noticed that Resident #1 only had one card of oxycodone-acetaminophen with 31 tablets when he/she believed the resident previously had two cards of oxycodone-acetaminophen, of which the first card had 31 tablets and the second card had 60 tablets; -After completion of the narcotic count and report, he/she took LPN E aside and asked if he/she knew why the other card of oxycodone-acetaminophen was gone, LPN E said he/she did not know; -He/She looked through the narcotic manifest and the narcotic destruction binder and found no record of the card of Resident #1's oxycodone-acetaminophen 60 tablets. During an interview on 09/05/24 at 3:08 P.M., RN D/IP said the following: -RN A/Former ADON worked Friday night shift 08/30/24; -Saturday morning (8/31/24), he/she told LPN E something wasn't right with the narcotic count; -Usually Resident #1 had two cards of oxycodone-acetaminophen, but that morning (8/31/24) the resident only had one card in the medication cart/lock box; -LPN E was in charge of the narcotic medications on day shift 08/30/24; -LPN E counted narcotics at change of shift (days to night) with RN A/Former ADON on 08/30/24; two cards of oxycodone-acetaminophen were in the narcotic box for the resident at that time; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN A/Former ADON was the only nurse with access to the medications (including the narcotics) on Friday night 08/30/24. -She didn't ask RN A/Former ADON about the missing card at the time of the count because she wanted to confirm the second card with LPN E before tipping off RN A/Former ADON. During an interview on 09/05/24 at 3:22 P.M., LPN E said the following: -He/She was the charge nurse on day shift, Friday 08/30/24 and had the keys to the narcotic medications; -RN A/Former ADON was the charge nurse on night shift, Friday 08/30/24; -RN D/IP was the charge nurse on day shift, 08/31/24; -After RN A/Former ADON left the facility the morning of 08/31/24, RN D/IP told him/her the narcotic count wasn't correct; -RN D/IP said he/she did not think the count was correct because when she counted the narcotic medications with RN A/Former ADON on Saturday morning, 08/31/24, there was only one card of Resident #1's oxycodone-acetaminophen in the medication cart/lock box; she was confirming with him/her that there had been two cards previously; -Resident #1 had two cards of oxycodone-acetaminophen in the medication cart/narcotic lock box for a long time; -When he/she counted with RN A/Former ADON on Friday night, 08/30/24, the narcotic count was correct, and Resident #1 had two cards of the medication in the cart/lock box; -When RN D/IP counted with RN A/Former ADON on Saturday morning, 08/31/24, there was only one card of Resident #1's oxycodoneacetaminophenn in the medication cart/lock box. During an interview on 09/05/24 at 4:10 P.M., the Administrator in Training (AIT) said the following: -The pharmacy delivered 60 tablets of -oxycodone-acetaminophen for Resident #1 on 08/15/24. This medication is not accounted for in the narcotic book or in the medication cart. RN A/Former ADON signed he/she received the medication but the medication is not in the facility. RN A/Former ADON ordered Resident #1's oxycodone-acetaminophen four times and the resident doesn't take the medication; -RN A/Former ADON ordered and received hydrocodone-acetaminophen, 14 tablets for Resident #2, and the medication was not in the facility; -RN A/Former ADON ordered Resident #1 and Resident #2's narcotic medications and took the medication from the facility; -Stealing residents' medications was misappropriation of resident property. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the DON's written statement, dated 09/05/24 at 3:30 P.M. showed the following: -On 09/01/24, during her investigation, she continued to see RN A/Former ADON had been the only nurse to order medication for Resident #1 (Oxycodone-Acetaminophen); -She looked at Resident #1's MAR and there wasn't any/sufficient documentation to warrant the continued ordering of this medication; -She met with the AIT on 09/02/24. They printed RN A/Former ADON's time cards and pharmacy receipt logs and went through the documentation; -RN A/Former ADON would order Resident #1's oxycodone-acetaminophen on a night shift he/she would work and take the narcotic after signing it in from pharmacy; -RN A/Former ADON would then destroy the documentation and not chart the narcotic into the narcotic flow sheet; -This instance occurred on the night shift of 08/14/24 and 07/05/24; -On 08/30/24, RN A/ADON received a delivery of a narcotic medication (hydrocodone-acetaminophen 84 tablets) for another resident (Resident #9) with two cards of the medication received; -On 08/30/24, RN A/Former ADON only logged in one card of Resident #9's narcotic medication and was able to take Resident #1's card of oxycodone-acetaminophen; -On 08/14/24, RN A/Former ADON also took a card of hydrocodone-acetaminophen 5-325 mg 14 tablets for Resident #2. During an interview on 09/05/24 at 2:30 P.M., the Director of Nursing said the following: -She got a phone call from RN D/IP on Saturday morning 08/31/24. RN D/IP told her something didn't look right in the narcotic box; -Both RN D/IP and LPN E thought Resident #1 had another oxycodone-acetaminophen card but the narcotic count was correct; -She received documentation from the pharmacy and compared pharmacy delivery tickets to RN A/Former ADON's time cards; -On 07/06/24 and 08/15/24, RN A/Former ADON electronically signed for two cards of oxycodone-acetaminophen (120 tablets) for Resident #1 and one card of hydrocodone-acetaminophen 14 tablets for Resident #2; -RN A/Former ADON took Resident #1's Oxycodone-Acetaminophen and Resident #2's Hydrocodone-Acetaminophen and the corresponding pharmacy delivery tickets; -RN A/Former ADON was the only nurse/employee on duty on night shift, 08/30/24, that had access to all residents' medications. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO 241498