STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32538	A. BUILDING: _____ B. WING _____	C 09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD POINTE ASSISTED LIVING	5002 GENE FIELD ROAD SAINT JOSEPH, MO 64506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II* Based on interview, and record review the facility failed to develop and implement written policies and procedures that prohibited misappropriation of resident property when Resident #1's controlled narcotic medication went missing, and the facility failed to conduct a sufficient and timely investigation. The facility census was 43. Review of the facility's 06/10/19 policy titled "Reporting Abuse to Community Management" showed: -Financial exploitation was defined as knowingly obtaining control over a residents property with the intent to permanently deprive the resident of the use of such property; -The investigation was to include interviews with the resident, family members, roommates (if applicable), and staff members on all shifts; -All events leading up to the alleged incident was to be review; -Any person with information should provide a written statement; -If investigation findings were substantiated,	A8023		

Becky Hampton, Administrator

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A8023	Continued From page 1 Department of Health and Senior Services (DHSS) was to be notified within two hours (indicating the facility should have conducted a thorough investigation within 2 hours of the reported missing narcotics). Review of the facility's investigation dated 09/12/25 showed: -Level One Medication Aide (LIMA) A noticed on 09/08/25 Resident #1's card of Hydrocodone (medication used for pain) and narcotic count sheet were missing; -LIMA A last recalled seeing both at the end of his/her shift on 09/04/25; -No other staff were interviewed regarding the missing medication; -A new card of 30 Hydrocodone pills was delivered to the facility on 08/14/25, and only administered on 08/14/25 and 08/15/25 according to Resident #1's August 2025 Medication Administration Record (MAR), leaving 28 pills unaccounted for; -A new card of 30 Hydrocodone pills was delivered to the facility on 09/04/25, and only administered on 09/04/25 according to Resident #1's September 2025 MAR, leaving 29 pills unaccounted for; -Staff were drug tested however no abnormalities were found to indicate usage of the Hydrocodone by staff; -LIMA A, the Director of Nursing (DON), and the Administrator looked through the medication cart, med room cabinets, and the residents room and did not find the cards of Hydrocodone or the narcotic count sheet for either card. 1. Review of Resident #1's record showed diagnoses included depression, anxiety, heart disease, and diabetes.	A8023		

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A8023	Continued From page 2	A8023		

Review of the resident's September 2025 Physician's Order Sheet (POS) showed Hydrocodone-Acetaminophen 5-325 milligram (mg), one tablet every six hours as needed for pain ordered on 11/28/23.

Review of the resident's August and September 2025 MAR showed LIMA B administered Hydrocodone to the resident on 08/14/25, 08/15/25, and 09/04/25.

Review of Pharmacy refill and delivery correspondence showed:
-On 08/14/25 an electronic prescription came directly from the physician;
-A card of 30 Hydrocodone pills was delivered to the facility and signed in by LIMA E;
-A refill fax signed by LIMA B was sent to the pharmacy on 09/02/25;
-On 09/04/25 a card of 30 Hydrocodone pills was delivered to the facility and signed in by LIMA A.

Observation of the medication cart on 09/15/25 at 1:30 P.M. showed:
-One card of Hydrocodone for Resident #1 delivered on 09/09/25 and its according narcotic count sheet;
-No other cards of Hydrocodone or narcotic count sheets were found for Resident #1.

During an interview on 09/16/25 at 11:50 A.M. Resident #1 said:
-He/She did not experience much pain at all to ask for a pain medication;
-He/She was unsure of the pills he/she did take;
-He/She was unsure if he/she even had orders for pain medications.

During an interview on 09/15/25 at 1:32 P.M. LIMA A said:

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A8023	Continued From page 3 -He/She was unsure if he/she saw and counted Resident #1's Hydrocodone on 09/07/25 due to dealing with another resident's count sheet missing, but later found; -When he/she came in on 09/08/25 he/she realized he/she did not remember seeing Resident #1's Hydrocodone on 09/07/25, and was still not seeing it on 09/08/25 at which time he/she reported the missing medication and narcotic sheet to the DON; -He/She did not have any information about the first card that had been delivered on 08/14/25, but there was also no card or count sheet for it; -There was never two cards of Resident #1's Hydrocodone at once; -He/She knew misappropriation of a resident's medication was not tolerated. During an interview on 09/16/25 at 1:24 P.M. LIMA B said: -He/She administered Hydrocodone to Resident #1 in the evening of 09/04/25 and returned the card to the cart; -The card and narcotic sheet was present when he/she counted narcotics at the end of his/her shift on 09/04/25; -He/She did not know where the missing Hydrocodone could have gone; -He/She knew misappropriation of a resident's medication was not tolerated. During an interview on 09/18/25 at 10:28 A.M. LIMA C said: -He/She did not recall seeing the Resident #1's card of Hydrocodone or narcotic sheet during his/her overnight shift on 09/05/25, but did not know it should have been there until Mary mentioned it on 09/08/25; -He/She knew misappropriation of a resident's medication was not tolerated.	A8023		

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A8023	Continued From page 4 During an interview on 09/18/25 at 11:53 A.M. LIMA D said: -He/She was made aware of the missing Hydrocodone but was unsure of where it could have gone; -He/She recalled seeing Resident #1's card of Hydrocodone and narcotic sheet when he/she last worked and did narcotic counts on 09/05/25; -He/She knew misappropriation of a resident's medication was not tolerated. During an interview on 09/15/25 at 1:15 P.M. the DON said: -He/she was unsure of where the narcotics could have gone; -He/She had not interviewed any staff regarding the missing Hydrocodone and narcotic sheet; -He/She confirmed the Hydrocodone pills were delivered to the facility and were now missing; -He/She did not tolerate misappropriation of any of residents' belongings, including medications; -He/She provided education to his/her medication staff but it did not include misappropriation. During an interview on 09/15/25 at 12:52 P.M. the Administrator said: -Cameras of the med room and throughout the hallways were available but he/she had not yet reviewed footage; -He/She drug tested staff which was inconclusive; -He/She planned to question staff but had not done so yet; -He/She had been busy over the last week and had not been able to conduct a thorough investigation to identify where the missing narcotics could have gone, or if staff had any information; -He/She did not tolerate misappropriation of resident property which included their	A8023		

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A8023	Continued From page 5 medications. *Higher class merited due to extent of violation. MO258284	A8023		

PLAN OF CORRECTION

Provider/Supplier Name:	Field Pointe Assisted Living by Americare
Street Address, City, Zip:	**5002 Gene Field Road, Saint Joseph, MO 64506**
Date of Survey:	09/22/2025
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	32538

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A8023	The filing of this plan of correction does not constitute any admission by the facility regarding the alleged violation stated in the summary Statement of Deficiencies dated 09/22/2025by the Missouri Department of Health and Senior Services. This plan of correction is filed as evidence of our continuing commitment to provide care in compliance with applicable law. In response to 19CSR 30-88.010(23) Develop/Implement A/N Policies <u>Immediate Action:</u> Resident #1 medication was replaced at the facility expense. Staff discovered to be involved in this missing medication are no longer employed. Education provided to Administrator and Director of Nursing on the following: 1. Identifying ANE and what constitutes exploitation/misappropriation 2. Abuse Investigation 3. Protecting of Resident During Abuse Investigation 4. Narcotic/Controlled Substance Security 5. Narcotic Count Discrepancy a) If count is off immediate notification to Administrator and or Director of Nursing b) Investigation started by Administrative staff as soon as notified of discrepancy, to include interviewing of all staff having access to Medications and interviewing all residents who are receiving controlled substance medications c) Notification to DHSS and Law Enforcement within no more than 2 hours of notification. Education to be completed by Operations Director on or before 10/09/2025	10/20/2025

Becky Hampton 10/10/2025
Administrator

	Education provided to all current staff on the following policies and procedures 1. Reporting Abuse to Community Management 2. Abuse Investigation 3. Protecting of Resident During Abuse Investigation 4. Narcotic/Controlled Substance Security 5. Narcotic Count Discrepancy d) If count is off immediate notification to Administrator and or Director of Nursing e) Investigation started by Administrative staff as soon as notified of discrepancy, to include interviewing of all staff having access to Medications and interviewing all residents who are receiving controlled substance medications f) Notification to DHSS and Law Enforcement within In-servicing to be completed by Administrator on or before 10/20/2025. Implementation of Card Count for all controlled substance to ensure that total number of cards to be on hand is reviewed by no less than two certified and or licensed staff at start of each shift or changeover of narcotic keys. This will be in addition completing narcotic count. <u>Ongoing Compliance:</u> Administrator will assure ongoing compliance through immediately starting a thorough investigation on any missing controlled substance, medications or any other reported/suspected abuse, neglect or misappropriation. Investigation will include documented interviews with staff and resident who have or may have knowledge of the occurrence. Administrator will ensure that all polices and procedure are followed related to ANE and Narcotic/Controlled Substance Security, including appropriate and immediate investigation, reporting to DHSS, Law Enforcement, resident, resident physician and legal representative. <u>Completion Date:</u> 10/20/2025	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.