PRINTED: 06/25/2025
FORM APPROVED

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20779C	A. BUILDING: _____ B. WING _____	C 05/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN PLACE RESIDENTIAL CARE OF JOP	2030 E ZORA ST JOPLIN, MO 64801

(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
A4356	19 CSR 30-86.043(49) Safe/Effective Medication System The administrator shall develop and implement a safe and effective system of medication control and use which assures that all residents' medications are administered or distributed by personnel at least eighteen (18) years of age, in accordance with physicians' instructions using acceptable nursing techniques. Until January 1, 1991, those facilities administering medications shall utilize personnel trained in medication administration (a licensed nurse, certified medication technician or level I medication aide) and shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident.' s condition. Distribution shall mean delivering to a resident his/her prescription medication either in the original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident' s physician so authorizes. After December 31, 1990, all persons who administer or distribute medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level I medication aide. I/II This regulation is not met as evidenced by: Class II Based on interview, and record review, the facility failed to maintain a safe and effective medication system when one facility staff member gave one resident (Resident #3) another resident's medication resulting in hospitalization. The facility	A4356		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jamie Nash RN | TITLE: RN Administrator | (X6) DATE: 7-10-2025

STATE FORM 6899 BUL911 If continuation sheet 1 of 10

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A4356	Continued From page 1 census was 19. Review of the facility's policy titled, "Medication Management," dated 10/14/21, showed the following information: -Residents are identified before administration of the drug. Photographs of the residents are included in the medication records; -The facility is responsible for the management of resident medications; -The facility shall ensure that all drugs are administered to each resident in accordance with physician's written order; -The policy does not address medication errors. 1. Review of the Resident #3's face sheet (brief look at resident information) showed the following: -Admission date of 07/31/22; -Diagnoses included diabetes, spinal stenosis (narrowing of the spine), and major depressive disorder. Review of the resident's care plan, dated 07/26/22, showed the resident was dependent on staff for medication administration. Review of the resident's progress note dated 04/23/25, at 6:30 P.M., showed the following; -Staff accidentally gave the resident the wrong medications; -Staff gave the resident clozapine (an antipsychotic medication that changes the activity of natural substances in the brain such as dopamine) 225 milligram (mg), crestor (a statin drug that is used to control high cholesterol) 10 mg, and gabapentin (an anticonvulsant medication that is used to treat seizures and pain) 100 mg; -Staff noticed the physician and Facility Director.	A4356		

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A4356	Continued From page 2 Staff given instructions to monitor the resident. (Staff did not document notification of the resident's family of the error.) Review of the resident's April 2025 Physician Order Sheet (POS) showed an order, dated 04/10/25, for gabapentin 600 mg, one tablet by mouth (po) twice daily (bid). The resident did not have an order for crestor or clozapine. Review of the resident's April 2025 Medication Administration Record (MAR) showed the following medications were scheduled for administration during the evening medication pass on 04/23/25: -Glucophage (antidiabetic medication) 1000 mg, give one tablet po bid; -Oxycodone (narcotic medication used for treating pain) 5 mg, give one tablet po three times a day (tid); -Ibuprofen (non-steroidal anti-inflammatory drug used to treat pain) 400 mg, give one tablet po bid; -All three medications were circled as not given and staff noted the resident was given another resident's medication instead. Review of the resident's progress notes showed the following: -On 04/23/25, at 6:45 P.M., the resident began slurring his/her words and stumbled with ambulation. Staff assisted the resident to the a chair; -On 04/23/25, at 7:00 P.M., the resident began leaning in the chair and was unable to sit up and/or stand. Staff checked the resident's vital signs and notified the Facility Director. The resident was pending being sent to the Emergency Department (ED). -On 04/23/25, at 7:45 P.M., Emergency Medical Services (EMS) arrived to the facility and took the	A4356		

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A4356	Continued From page 3	A4356		

resident to the ED;
-On 04/23/25, at 10:45 P.M., the resident's family called and let the facility staff know that the resident was admitted for observation and was still "sleeping" at that time.

Review of the facility's medication error report, dated 04/23/25, showed the following:
-The resident was given clozapine (generic form of clozaril) 200 mg, clozaril 25 mg (brand name-same as clozapine), crestor 20 mg, and gabapentin 100 mg;
-Resident outcome was that the resident was sent to the ED;
-Corrective action included holding the resident's scheduled medication until physician gave further direction. No corrective action was noted for the staff member making the error;
-Measures to prevent the incident from happening again included for staff to double check the resident medications and not to pre-pop medications.

Review of the resident's assessment and plan from the ED, dated 04/24/25, showed the following:
-The resident arrived to the ED with altered mental status and lethargy after ingesting the wrong medication;
-The resident was diagnosed with an acute antipsychotic overdose.

During an interview on 05/24/25, at 2:08 P.M., Certified Medication Technician (CMT) B said the following:
-Staff are expected to follow the five rights of medication administration when passing medication. Those rights include right resident, right medication, right dose, right route, and right time;

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A4356	Continued From page 4 -Staff are expected to stay with the resident and observe the resident take the medication; -He/she had heard the resident was administered the wrong medications plus his/her own scheduled medication; -There is one staff member that makes frequent medication errors; -If he/she were to make a medication error, he/she would report it to the physician, family, and Facility Director; -While waiting for direction from the physician, he/she would monitor the resident for any adverse side effects and document them. During an interview on 05/24/25, at 3:24 P.M., the Facility Director said the following: -She expected staff to follow the five rights of medication administration; -She expected staff to match the MAR to the medication and the resident a few times before administration for accuracy; -She was notified of the medication error by phone on 04/23/25, around 6:40 P.M., and the staff member reported to her that the resident was administered the wrong medication and was "out of it" and unable to ambulate or sit up; -The ED told her that the resident was "snowed", and it took some time before he/she was able to awaken from the sedation; -The resident continued to not be able to self-ambulate so had to go to a rehab facility for strengthening. Once he/she was back to baseline, he/she would be admitted back to the facility; -The CMT has made errors before because he/she gets distracted. MO00254728	A4356		

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A8030	Continued From page 5	A8030		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to ensure all residents were treated with dignity and respect when staff members failed to respect one resident's wishes, treated the resident as a child, and took away his/her rights as punishment for one resident (Resident #1). The facility census was 18. Review of the facility's policy, titled "Resident Rights," undated, showed the following information: -Each resident has the right to voice grievances with respect to treatment or care that was or was not furnished; -Each resident has the right to be free from discrimination, interference, and cohesion; -Each resident has the right to retain and use personal possessions, and manage personal financial affairs; -Each resident has the right to privacy. Review of the facility's Employee Handbook, dated 05/22/08, showed the following information:	A8030		

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A8030	Continued From page 6 -Employees are expected to maintain a pleasant attitude toward the resident's and their families; -Employees are expected to treat all residents with dignity and show a genuine interest in their welfare. 1. Review of the Resident #1's face sheet (brief look at resident information) showed the following: -Admission date of 12/01/23; -Diagnoses include schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), diabetes, and obesity. Review of the resident's monthly summary, dated 03/27/25, showed the resident complains while walking that he/she needs a break and with complains of shortness of breath. However, with encouragement he/she continues and completes the walk. Additionally, the resident attempts to talk the Facility Director out of walking and requests someone else. The resident is easily re-directed. Review of the resident's care plan, dated April 2025, showed the resident received assistance from staff with dressing, bathing, mobility, medication administration, and toileting. Review of the resident's monthly summary, dated 04/28/25, showed the resident decided he/she will no longer walk. The Facility Director notified the resident's Power of Attorney (POA). The resident agreed to walk twice daily after discussion with POA. During the first walk after the discussion, the resident began complaining and proceeded to fabricate the discussion he/she had with his/her POA. The Facility Director told the resident there will no-longer be walks that involve her. The Facility Director is aware of the story fabrication.	A8030		

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A8030	Continued From page 7 During an interview on 05/24/25, at 10:37 A.M., the resident said the following: -The Facility Director yells at him/her and says that he/she is lazy in private and in public settings; -The Facility Director has taken away the ability for staff to braid his/her hair; -The Facility Director has taken away his/her ability to buy what he/she wants to buy, such as soda; -The Facility Director started taking away these rights when he/she refused to walk with her anymore due to verbal mistreatment; -He/she stays mostly in his/her room now so he/she does not have to encounter the Facility Director. During an interview on 05/24/25, at 1:17 P.M., Resident #2 said the following: -He/she had witnessed the Facility Director "go off" and/or yell at Resident #1 in the dining hall and tell him/her that he/she is lazy for not wanting to walk. During an interview on 05/24/25, at 1:53 P.M., Personal Care Assistant (PCA) A said the following: -Several residents have complaints about The Facility Director, that she is mean; -He/she has witnessed the Facility Director yell at the resident and tell him/her that he/she is lazy; -The Facility Director comes off as mean to the resident due to the yelling and she pushes the resident too hard to do things the resident does not want to do; -He/she would say the way the Facility Director acts could be perceived as verbally abusive; -The Facility Director had threatened to take away resident rights when they don't listen to her;	A8030		

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A8030	Continued From page 8 -The staff are not aloud to wash and braid the residents hair anymore due to him/her not wanting to exercise; -The facility staff are not allowed to help the resident with any tasks due to him/her not wanting to exercise, only the Facility Director is allowed to assist the resident, which the resident refuses contact with; -The resident stays isolated in his/her room now due to the Facility Director; -The resident also gets a $50 dollar allowance each month. The Facility Director says what he/she can and can not buy; -He/she does not feel the resident is being treated fairly and or with any dignity. During an interview on 05/24/25, at 2:08 P.M., Certified Medication Technician (CMT) B, said the following: -The Facility Director was "stern" and expected the rules to be followed. If they are not followed, she will educate the residents on proper behavior; -He/she has been told by the Facility Director, not to braid the resident's hair anymore, due to him/her not wanting to exercise; -The resident pushes the rules, and if he/she won't listen to the rules then they will take stuff away from him/her. He/she does not feel that this appropriate, but does what he/she is told; -Because the resident is child-like, so they just treat her like a child; During an interview on 05/24/25, at 3:24 P.M., the Facility Director said the following: -Residents have all their rights, however she will interfere with those rights if the resident's mistreat the staff; -The resident can be very rude. She contacted the resident's POA about his/her demanding and rude behavior, to which the POA said to be stern	A8030		

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A8030	Continued From page 9 with the resident and not to do anything extra for him/her; -The resident wants his/her hair braided, but if he/she doesn't ask in the appropriate manner, he/she doesn't get it; -The resident doesn't do anything for his/her self and has to; -She was the one to walk with the resident because that is what the POA wanted, but she has "washed her hands of that mess"; -She has not yelled at any resident, but does talk loud and does not have a warm personality; -She has told the resident he/she is lazy, but didn't yell it, or say it in public; -She does not feel that this is a dignity concern. Resident's get treated how they treat staff. *The higher classification merited due to extent of the violation and impact on the resident. MO00254728	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Autumn Place RCF of Joplin -Tammie Nash RN, Administrator
Street Address, City, Zip:	2030 E.Zora St. Joplin, MO 64801
Date of Survey:	May 24, 2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20779C	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4356	The administrator will create a policy to be included in the	
	Medication Management policy addressing medication errors.	7/14/2025
	Medication errors have the potential to affect any resident at any	
	Given time, therefore preventative measures that result in safe	
	Practice will be followed. These measures include:	
	Following 5 rights of medication administration-	
	*Right Patient *Right Drug *Right Dose *Right Route *Right Time	7/14/2025
	The L1MA will eliminate all distractions while completing medication passes. This will include alerting residents that medications are being prepared for pass, please do not disturb. Additionally, the L1MA will close the medication room door to further eliminate distractions until the medication passes are completed.	7/14/2025
	The administrator will create a monitoring plan to include shift supervisors monitoring charts bi-monthly for errors. Reports will be turned in to the administrator for review.	7/14/2025
	Staff will be in-serviced on all above corrective actions.	7/14/2025

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.

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Provider/Supplier Name:	**Autumn Place RCF of Joplin-Tammie Nash RN, Administrator**	
Street Address, City, Zip:	**2030 E.Zora St. Joplin, MO 64801**	
Date of Survey:	**May 24, 2025**	
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A8030	Staff will ensure voiced grievances will be addressed with respect to treatment or care that was or was not furnished Staff will ensure EVERY resident's rights are observed and followed. Staff will ensure that the resident's plan of care is followed and any and all assistance needed will be provided to the resident while also encouraging as much independence as possible.	7/14/2025
	All resident's have the potential to be affected at any given time.	7/14/2025
	Staff will ensure each resident's privacy is maintained at all times.	7/14/2025
	Staff will be in-serviced on above corrective actions.	7/14/2025
	All staff will hold each other accountable if residents rights are infringed upon and report to the administrator who will report to his/her superior.	7/14/2025