STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265655	A. Building B. Wing	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Living Center	404 E Third Street Stover, MO 65078

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to complete an investigation related to missing controlled narcotic medication for one resident (Resident #1) when staff identified three missing controlled narcotics. The facility census was 53.1. Review of the facility's Abuse and Neglect, Prevention, Investigation and Reporting policy, revised 06/23/2022, showed all items of concern related to misappropriation shall be investigated urgently with swift correction which shall include education to staff members on prevention of such. All collected information and documents shall be maintained in the administrator's office.Review of the facility's Guideline for Discrepancy in Count of Controlled Medication, undated, showed the purpose of the guidelines are to assure controlled medications were accounted for at least three times daily. All controlled medications are to be counted by the Certified Medication Technician (CMT) and/or licensed nurse at each shift change. Any discrepancy is to be reported immediately to the charge nurse/Director of Nursing (DON) Parties involved are to stay in the medication room until the issue can be resolved. Medications are to be recounted by licensed staff and all attempts made to determine where and when the error occurred. If the error/medication cannot be located the administrator is to be notified and all involved parties interviewed. The incident is to be reported to the Division of Health and Senior Services hotline. The pharmacist is to be notified of the discrepancy.2. Review of Resident #1's face sheet, dated 11/10/25, showed the resident admitted to the facility on [DATE] with diagnoses of generalized weakness, and a right femur fracture.Review of the resident's Physician Order Sheet (POS), dated 10/30/25 through 11/10/25, showed an order for Clonazepam 0.5 milligrams (mg) give one tablet by mouth at bedtime and Clonazepam 0.5 mg one tablet twice per day as needed.Review of the residents Controlled Drug Records, dated 10/30/25 through 11/10/25, showed facility staff documented they received Clonazepam 0.5 mg 155 tablets in one bottle on 10/30/25. Review showed staff documented they received 79 tablets on one record and 76 tablets on a separate record to allow for ease of counting on the controlled narcotic count sheet. Review showed staff documented three missing doses on the 76-tablet controlled narcotic count sheet as indicated by circling doses 68, 69, and 70. Review of the resident's Medication Administration Record (MAR), dated 10/30/25 through 11/10/25, showed staff documented Clonazepam 0.5 mg one tablet administered on 10/30/25, 10/31/25, 11/01/25, 11/02/25, 11/03/25, 11/04/25, 11/05/25, 11/06/25, 11/07/25, 11/07/25, 11/08/25, and 11/09/25. Review of the resident's Individual Narcotic Count Sheet, dated 11/11/25, did not contain documentation two nurses reconciled the Clonazepam 0.5 mg from 10/30/25 through 11/10/25. Review of the resident's Nurses Progress Notes, dated 10/30/25 through 11/09/25, did not contain documentation related to missing controlled narcotic medications.Review of the facility's medication records showed the records did not contain documentation of an investigation related to the missing controlled narcotic medications.Observation on 11/10/25 at 10:05 A.M., showed the resident's bottle of clonazepam contained 141 tablets.During an interview on 11/10/2025 at 9:59 A.M., CMT B said (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she was aware the resident's medication count was incorrect. CMT B said an unidentified CMT had recognized a medication count error the weekend prior. CMT B said he/she did not know who investigated the count error or what documentation was completed other than the three circled doses on the controlled drug record sheet. CMT B said the nurses are responsible for investigating and documenting medication count issues.During an interview on 11/10/2025 at 11:41 A.M., Licensed Practical Nurse (LPN) A said a CMT or nurse taking over the medication cart is responsible for ensuring medication counts are correct. LPN A said CMT's would be expected to notify a nurse of incorrect medication counts and the nurse would review the records and investigate. LPN A said the nurse would inform the DON if the discrepancy could not be resolved. LPN A said he/she did not know how or where count errors were documented, but he/she thought the DON would document the issue. LPN A said he/she was not aware of residents' medication counts needing review or investigation.During an interview on 11/10/2025 at 11:48 A.M., the DON said when a resident brings controlled medications from home two nurses count the medications to verify counts. The DON said staff should count pills at every shift change and if medication counts did not match, he/she would interview staff to identify the problem. The DON said he/she thought one of the night nurses noticed the incorrect pill count on 11/03/25. The DON said he/she spoke with the two nurses who counted the resident's medication on admission, and he/she determined the nurses counted incorrectly but he/she could not say if the pills were counted incorrectly or taken. The DON said he/she never asked staff why the medication discrepancy was not identified until 11/03/25 after he/she determined a counting error took place on 10/30/25. The DON said he/she notified the administrator but did not receive any further instruction from the administrator. The DON said he/she did not know the facility's policy related to count discrepancies in controlled medications. The DON said he/she did not document his/her investigation and did not document the discrepancy on the controlled medication sheet or in the resident's chart.During an interview on 11/10/2025 at 12:03 P.M., the administrator said CMTs, and nurses should catch incorrect medication counts at shift change when they count the controlled medications. The administrator said he/she expects all controlled medications to be counted accurately at every shift change. The administrator said the charge nurse or DON should be notified of any discrepancies in the medication counts. The administrator said the DON is responsible for investigating medication discrepancies and documenting his/her findings on the medication sheet and in the resident's progress notes. The administrator said he/she was not aware the DON did not document the resident's medication count discrepancy or the result of his/her investigation. The administrator said he/she was aware of an issue with one resident's medication count, but he/she did not recall which resident. The administrator said the DON assured him/her the resident's medications were counted incorrectly when the resident was admitted . The administrator said he/she was aware staff did not follow facility policy. Complaint 2664063