

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2023
NAME OF PROVIDER OR SUPPLIER Aspen Point Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2840 West Clay St Saint Charles, MO 63301	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35615</p> <p>Based on interview and record review, the facility failed to ensure three residents (Resident #1, #3 and #5), in a review of seven sampled residents, were free from misappropriation of property when Licensed Practical Nurse (LPN) A misappropriated residents' narcotic medications. The facility census was 67.</p> <p>On 12/4/23 at 8:05 A.M. the administrator was notified of the past noncompliance which occurred on 11/9/23. On 11/9/23 the administrator identified LPN A misappropriated Resident #1's narcotic pain medication (oxycodone, an opioid pain medication). Upon discovery, staff suspended LPN A, conducted an investigation, followed the facility policy, and notified appropriate parties, including local law enforcement. Staff reviewed the abuse and neglect policies on 11/9/23 which included misappropriation of resident property and all staff was educated on 11/10/23 on the facility misappropriation policy including narcotic medication diversion. LPN A was terminated, and the deficiency corrected on 11/21/23.</p> <p>Review of the facility policy Abuse, Neglect and Exploitation, dated 8/22/22, showed the following:</p> <ul style="list-style-type: none"> -It was the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, neglect, exploitation and misappropriation of resident property; -Misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent; -The facility would develop and implement written policies and procedures that prohibited and prevented misappropriation of resident property, established procedures to investigate any such allegations and included training for new and existing staff on activities that constituted misappropriation of resident property; -The facility would provide ongoing oversight and supervision of staff in order to assure policies were implemented as written; -New employees would be educated on misappropriation of resident property during initial orientation; -Existing staff would receive annual education through planned in-services and as needed. <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 265118	If continuation sheet Page 1 of 8

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility-controlled substance Administration and Accountability policy, dated 2021, showed the following:</p> <ul style="list-style-type: none"> -It was the policy of the facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility would have safeguards in place in order to prevent loss, diversion or accidental exposure; -All controlled substances obtained from a medication cart or cabinet were recorded on the designated usage form; -In all cases, the dose noted on the usage form must match the dose recorded on the Medication Administration Record (MAR), controlled drug record or other specified form and placed in the resident's medical record; -The Controlled Drug Record served the dual purpose of recording both narcotic disposition and resident administration; -The Controlled Drug Record was a permanent medical record document and in conjunction with the MAR was the source for documenting any resident specific narcotic dispensed from the pharmacy; -Resident specific controlled substances were stored under double lock until administered to the resident; -The entire amount of controlled substances obtained or dispensed are accounted for. Two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record, or Controlled Drug Record; -Two licensed nurses account for all controlled substances and access keys at the end of each shift; -Any discrepancy in the count of controlled substance or disposition of the narcotic keys was resolved by the end of the shift during which it was discovered; -Resolution could be achieved by review of dispensing and administration records and consulting with all staff with access; -Any discrepancies which could not be resolved must be reported immediately by notifying the Director of Nursing, charge nurse or designees and the pharmacy. Complete an incident report detailing the discrepancy, steps taken to resolve the issue and the names of all licensed staff working when the discrepancy was noted. The DON, charge nurse, or designee must also report any loss of controlled substances where theft was suspected to the appropriate authorities such as local law enforcement; -Staff could not leave the area until discrepancies were resolved or reported as unresolved discrepancies. <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Review of the facility abuse investigation report, dated 11/15/23, showed the administrator documented on 11/9/23 at 12:00 A.M. narcotic diversion incident occurred regarding Resident #1. LPN A was involved when Resident #1 claimed he/she did not receive his/her 12:00 A.M. narcotic medication. The facility summary of investigation findings showed narcotics were diverted from residents. LPN A resigned when asked to take a drug test.</p> <p>2. Review of Resident #1's care plan, dated 8/11/23, showed the following:</p> <ul style="list-style-type: none"> -Diagnoses of firearm discharge, post-traumatic stress disorder, open wound to the right lower leg, muscle weakness; -The resident had history of a traumatic event related to assault with a weapon, staff should administer the resident's medications as ordered to relieve anxiety and stressors; -The resident used opioids for pain control. Staff should educate and monitor the resident for side effects. <p>Review of the resident's Physician Order Sheet (POS) dated 10/8/23 showed an order for oxycodone (narcotic opioid pain medication) 5 milligrams (mg), give one tablet every four hours as needed for pain.</p> <p>Review of the resident's significant change Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 11/1/23 showed the following:</p> <ul style="list-style-type: none"> -Cognitively intact; -No scheduled pain medication received; -Received as needed pain medication for frequent moderate pain that affected the resident's sleep, therapy activity and day to day activities. <p>Review of the resident's Controlled Drug Receipt/Record/Disposition form showed on 11/8/23 at 8:00 P.M. LPN A signed out oxycodone 5 mg, one tablet.</p> <p>Review of the resident's Medication Administration Record (MAR), dated 11/8/23, showed no documentation LPN A administered oxycodone 5 mg one tablet at 8:00 P.M.</p> <p>Review of the resident's Controlled Drug Receipt/Record/Disposition form showed on 11/9/23 at 12:00 A.M. LPN A signed out oxycodone 5 mg, one tablet.</p> <p>Review of the resident's MAR dated 11/9/23 showed no documentation LPN A administered oxycodone 5 mg one tablet at 12:00 A.M.</p> <p>Review of the Director of Nursing's (DON) written statement, dated 11/9/23, showed the following:</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 11/9/23 at 6:30 A.M., LPN B informed the DON, Resident #1 said he/she had not received any pain medication since 11/8/23 at 8:00 P.M. The resident asked LPN B for a pain pill, LPN B checked the narcotic sign out sheet and found a pain pill was signed out on 11/9/23 at 12:00 A.M. LPN B asked the nurse (LPN A) about it and LPN A informed LPN B he/she had lost the pain pill and needed LPN B to waste the pain medication (co-sign the narcotic disposition record) with LPN A so LPN A could remove another pain pill (from the resident's narcotic card located in the medication cart);</p> <p>-The DON then asked LPN A why the resident said he/she did not receive a pain pill at 12:00 A.M. yet one was signed out for that time. LPN A said he/she had the pain pill in his/her pocket and intended to give Resident #1 the pain pill. LPN A removed a pill from his/her pocket in a container labeled with a different resident's name. The DON asked why the container had another resident's name and LPN A said that it was an extra container. The DON asked why it had taken over six hours since the pain pill was removed (from the locked narcotic drawer and signed out on the resident's narcotic disposition form) before giving the pain pill to Resident #1 and LPN A said he/she got busy.</p> <p>Review of LPN B's written statement obtained by the facility, dated 11/9/23, showed the following:</p> <p>-On 11/9/23 at 6:00 A.M., LPN B answered the resident's call light and the resident said he/she wanted a pain pill for leg pain. Resident #1 said he/she last received a pain pill on 11/8/23 at 8:00 P.M. LPN B checked the narcotic sign out book and informed the resident he/she had a pain pill on 11/9/23 at 12:00 A.M. as signed out by LPN A. Resident #1 said he/she never got the pain pill at 12:00 A.M. The only pain pill he/she received was at 8:00 P.M. the previous night;</p> <p>-LPN B asked LPN A if he/she gave Resident #1 a pain pill on 11/9/23 at 12:00 A.M. LPN A said he/she forgot to give the pain pill and the pain pill was lost. LPN A had the pain pill somewhere and asked LPN B to co-sign the pain pill was destroyed.</p> <p>Review of the facility's interview with LPN A showed the facility's Regional Corporate Nurse documented on 11/9/23 at about 10:00 A.M. LPN A came back to the facility regarding a concern with narcotics. LPN A's speech was slurred, his/her gait was unsteady, pupils were pinpoint when he/she arrived at the facility. The Regional Corporate Nurse questioned LPN A regarding Resident #1 not receiving his/her 12:00 A.M. pain pill. LPN A handed the Regional Corporate Nurse a small white round pill that was stamped with the numbers 439. The Regional Corporate Nurse identified the pill as Loratadine (antihistamine used for allergy relief) 10 mg. The Regional Corporate Nurse identified the resident's oxycodone 5 mg, was a small white round pill with a scored center and stamped with ALG 263. LPN A was asked to take a drug test. At that time LPN A immediately resigned his/her position, signed a resignation form and refused to take a drug test.</p> <p>During an interview on 11/21/23 at 1:10 P.M. the resident said he/she had pain in the right leg. He/She asked LPN A for a pain pill about 12:00 A.M. on 11/9/23 and did not receive the pain medication (oxycodone). The resident asked again about 5:00 A.M. The resident did not know what happened at 12:00 A.M. to his/her pain pill.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/21/23 at 3:35 P.M. LPN B said at about 6:00 A.M. on 11/9/23 the resident wanted a pain pill (oxycodone 5 mg) and said he/she was waiting for LPN A to bring it. LPN B checked the narcotic sign out book and LPN A had signed out a dose of oxycodone 5 mg at 12:00 A.M. The resident said he/she did not receive the 12:00 A.M. dose. LPN B asked LPN A about the 12:00 A.M. oxycodone 5 mg signed out of the narcotic book. LPN A said he/she forgot to give the dose and it was still in his/her pocket. LPN B did not see the pill LPN A said was in his/her pocket.</p> <p>3. Review of Resident #3's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Cognitively intact; -Received no scheduled pain medication; -Received no as needed pain medication; -The resident had no pain. <p>Review of the resident's POS dated 9/1/23 (original order dated 11/9/21) showed oxycodone 10 mg every 4 hours as needed for pain.</p> <p>Review of the resident's care plan, dated 10/19/23, showed the following:</p> <ul style="list-style-type: none"> -Diagnoses of stroke, arthritis, rheumatoid arthritis (degenerative arthritis), muscle wasting, and pain in the left knee; -The resident was on pain medication. Staff should monitor for adverse reactions and monitor mobility. <p>Review of the resident's Controlled Drug Receipt/Record/Disposition form showed the following:</p> <ul style="list-style-type: none"> -On 10/24/23 the facility received oxycodone 10 mg, 30 tablets from the pharmacy; -On 10/25/23 at 9:30 P.M. LPN A signed out oxycodone 10 mg one tablet; -On 10/26/23 at 4:00 A.M. LPN A signed out oxycodone 10 mg one tablet; -On 10/29/23 at 8:00 P.M. LPN A signed out oxycodone 10 mg one tablet; -On 10/31/23 at 1:00 A.M. and 6:00 A.M. LPN A signed out oxycodone 10 mg one tablet; <p>Review of the resident's MAR dated October 2023 showed no documentation LPN A administered oxycodone 10 mg on 10/25/23 at 9:30 P.M., 10/26/23 at 4:00 A.M., 10/29/23 at 8:00 P.M., 10/31/23 at 1:00 A.M. or 6:00 A.M.</p> <p>Review of the resident's Controlled Drug Receipt/Record/Disposition form showed the following:</p> <ul style="list-style-type: none"> -On 11/2/23 at 5:00 P.M. and 9:00 A.M. LPN A signed out oxycodone 10 mg one tablet; <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 11/3/23 at 6:00 P.M. and 11:00 P.M. LPN A signed out oxycodone 10 mg one tablet;</p> <p>-On 11/4/23 at 6:00 A.M. LPN A signed out oxycodone 10 mg one tablet;</p> <p>-On 11/8/23 at 12:00 A.M., 6:00 A.M., 4:30 P.M. and 9:50 P.M. LPN A signed out oxycodone 10 mg one tablet;</p> <p>-On 11/9/23 at 2:00 A.M. and 6:00 A.M. LPN A signed out oxycodone 10 mg one tablet.</p> <p>Review of the resident's MAR dated November 2023 showed no documentation LPN A administered oxycodone 10 mg</p> <p>on 11/2/23 at 5:00 P.M. or 9:00 A.M., 11/3/23 at 6:00 P.M. or 11:00 P.M., on 11/4/23 at 6:00 A.M., 11/8/23 at 12:00 A.M. or 6:00 A.M. or 4:30 P.M. or 9:50 P.M., on 11/9/23 at 2:00 A.M. or 6:00 A.M.</p> <p>Review of the resident's Controlled Drug Receipt/Record/Disposition form for 30 tablets of oxycodone, showed LPN A signed out 16 tablets of the 25 tablets administered between 10/25/23 and 11/8/23 with no documentation LPN A administered the oxycodone 10/325 mg.</p> <p>Review of the resident's Controlled Drug Receipt/Record/Disposition form for 30 tablets of oxycodone, showed LPN A signed out seven tablets of the 19 tablets administered between 10/25/23 and 11/8/23</p> <p>During an interview on 11/21/23 at 12:05 P.M. the resident said he/she sometimes had pain. He/She did not take the narcotic pain medication oxycodone except maybe once every two weeks. He/She never took pain pills every day or multiple times per day. He/She was afraid of being hooked on the pain medication.</p> <p>4. Review of Resident #5's quarterly MDS, dated [DATE], showed the following:</p> <p>-Moderately impaired cognition;</p> <p>-Received no scheduled pain medication;</p> <p>-Received as needed pain medication;</p> <p>-The resident had no pain.</p> <p>Review of the resident's POS, dated 10/1/23, showed the following:</p> <p>-Diagnoses of heart failure, spinal stenosis (narrowing of the spinal column), muscle weakness, knee pain and need for assistance with personal care;</p> <p>-Hydrocodone/acetaminophen (an opioid narcotic pain medication also called Norco) 10/325 mg every 8 hours as needed for pain.</p> <p>Review of the resident's care plan, updated 10/24/23, showed no staff direction regarding pain management and administration of narcotic pain medications.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Controlled Drug Receipt/Record/Disposition form showed the following:</p> <ul style="list-style-type: none"> -On 10/27/23 the facility received Norco 10/325 mg 30 tablets from the pharmacy; -On 10/30/23 at 6:00 A.M. LPN A signed out Norco 10/325 mg one tablet; -On 10/31/23 at 12:00 A.M. LPN A signed out Norco 10/325 mg one tablet. <p>Review of the resident's MAR dated October 2023 showed no documentation LPN A administered Norco 10/325 mg on 10/30/23 at 6:00 A.M. or on 10/31/23 at 12:00 A.M.</p> <p>Review of the resident's Controlled Drug Receipt/Record/Disposition form showed the following:</p> <ul style="list-style-type: none"> -On 11/3/23 at 5:00 A.M. and 9:00 P.M. LPN A signed out Norco 10/325 mg one tablet; -On 11/4/23 at 6:00 A.M. LPN A signed out Norco 10/325 mg one tablet; -On 11/8/23 8:00 P.M. LPN A signed out Norco 10/325 mg one tablet; -On 11/9/23 at 5:00 A.M. LPN A signed out Norco 10/325 mg one tablet. <p>Review of the resident's MAR dated November 2023 showed no documentation LPN A administered Norco 10/325 mg on 11/3/23 at 5:00 A.M. or 9:00 P.M., 11/4/23 at 6:00 A.M., 11/8/23 at 8:00 P.M. or 11/9/23 5:00 A.M.</p> <p>Review of the resident's Controlled Drug Receipt/Record/Disposition form for 30 tablets of Norco, showed LPN A signed out seven tablets of the 19 tablets administered between 10/25/23 and 11/8/23 with no documentation LPN A administered the Norco 10/325 mg.</p> <p>During an interview on 11/21/23 at 12:20 P.M. the resident said he/she had knee pain and took pain pills (Norco) two times daily, one in the morning and one around bedtime. He/She had to ask for the pain medication and did not take the pain medication at night. He/She usually slept all night.</p> <p>During an interview on 11/21/23 at 10:40 A.M. the DON said on 11/9/23 at 6:30 A.M. Resident #1 wanted a pain pill (oxycodone 5 mg). LPN B checked the narcotic sign out sheet. LPN A had signed out the resident's pain pill on 11/9/23 12:00 A.M., the resident said he /she did not receive a pain pill at 12:00 A.M. The DON found LPN A (night shift charge nurse) and asked if he/she gave Resident #1 a pain pill at 12:00 A.M. LPN A said he/she still had the pain pill in his/her pocket and pulled a medication cup from his/her pocket that contained a pill. An investigation was started at that time. LPN A left the facility and returned about 9:00 A.M. and showed the DON a medication cup pulled from LPN A's pocket containing a white pill. The DON and the Regional Corporate Nurse identified the pill in the medication cup as Loratadine. LPN A stood up and said he/she resigned when asked for a drug test. LPN A did not deny that he/she took Resident #1's oxycodone and put loratadine in the medication cup.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/4/23 at 8:05 A.M. the administrator said staff should sign out all narcotics at the time the medication was removed from the locked medication cart and document administration of the residents' pain medication on the MAR. Staff should not divert any narcotics or any other medication. Staff should administer all narcotics immediately once removed from the medication cart, should not pocket any medication including narcotics and if narcotics were not administered, locked the medications back up in the medication cart and destroy following the facility policy. LPN A did not follow the facility policy regarding narcotic administration and safety.</p> <p>MO227319</p>		