| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265279 | A. Building<br>B. Wing | 03/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cedar Pointe | 1800 White Columns Drive<br>Rolla, MO 65401 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>43024<br><br>Based on observation, interview, and record review, facility staff failed to maintain personal medical information in a manner to protect three residents' privacy (Residents #1, Resident #2, Resident #3). The facility census was 77.<br><br>1. Review of the facility's Resident Confidentiality/Health Insurance Portability and Accountability Act (HIPPA), undated, showed the care of the patient is always personal in nature, and therefore any protected health information about his/her condition, treatment or personal data is absolutely confidential and must not be discussed with anyone other than those who are directly responsible for his/her care and treatment. Information generated through contact between patient and health care provides at the facility is privileged and confidential. This privilege extends to all form and formats in which the information is maintained and stored, including, but not limited to verbal, written and/or electronic forms;<br><br>Review of the facility's Administering Medications Policy, revised December 2012, showed the medication cart and/or Medication Administration Record (MAR) must be clearly visible to the personnel administering medications, and must be inaccessible to residents or others passing by.<br><br>2. Observation on 2/28/24 at 9:57 A.M., showed Certified Medication Technician (CMT) A prepared Resident #1's medication and entered his/her room to administer medication. Observation showed the resident's Electronic Health Record (EHR) open and visible to residents and visitors.<br><br>3. Observation on 2/28/24 at 10:04 A.M., showed CMT A prepared Resident #2's medication. Observation showed the CMT left the cart to retrieve a blood pressure cuff from the nurse's station. Observation showed the resident's EHR open and visible to residents and visitors. CMT A returned to the cart and retrieved the resident's medications and entered his/her room to administer the medication. Observation showed the resident's EHR open and visible to residents and visitors.<br><br>4. Observation on 2/28/24 at 10:50 A.M. and 11:08 A.M., showed the medication cart unattended at the nurses station. Observation showed Resident #3's EHR open and visible to residents and visitors.<br><br>5. During an interview on 2/28/23 at 11:10 A.M., the assistant director of nursing (ADON) said staff are supposed to close the screen or put a lock on it to cover patients' information when leaving the medication cart. He/She said it is important we follow HIPPA rules and regulations to protect resident information and to ensure staff are charting under the correct name for accuracy. He/he does not know why this would not be getting done.<br><br>(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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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/28/24 at 4:45 P.M., CMT A he/she has a habit of leaving EHR records up and is trying to work on it because he/she knows it is important to protect resident's information. He/She said it is an oversight on his/her part because he/she only leaves for a minute or two and will come right back.<br><br>During an interview on 3/5/24 at 3:20 P.M., the administrator said staff are instructed lock browser or close screen when not physically at the medication cart because HIPPA information is not meant to be shared with everyone. He/She does not know EHR are not being locked.<br><br>MO00232230 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>43024<br><br>Based on interview and record review, facility staff failed to follow professional standards when they failed to destroy narcotics with two staff present according to policy for one resident (Resident #4), failed to maintain documentation of a controlled substance destruction sheet for one resident (Resident #5), and failed to remove medications as directed from the ISTAT. The facility census was 77.<br><br>1. Review of the facility's Controlled Substances policy, revised October 2014, showed staff are to document the disposal on the medication disposition record, (the medication disposition record will contain the following information: method of disposition, reason for disposition and signature of witnesses). Review showed the documentation should include the signature(s) of at least two witnesses. Review showed disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident and completed medication disposition records shall be kept on file in the facility for at least two years or as mandated by state law governing the retention and storage of such records.<br><br>Review of an inservice education form, dated 8/1/2023, showed due to the number of changing orders and discontinued orders, narcotics are no longer going to be the Director of Nursing's (DON) responsibility. Review showed any non narcotic medications are to be sent back to the pharmacy for destruction. Review showed the Assistant Director of Nursing (ADON) will be in charge of monitoring and auditing the medication carts and destroying medications on the spot with a nurse or Certified Medication Technician (CMT) to witness. Review showed medications are not to be destroyed unless two nurses destroy them or a nurse and a med tech destroy them together. Review showed the DON signed the inservice education form.<br><br>Review of the Controlled Substance Card tracking form, dated February 2024, showed on 2/16/24 at 6:00 P. M., one card of 30 Oxycodone for Resident #1 was signed out on behalf of the Director of Nursing (DON) for destruction.<br><br>Review of Resident #4's Individual Controlled Substances record, showed staff documented on 09/05/23 teh facility received 30 Oxycodone tablets 5 milligrams (mg) with an expiration date of 9/4/24. Review showed the DON documented he/she wasted 30 tablets on 2/16/24. Review showed the record did not contain the method of disposition, the reason for disposition and failed to obtain a second signature as a witness for disposition.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/28/24 at 11:02 A.M., the ADON said the facility has a new policy, effective August of 2023, the DON is no longer in charge of narcotics because there were multiple complaints and concerns with the DON and his/her handling of narcotics. He/She said on 2/19/24 he/she was checking the narcotics from the weekend and saw a card of Oxycodone had been pulled from the narcotics cart and was destroyed by the DON, when he/she asked the DON for the individual controlled substances records the DON could not provide it. He/She then asked CMT C, who signed the card out on behalf of the DON if he/she helped destroy the medications and CMT C said the DON declined because he/she said it had to be two nurses, he/she said he/she came to the DON's office with the card and the drug buster to destroy them. The DON later brought the individual controlled substance record to the him/her with only his/her signature and said he/she and Registered Nurse (RN) B destroyed them together but RN B forgot to sign the sheet. He/She said the DON came in and tried to get him/her to sign the sheet because he/she was worried RN B might not remember he/she signed it. He/She said he/she called to verify with RN B and he/she said he/she never destroyed those medications and was never asked too. He/She turned the discrepancy into the administrator.<br><br>During an interview on 3/5/24 at 3:39 P.M., RN B said he/she did not destroy a medication with the DON on 2/16/24. He/She said the DON never asked him/her to destroy any medications with him/her and is not sure why she told people that he/she did. He/She said there have been issues with narcotics being discontinued and destroyed without witnesses and narcotic cards found in the DON's office and purse in the past and that is when the ADON start taking over narcotics.<br><br>During an interview on 3/5/24 at 3:40 CMT C said he/she was working on 2/16/24 and was conducting her evening medication pass when the DON started going through resident's narcotics. He/She said a specific card had not been used and it needed to be destroyed. He/She said he/she signed the card out on behalf of the DON because he/she asked and took the card and the drug buster to his/her office to properly destroy the medications. He/She said the DON declined to destroy the medications with him/her because he/she is not a nurse. He/She offered to grab a few other nurses but the DON declined and said he/she would just wait until 2/19/24 to destroy with the ADON. He/She said he/she knows that the DON is not allowed to handle narcotics because they had been educated on that in that past but the DON fires people who question him/her about narcotics and he/she could not afford to lose his/her job. He/She left the narcotics with the DON and before he/she could report to the ADON about the situation the ADON questioned him/her.<br><br>During an interview on 3/18/24 at 11:04 P.M., the DON said the incident took place late on 2/16/24, he/she was checking the narcotic box and realized a resident hadn't used his/her narcotics in a timely manner. He/She said he/she asked CMT C to bring him/her the narcotics in his/her office, he/she said he/she did not destroy medications with the CMT because he/she thought he/she needed another nurse. He/She said he/she destroyed the narcotics with RN B and does not know why he/she said he/she did not destroy the narcotics. He/She said he/she did not notice RN B did not sign off on the medication destruction sheet until later and denies asking any other nurse to sign off on the destruction sheet, after the fact. He/She said he/she is not supposed to be involved in narcotics because of the bullshit lies and high school drama about him/her being addicted to narcotics but he/she was trying to get his/her ducks in a row before going on medical leave.<br><br>2. Review of Resident #5's Controlled Substance Card tracking form, dated June 2024, showed on 7/27/23 at 10:00 A.M., one card of Hydrocodone was signed out by the DON.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Individual controlled substances record destruction book for 2023-2024, showed the book did not contain a distruction sheet for the resident's card of hydrocodone.<br><br>During an interview on 2/28/24 at 1:15 P.M., Resident #2's family member said his/her parent was a resident at the facility in June 2023. He/She had spoke to the DON and wanted to decline the Hydrocodone prescribed for his/her parent unless his/her other medications were not effective. He/She said the DON said he/she would pull the card and he/she said no, he/she can have them just on a last resort basis. He/She said the next day his/her parent decided to go home and the hydrocodone's were no longer in the narcotic box and had been signed out by the DON. He/She said the hydrocodone's were no longer present because they had been discontinued.<br><br>During an interview on 3/18/24 at 11:04 P.M., the DON said another nurse had reported the hydrocodone was found in his/her office but he/she wasted the narcotics and there should be a destruct sheet on them, kept on file for five years. He/She could not remember who he/she wasted the narcotics with.<br><br>3. Observation on 2/28/24 at 10:18 A.M., showed the medication cart contained two medication cups with various pills with handwritten last names on the cups. The cups did not contain names of the medication in the cups.<br><br>During an interview on 2/8/24 at 10:18 A.M., CMT A said he/she got all the medications out of the ISTAT at one time he/she needed for her 12 hour shift to save him/her time and because he/she heard that it cost money every time the ISTAT is opened.<br><br>During an interview on 2/28/24 at 11:02 A.M., the ADON said it is not acceptable to prepop medications for later administration because a resident could receive the wrong medication, he/she said it might be happening to save time and because they are told it cost money to open the ISTAT.<br><br>During an interview on 3/5/24 at 3:20 P.M., the administrator said staff are not permitted to pre-pop medications because it leaves too much room for error. Staff should immediately gather medications and administer them right away even from the ISTAT. He/She does not know why staff would be prepopping medications.<br><br>MO00232230 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>43024<br><br>Based on observation, interview and record review, facility staff failed to ensure the residents' environment remained free of accident hazards when to staff failed to properly store medications. The facility census was 77.<br><br>1. Review of the facility's Administering Medications Policy, revised December 2012, showed staff are directed during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide.<br><br>2. Observation on 2/28/24 at 9:57 A.M., showed Certified Medication Technician (CMT) A left the medication cart unlocked and unattended in the hall, with his/her keys in the lock. Observation showed CMT A returned to the medication cart and retrieved the keys but did not lock the cart.<br><br>Observation on 2/28/24 at 10:04 A.M., 12:49 P.M., and 12:53 P.M., showed CMT A left the medication cart unlocked and unattended in the hall, with his/her keys in the lock.<br><br>Observation on 2/28/29 at 3:33 P.M., showed the treatment cart unlocked and unattended. Observation showed 15 insulin pens in the top drawer. Observation showed an unidentified staff approach the cart, retrieve a blood pressure cuff and re-enter a resident's room and left the cart unlocked and unattended, in the hall.<br><br>During an interview on 2/28/24 at 11:02 P.M., the Assistant Director of Nursing (ADON) said medication carts should be locked at all times to prevent other staff, residents or visitors access to the medications inside. He/She said he/she does not know why this is not being done except oversight.<br><br>During an interview on 2/28/24 at 4:45 P.M., CMT A said he/she accidentally leaves the keys in the medication cart with it unlocked because he/she knows he/she will be right back, but has been working on fixing the issue. He/She said it is important to lock the cart for the resident's safety.<br><br>During an interview on 2/28/24 at 3:20 P.M., the administrator said when medication or treatment carts are not in attendance they need to be locked without keys present so all contents are secured. He/She does not know why this is not being done.<br><br>MO00232230 |