STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265279	A. Building B. Wing	10/01/2024

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43010 Based on interview and record review, facility staff failed to contact one resident's (Resident #4's) responsible party when the resident passed away at the facility. The facility census 67. 1. Review of the facilty's Discharge of a Resident due to death policy, undated, showed staff are instructed to notify the family or the responsible party. 2. Review of Resident #4's Entry Minimum Data Set (MDS), a federally mandated assesment tool, dated 9/21/24, showed staff assessed the resident as: -admitted to the facility 9/21/24; -Diagnosis of skin cancer of scalp and neck, liver cancer with bile duct involved, rectal cancer, and throat cancer; -Received hospice services. Review of the residents nurses notes, dated 9/26/24, showed staff documented the resident passed away at 8:02 A.M. Review showed the nurses note did not contain documentation staff contacted the next of kin or family for the resident. During an interview on 10/1/24 at 10:15 A.M., Licensed Practical Nurse (LPN) B said staff are expected to contact the resident's family, doctor, administrative staff, and the coroner when a resident passes. LPN B said he/she worked the day the resisdent passed and he/she had not contacted the family because it had slipped through the cracks. He/She later asked hospice to contact the family since he/she had not done so. During an interview on 10/1/24 at 10:23 A.M., the Director of Nursing (DON) said staff are expected to notify the family, hospice, the doctor, and coroner in the case a resident passes. During an interview on 10/1/24 at 11:40 A.M., the administrator said staff are expected to notify the doctor, the family, hospice, and furneral home of the resident's passing. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/24 at 11:00 A.M., the resident's next of kin said he/she was not not notified by the facility of his/her spouses' passing. He/She said he/she was notified by hospice hours after his/her passing. MO00242752

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43010 Based on interview and record review, facility staff failed to prevent the misappropriation of three resident's (Resident #1, Resident #2, and Resident #3's) narcotic medications when Licensed Practical Nurse (LPN) A took the medication without authorization of the residents or the residents' responsible parties. The facility census was 67. 1. Review of the facility's Abuse Policy and Procedures/Investigation Protocols, dated 12/14/18, showed the facility defined misappropriation as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belonging or money without the resident's consent. 2. Review of the facility's investigation, dated 9/20/24, showed the ADON was notified LPN A displayed suspicious behavior on his/her shift. When the ADON arrived he/she observed the behaviors and issued LPN A a drug test with Human Resources (HR). The test was positive for oxycodone. The ADON notified the DON and performed a narcotic count with LPN C. During the count three narcotic log sheets with the cards could not be located on the medication cart. LPN A denied knowing what happened to the sheets or the medications. The ADON and LPN C found tops of the three medication cards and the cards in the trash with identified as Resident #1, #2, and #3. Staff called the police department. LPN A was arrested. Review showed staff were inservived on their controled drug policy and medication administration policies. Review of the police records, dated 9/20/24, showed the officer arrived to the facility at 6:12 A.M. and spoke to the ADON about the stolen narcotics. Review showed the office interviewed LPN A and LPN A said he/she used the record sheets to sign out medications for several patients but put the sheets back on the nursing station table where they belonged. LPN A said he/she did not steal any medications. Review showed the officer searched LPN A's vehicle and found several orange and white Oxycodone capsules opened, two straws with white residue, three cards with white powder residue, numerous narcotic record sheets from another nursing facility, and several medication packages for Oxycodone , Oxycotin (narcotic pain medication) and Hydrocone (narcotic pain medication). The officer placed LPN A under arrest. Review showed LPN A said he/she had the missing record sheets concealed in his/her pants. The officer retreived three missing record sheets from LPN A. LPN A told the officer he/she took five narcotic medications throughout his/her 12 hour shift the previous night. Review showed LPN A said most of the pills were Oxycodone and Hydrocodone. 4. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated 7/23/24, showed staff assessed the resident as follows: -Cognitively intact; -Diagnosis unspecified pain; -Received scheduled pain management; -Received as needed pain medication; -Experienced pain frequently. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Physician's Order Sheet (POS), dated October 2024, showed an order for Oxycodone five milligrams (mg) take one tablet by mouth every six hours as needed for severe pain. Review of the narcotic log book showed it did not contain the narcotic log sheet for the Oxycodone. 5. Review of Resident #2's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Diagnosis of arthritis in the bones of the left knee, and left knee pain; -Received scheduled pain management; -Received as needed pain medication; -Experienced pain occasionally. Review of the resident's POS, dated October 2024, showed an order for Hydrocodone 5/325 mg take one tablet by mouth every six hours as needed for pain, moderate to severe (4-10). Review of the narcotic log book showed it did not contain the narcotic log sheet for the Hydrocodone. 6. Review of Resident #3's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Diagnosis of necrosis (death of body tissue) of amputation stump, right lower extremity; -Received scheduled pain management; -Received as needed pain medication; -Experienced pain almost constantly. Review of the resident's POS, dated October 2024, showed an order for Hydrocodone 5/325 mg take one tablet by mouth nightly and take one table by mouth as needed daily for dressing change. Review of the narcotic log book showed it did not contain the narcotic log sheet for the Hydrocodone. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview on 10/1/24 at 10:23 A.M., the Director of Nursing (DON) said he/she was made aware by the ADON and Human Recourses of a possible narcotic diversion. He/She said LPN A was drug tested by the ADON and Human Resource and was found to be positive for Oxycodone. He/She did the narcotic count with the ADON upon arrival to the facility. He/She said he/she was unable to find three narcotic count sheets and and blister packs for three separate residents. He/She said they searched the trash and shred bin and found the tops of the medication cards without the blister packs. He/She said the police were called and LPN A was escorted off the property and taken to jail. During an interview on 10/1/24 at 10:36 A.M., The Human Resource employee said he/she was notified by the ADON of LPN A having odd behaviors on his/her shift. He/She said it's their policy to drug test under suspicion. He/She said LPN A tested positive for Oxycodone. The human resouce employee said he/she was a witness to the drug testing and stayed with LPN A until the police arrived. During an interview on 10/1/24 at 2:12 P.M., LPN C said he/she was orienting LPN A and was told to let him/her take the lead. He/She said LPN A was not signing narcotics out as they were given and started noticing LPN A disappearing for extended periods of time to the bathroom. His/Her eyes appeared red and glassy. LPN C said he/she notified the ADON of the suspicious behaviors between 5:00-6:00 A.M LPN C said he/she and the ADON did a narcotic count and noticed three cards missing along with the narcotic log sheets for residents #1, #2, and #3. During an interview on 10/1/24 at 2:24 P.M., the ADON said he/she was notified by LPN C around 5:00-6:00 A.M. LPN A was having suspicious behaviors. ADON said he/she arrived at the facility and watched LPN A do the last medication pass. He/She said LPN A's eyes were red, glassy and he/she was not making sense. ADON said he/she and the Human Resource employee completed a drug tested on LPN A and his/her test came back positive for Oxycodone. He/She asked LPN A if he/she had a script for the Oxycodone and he/she said no. ADON said he/she did a narcotic count with LPN C and there were three missing narcotic count sheets and three pill cards for Resident #1, #2, and #3. The ADON said LPN A could not tell him/her where the sheets or medications were at. He/She said the tops to the pill cards were later found in the shred bin and the cards were found empty in the trash. MO00242385