STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265383	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountainbleau Lodge	2001 North Kingshighway Cape Girardeau, MO 63701

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31057 Based on observation, record review, and interview, the facility failed to provide protective oversight for one (Resident #1) of four sampled residents, when facility staff left the facility's medication overflow cart unlocked and unattended. Resident #1 gained access to the cart and took two medication cards of gabapentin (a medication used to treat seizures disorder and used for nerve pain) and one card of Metoprolol (a medication used to treat high blood pressure) to his/her room. He/She reported taking 6 pills of Gabapentin and 6 pills of Gabapentin were missing which placed the resident in danger of potential overdose. The facility census was 27. The administrator was notified on 06/11/24 at 10:30 A.M. of an Immediate Jeopardy (IJ) past non-compliance which began on 06/09/24. On 06/10/24, the facility performed education to licensed and certified staff on proper safety of medication carts and the need to keep the cart locked at all times. The IJ was corrected on 06/10/24. Review of the facility policy Security of Medication Cart, dated April 2007, showed: - The nurse must secure the medication cart during the medication pass to prevent unauthorized entry; - Medication carts must be securely locked at all times when out of nurse's view; - When the medication cart is not being used, it must be locked and parked at the nurse's station or inside the medication room. - The policy did not address measures to ensure the medication carts were locked while not in use; - The policy did not address the use of a secondary medication cart designated as the overflow medication cart, it's placement in the hall or it not being monitored at all times. 1. Review of Resident #1's medical record showed: - An admitted [DATE] with diagnoses of brain cancer, depression, anxiety, repeated falls, disorder of the central nervous system, and headaches; - Alert and oriented to person place and time, no cognitive concerns; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Able to make needs known; - Independent with personal care. Review of the resident's June 2024 Physician Order Sheet showed: - An order dated 03/19/2024, pain assessment every shift; - An order dated 03/20/2024, admit to Hospice care; - An order dated 05/08/2024 for Gabapentin 100 mg, two capsules by mouth every eight hours for nerve pain. Review of the facility finalization report of incident, dated 06/10/2024, showed: - After interview with staff and resident it was found that the medication overstock cart was unlocked and not secured at the time the resident opened it and removed medication cards from the cart. Review of the facility camera footage, dated 06/09/2024 at 8:03 P.M., showed: - A medication cart parked in the corner of 100 and 200 hall intersection, across from the nurse's station; - No staff were seen on the video; - The resident walked down the 200 Hall towards the corner of the 100 and 200 hall intersection; - The resident sat down in a chair located in front of the medication cart; - The resident reached behind him/her and opened the second drawer of the cart, looked over his/her shoulder and took an undistinguishable amount of medication cards from the cart; - The resident then closed the drawer and walked towards his/her room to the to the right of the medication cart and out of camera view. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/11/2024 at 9:35 A.M., the Director of Operations (DOP) said on 06/09/2024 at approximately 9:00 P.M. she received a call from the Assisted Living Supervisor (ALS) stating he/she had been monitoring the cameras for the skilled unit and observed the resident sitting down in front of the overflow medication cart located on the 100/200 hall area, removed medication cards from the medication overflow cart and then return to his/her room. The ALS immediately notified Licensed Practical Nurse (LPN) A on the skilled unit to immediately go to Resident #1's room and check to see what he/she had or if the resident had medication cards in his/her possession. LPN A retrieved two medication cards of Gabapentin (60 capsules) of 300 mg of Gabapentin and one card (30 pills) of Metoprolol. Upon interviewing the resident, he/she admitted to ingesting 6 pills of 300 mg Gabapentin capsules and 6 pills were missing. The physician was notified and advised at that dosage, it did not meet the level of overdose and to continue monitor the resident. The DOP said the facility has a very small medication room behind the nurse's station, so the extra cards of medications, or the overflow, must be stored in another cart which is kept in the corner created with the intersections of hallways 100 and 200, and across from the nurse's station. They refer to this cart as the overflow medication cart. The DOP would expect the nurse to only unlock the overflow cart when he/she was working directly from it. Once done, it should be locked. It is sitting across from the nurse's station, so it is more likely to be monitored, however, the nurse's station is not always manned. The DOP was not aware of the last time the medication had been used or checked for being locked. During an interview on 06/11/2024 at 10:00 A.M., the resident said he/she had been in the dining room and was heading back to his/her room. The resident said he/she was in so much pain at that time he/she was desperate because it was not time for his/her as PRN (as needed) pain medication. As he/she neared the corner where the medication cart was stored, he/she saw no one was around. The resident said he/she did not know if the cart would be unlocked, but couldn't remember ever seeing staff lock or unlock it. The resident said he/she made a very stupid mistake and decided to check to see if he/she could get into the cart to find anything to take. The resident said he/she sat down in the chair beside the cart, reached down and tugged on the drawer, which opened easily. The resident said he/she checked over his/her shoulder to make sure no one was around and quickly reached in and grabbed 3 cards of medications. He/She looked only enough to see gabapentin on the card, and he/she knew that was also one of his/her medications. Once in his/her room, the resident saw he/she had taken a card of his/her own medication and took six of the capsules. The resident said there was nothing at the medication cart to stop anyone from reaching in to get some of them, but he/she shouldn't have done it. During an interview on 06/11/2024, at 9:50 A.M., Certified Medication Technician (CMT) C said the medication cart should be always locked. Only the nurses have keys to access the overflow medication cart. CMT C said he/she had never checked because it should always be locked. He/she worked the day of the incident and LPN A was in charge of the overflow cart, maintaining responsibility of the keys. During an interview on 06/11/2024 at 9:45 A.M., Registered Nurse (RN) B said the overflow medication cart should always be locked unless being used to retrieve medications, then re-locked. No one should have to check the cart for being unlocked, as it should never be left that way. Complaint #MO237379