| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265430 | A. Building<br>B. Wing | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor View Nursing and Rehabilitation | 6400 the Cedars Court<br>Cedar Hill, MO 63016 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48247<br><br>Based on observation, interview, and record review, the facility failed to follow physician's orders for one resident (Resident #1) out of eleven sampled residents when Resident #1 did not receive five doses of his/her seizure medication. The facility census was 87.<br><br>Review of the facility's policy titled, Medication Administration, dated 09/01/22, showed:<br><br>- Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards, in a manner to prevent contamination or infection;<br><br>- Correct any discrepancies and report to the nurse manager;<br><br>- The policy did not address what to do if the medication was not available.<br><br>1. Review of Resident #1's medical record showed:<br><br>- admitted [DATE];<br><br>- Diagnoses of epilepsy (a neurological condition characterized by recurrent seizures due to abnormal electrical activity in the brain), history of malignant neoplasm of the brain (brain cancer), diabetes mellitus (elevated blood sugar) and generalized anxiety disorder (GAD - persistent worry and fear about everyday situations);<br><br>- August 2024 Physician Order Sheet (POS) showed an order for cenobamate (a seizure medication) 150 milligram (mg) by mouth at bedtime for seizures, dated 06/19/24;<br><br>- Nurses' Note, dated 08/24/24 at 9:34 A.M., resident in a full body seizure and did not respond to verbal stimuli. Resident continued to have a seizure for four minutes. Resident awakened but was lethargic. A Certified Medication Technician (CMT) reported the resident hadn't received all his/her seizure medication. The resident had been out of his/her night time seizure medication for several days. The pharmacy was called about the missing night time seizure medication and said the medication had been delivered to the facility on [DATE]. The missing night time medication was found on the nurse medication cart instead of the CMT cart. The physician was notified and received an order to give a one time dose of cenobamate 150 mg now and to resume the cenobamate 150 mg night time dose on 08/24/24. The resident received a small scratch to the left hand.<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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265430 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/30/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Arbor View Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 6400 the Cedars Court Cedar Hill, MO 63016 | |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Medication Administration Record (MAR), dated 08/01/24 through 08/31/24, showed:<br><br>- Cenobamate 150 mg not administered on 08/19/24, 08/20/24, 08/21/24, 08/22/24 and 08/23/24;<br><br>- Five missed doses out of 31 doses.<br><br>Review of the Medication Error report, dated 08/24/24 at 10:14 A.M., showed Resident #1 had a four minute seizure in his/her room. The CMT informed the nurse the resident had been out of his/her bed time dose of cenobamate for multiple days. The pharmacy was called for a STAT (immediate) refill of the resident's cenobamate. The pharmacy said the prescription was delivered to the facility on [DATE]. Upon further investigation, Resident #1's cenobamate was found in the nurses's medication cart and not the CMT medication cart.<br><br>Review of Resident #1's Controlled Drug Receipt/Record/Disposition Form showed Registered Nurse (RN)/Assistant Director of Nursing (ADON) received 14 tablets of cenobamate on 08/19/24, from the pharmacy.<br><br>During an interview on 10/08/24 at 10:30 A.M., the ADON said the facility had medication carts for the nurses and medication carts for the CMTs to administer medications from. She checked in Resident #1's refill of cenobamate medication on 08/19/24, and placed it in the nurse's medication cart by mistake.<br><br>During an interview on 10/08/24 at 12:40 P.M., RN A said it was the facility's policy for CMTs to notify the nurses when a medication was unavailable to administer to a resident. The nurse would call the pharmacy for a STAT fill of a resident's medication.<br><br>During an interview on 10/08/24 at 1:30 P.M., the Director of Nursing (DON) and the ADON/RN E said they would expect a CMT to immediately notify the nurse of any unavailable medication or missed doses, so the nurse could immediately initiate the refill process.<br><br>During an interview on 10/08/24 at 1:35 P.M., the Administrator said she would expect medications to be available and administered according to the physician orders.<br><br>During a telephone interview on 10/15/24 at 3:03 P.M., the Physician said he/she would expect residents to receive their medications as ordered. The facility notified him/her of Resident #1's seizure on 08/24/24, along with the missed cenobamate doses. Resident #1 did not have another seizure after his/her cenobamate medication was restarted on 08/24/24, so the resident's seizure could have been induced by the missed doses of the cenobamate medication.<br><br>During an interview on 10/30/24 at 3:25 P.M., the Pharmacy Manager said Resident #1's cenobamate 150 mg per mouth at 8:00 P.M., was sent out to the facility on [DATE], with a count of 14 tablets. Licensed Practical Nurse (LPN) D signed for the medication on 08/16/24. On 08/19/24, 14 tablets of the same medication was sent to the facility and RN E signed for the medications at the facility. On 08/28/24, 14 tablets of the same medication was sent to the facility and LPN F signed for the medication at the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265430 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/30/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Arbor View Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 6400 the Cedars Court Cedar Hill, MO 63016 | |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/30/24 at 3:45 P.M., RN J said he/she was not made aware of Resident #1's missing prescription of cenobamate 150 mg per mouth at 8:00 P.M., until he/she questioned a CMT about the the resident missing several doses of his/her seizure medication while the resident was actively having a seizure on 08/24/24. The night nurse, RN E, signed off on the medication and placed the medication in the nurse cart instead of the CMT cart. He/She said two CMTs were working during that time, CMT G and CMT H, and they both notified the night nurses, RN E and LPN I, about the medication not being available. The night nurses did not pass along any information to any day shift nurses, including himself/herself that the medication wasn't available. The day shift CMTs were not aware of the missing medication because it was scheduled for 8:00 P.M. He/She never had an issue with getting any medications, including routine medications, from the pharmacy if he/she called in a medication by 5:00 P.M., then the medication would arrive by 2:00 A.M., the next day. If a medication was out, he/she would first check the Pixis (a locked stat safe box with medications) to see if the medication was in there and call the pharmacy for a refill. If a medication needed a prescription any time between 7:00 A.M. - 5:00 P.M., he/she would walk to the physician's office and get it signed.<br><br>During an interview on 10/30/24 at 4:00 P.M., RN E said she just became the DON a week ago and was the previous ADON. She worked as a night nurse (Nurse Manager) on 08/19/24 and 08/20/24. She received Resident #1's cenobamate 150 mg per mouth at 8:00 P.M., on 08/19/24, and placed it in the nurse's medication cart because it came with a narcotic sheet, and nurses pass a lot of the narcotics. The nurses only pass narcotics on the night shift. There were typically two nurses on the night shift, and they were the ones who sign in the medications. If a medication was out, then she would call the pharmacy immediately and if a medication was missing, she would look in all the med carts. She would expect CMTs to not document Resident #1's cenobamate was not here and they should have looked for it. She said the resident missing five days of the medication could have been avoided.<br><br>During a telephone interview on 11/05/24 at 12:32 P.M., CMT L said he/she worked on 08/20/24, and 08/22/24, that week. He/She remembered charting the medication was not available which should have shown up as a progress note, but couldn't say for sure if he/she followed up with the charge nurse to report it. The nurses sign for the pharmacy deliveries at night, the medication was put in the wrong cart, and all the carts were not searched. Any narcotic medications that come in were locked up by the nurses.<br><br>During a telephone interview on 11/05/24 at 12:38 P.M., CMT H said he/she couldn't recall any instances of a resident missing doses of medication during that time frame. If that happened, he/she would inform the charge nurse and would chart that they were waiting on the pharmacy.<br><br>During a telephone interview on 11/05/24 at 12:46 P.M., LPN D said he/she doesn't normally work on the hall Resident #1 resided and didn't remember if he/she was working during the time frame when the doses were missed. If a CMT reported a resident was out of medication, he/she would call the pharmacy. The pharmacy usually made two runs per day, around 12:00 A.M., and 3:00 P.M., but if a resident was out of medication, they could put in for a STAT delivery. The nurses received the meds from the pharmacy and controlled drugs were put in the locked box, but the others were put in the CMT carts.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265430 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/30/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor View Nursing and Rehabilitation | 6400 the Cedars Court<br>Cedar Hill, MO 63016 |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 11/05/24 at 5:30 P.M., the Compliance Officer for the Pharmacy said Resident #1's cenobamate 150 mg was a controlled substance and it had a 30 day prescription. He/She said on 07/15/24, 14 tablets were sent to the facility; on 07/31/24, another 14 tablets were sent to the facility; and on 08/15/24, two tablets were sent to the facility to fulfill the 30 day prescription. LPN D signed for those two tablets at 12:32 A.M. on 08/16/24. On 08/16/24, a request was made for a refill, but the insurance refused due to needing a new signed prescription. On 08/19/24, 14 tablets were delivered at 6:07 P.M., and RN E signed for the medication. On 08/29/24, 14 tablets were delivered and LPN F signed for the medication. The pharmacy had a cut off time at 12:00 P.M., for refill requests, and those made by 12:00 P.M., would arrive the same day. Typically refill requests were sent in three days prior to a resident's last dose of medication. The pharmacy also did another delivery at 1:00 A.M., for new prescriptions that were called in after the 8:00 P.M., cut off time.<br><br>COMPLAINT #MO 242770 |