

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Amberwood Estates Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5303 Bermuda Drive Normandy, MO 63121	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, interview and record review, the facility failed to ensure the services provided met acceptable professional standards of care when staff failed to ensure ordered Tramadol (narcotic used to treat pain) 50 milligram (mg) was processed timely by the pharmacy. When the medication was not delivered timely, staff failed to promptly contact the physician for medication order processing. As a result, the resident did not receive the ordered Tramadol for a total of 6 missed doses (Resident #1). The sample was 7. The census was 76.</p> <p>Review of the physician order policy, dated 1/1/22 showed:</p> <ul style="list-style-type: none"> -Policy: -Electronic orders: (Direct into any clinical record): -Physicians may be given access to any one of the systems of the clinical record for use to provide orders; -Orders will be directly entered into the system and automatically become a part of the clinical record; -Orders entered into the clinical record following acknowledgement of a written physician's order by a facility staff member; -Timeframe for physician or Licensed Independent Practitioner (LIP) signatures for above and physician order sheet (POS): -Physician and LIP orders will be signed in accordance with federal and state guidelines; -This process can, but may not be limited to the following: -Have a physician box where orders can be signed when the physician is in the facility; -Mail directly to the physician (weekly, bi-monthly or monthly); -Medical records staff/designee to take and deliver to the physician and pick-up; -Flag chart with sign here notice; <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
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Be electronically signed in the health record.</p> <p>Review of Resident #1's medical record, showed:</p> <p>-re-admitted : 4/8/25;</p> <p>-Moderate cognitive impairment;</p> <p>-Wounds to the heel.</p> <p>Review of the care plan, in use during the onsite, showed:</p> <p>-Focus: The resident is at risk for pain related to stroke;</p> <p>-Goal: The resident will not have an interruption of activities related to pain;</p> <p>-Interventions: Staff administer pain medication as ordered, anticipate the need for pain relief.</p> <p>Review of the POS, showed: an order dated 4/22/25: Tramadol 50 mg, take one tablet twice a day for heel pain.</p> <p>Review of the progress notes, showed:</p> <p>-On 4/22/25 at 1:28 A.M., a nurse note: an order for Tramadol 50 mg. Give one tablet twice a day for pain in both feet;</p> <p>-On 4/22/25 at 9:39 A.M.: medication note: Tramadol 50 mg, waiting on script from physician;</p> <p>Review of the April 2025 Medication Administration Record (MAR), showed:</p> <p>-An order, for Tramadol 50 mg: Take one tablet twice a day. Start: 4/22/25 and scheduled daily at 9:00 A.M. and 6:00 P.M.;</p> <p>-On 4/22/25 at 9:00 A.M., documented as 9 or other/see progress notes; at 6:00 P.M., documented as administered;</p> <p>-On 4/23/25 at 9:00 A.M., documented as 9 or other/see progress notes; at 6:00 P.M., left blank;</p> <p>-On 4/24/25 at 9:00 A.M., and 6:00 P.M., documented as 9 or other/see progress notes;</p> <p>-On 4/25/25 at 9:00 A.M., documented as 9 or other/see progress notes.</p> <p>Review of the Nurse Practitioner (NP) visit note, dated 4/23/25, showed:</p> <p>-Chief complaint: follow up visit;</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Tramadol 50 mg: Take one tablet twice daily for pain to both feet;</p> <p>-Lidocaine patch: apply once daily to both heels for pain;</p> <p>-Plan: the resident is started on Tramadol for better management of pain in both heels. Continue Lidoderm patch to both heels and Tylenol as needed (PRN).</p> <p>Review of the progress notes, showed:</p> <p>-On 4/23/25 at 10:24 A.M.: medication note: Tramadol 50 mg, medication unavailable. The pharmacy waiting for the script. As needed acetaminophen (Tylenol) administered;</p> <p>-On 4/24/25 at 11:45 A.M.: medication note: Tramadol 50 mg. Medication is not available, waiting for pharmacy;</p> <p>-On 4/24/25 at 8:33 P.M.: medication note: Tramadol 50 mg. The resident was asleep and not administered, NP made aware;</p> <p>-On 4/25/25 at 11:10 A.M., a medication note: Tramadol 50 mg. Medication not available. NP in the building and will call the new script to the pharmacy.</p> <p>Review of the facility's emergency stock (e-kit), showed:</p> <p>-Tramadol 50 mg;</p> <p>-Quantity: 6 tablets.</p> <p>During an interview on 4/30/25 at 11:22 A.M., Licensed Practical Nurse (LPN) A said it is very difficult at times to access the facility's e-kit for narcotics. When the NP writes an order for a narcotic, the staff notifies the pharmacy. Narcotic medications need a prescription. The pharmacy will not allow access to the e-kit if the pharmacy has not received the signed prescription. The facility does not have a protocol for ensuring the prescription is signed when the order is entered. The staff can administer ordered non-narcotic medications until the physician sends the signed prescription to the pharmacy.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/25 at 12:02 P.M., the Director of Nursing (DON) said she had been at the facility for three weeks. The NP visited the facility daily during the week and she does not have a Drug Enforcement Administration (DEA) number. The NP writes orders for narcotics and does not have the necessary DEA number for the pharmacy to fill the prescription. The staff have to attempt to contact the physician to obtain the needed information to ensure the pharmacy can send the medication. The pharmacy will not provide the e-kit access code regardless if the NP has written the order. Staff must have the e-kit access code to pull the narcotic from the e-kit. The residents who are ordered narcotic medication by the NP have had a delay in administration of the narcotic. The pharmacy requires a paper prescription to be signed and faxed before the medication order can be processed. This has caused a delay in narcotic pain medication administration. The facility is attempting to get a new system in place. The staff should call the DON and Assistant Director of Nursing when a narcotic is ordered. The DON said the resident did not receive any Tramadol until the medication was received on 4/25/25. The resident received the first dose at 6:00 P.M. Staff should not document a medication was administered when the medication was not delivered to the facility. The medication was not available on 4/22/25, and the resident did not receive the 6:00 P.M. dose as documented.</p> <p>MO00252542</p> <p>MO00252365</p>		