STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265775	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center of Lemay Inc	9353 South Broadway Saint Louis, MO 63125

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 44950 Based on interview and record review, the facility failed to ensure services provided meet professional standards of practice when a facility nurse pre-pulled medications for residents, documented the medications as administered, and never administered the medications. This resulted in nine residents not receiving their ordered medications (Residents #4, #5, #11, #7, #9, #8, #10, #1 and #12). The census was 44. The sample was 14. The administrator was notified on 6/21/24, of the past non-compliance. The facility educated staff of the requirement to administer medications at the time they are pulled and that only the staff person who pulls the medications are allowed to administer the medication. The facility conducted an investigation to determine which residents were affected and are monitoring ongoing compliance. The deficiency was corrected on 6/10/24. Review of the Controlled Substance Policy, revised 2/2021, showed: Controlled substances are subject to special handling, storage. disposal and record-keeping requirements. The facility will maintain compliance with these special provisions. Procedures: -Controlled substances in Schedules II, III and IV are subject to special handling, storage, disposal and record-keeping requirements. Such drugs are to be accessible only to authorized nursing and pharmacy personnel. The Director of Nurses is responsible for the control of such drugs; -Drugs listed in Schedules II, III, and IV are to be stored under double-lock conditions. The key to the separately locked storage area is not the same key that is used to gain access to other drugs. The medication nurse on duty at the time will maintain possession of the key. The key must remain in the possession of the licensed nurse that completed the count at all times during their shift. Should it be necessary to give the keys to another licensed nurse(ex. Leaving the facility for lunch) a count will be done to verify the inventory. A count will be done again when the keys are returned to the original licensed nurse; -The authorized person receiving and checking in a drug in Schedules II, III, and IV is to prepare a controlled substance proof of use record form for that medication, if one is not provided by the pharmacy. Thereafter. a physical inventory of that medication will be made at the change of each nursing shift. Shift Verification Count Sheets/Packages shall be completed at the change of each shift; (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265775	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center of Lemay Inc	9353 South Broadway Saint Louis, MO 63125

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The persons performing the inventory will sign to verify that the inventory was done. All controlled substances are to be counted every shift. The count is to be performed by the on coming licensed nurse and the off-going licensed nurse. The oncoming nurse will be responsible for looking at the medication to verify the amount of medication present at the time of the count. The off-going nurse will be responsible for viewing the Controlled Substance Proof of Use Record to verify the amount on the record at the time of the count. Both nurses will sign on the NARCOTIC SIGN IN & OUT SHEET that the count was completed; -Any discrepancy in the inventory of a controlled substance is to be reported to the Director of Nurses immediately. The Director of Nurses is responsible for investigating and making a reasonable effort to reconcile all reported discrepancies. The discrepancy of a controlled substance is to be reported to the Administrator and the Regional Nurse immediately. If a discrepancy is not reconciled. the Director of Nurses is to document the details on the audit record, including the possible shift or persons responsible for the discrepancy, and the efforts made to reconcile it. Review of an undated picture, showed 11 medication cups sat on top of a medication cart. Each medication cup contained one pill. Names written on the bottoms of the cups and visible through the cup included Residents #4, #5, #11, #7, #9, #8, #10, #1, and #12. The name of the pill not identified. 1. Review of Resident #4's medical record, showed: -Diagnoses included osteoarthritis of the knee; -An order dated 4/25/24 for tramadol HCL (pain medication) 50 milligram (mg) for pain related to osteoarthritis of the knee, at bedtime; -Scheduled administration time 10:00 P.M.: -A narcotic medication run sheet, showed Licensed Practical Nurse (LPN) A pulled the tramadol 50 mg on 6/8/24 at 3:06 P.M.; -A progress note dated 6/10/24 at 10:40 A.M., showed the resident did not receive his/her tramadol 50 mg on 6/8/24. Physician made aware. 2. Review of Resident #5's medical record, showed: -Diagnoses included epilepsy (seizure disorder) and attention-deficit hyperactivity disorder; -An order dated 12/27/23, for lorazepam (Ativan, used to treat anxiety) 0.5 mg three times a day for anxiety: -Scheduled administration times at 9:00 A.M., 12:00 P.M., and 5:00 P.M.; -A narcotic medication run sheet, showed LPN A pulled lorazepam 0.5 mg on 6/8/24 at 10:21 A.M., 3:03 P.M. , and 3:07 P.M.; -A progress note dated 6/10/24 at 10:17 P.M., showed the resident did not receive his/her Ativan on 6/8/24. Physician made aware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265775	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center of Lemay Inc	9353 South Broadway Saint Louis, MO 63125

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #11's medical record, showed: -Diagnoses included anxiety disorder; -An order dated 5/21/24, for lorazepam 0.5 mg two times a day related to anxiety disorder: -Scheduled administration times 9:00 A.M. and 5:00 P.M.; -A narcotic medication run sheet, showed no documentation the lorazepam 0.5 mg was pulled for the resident; -A progress note dated 6/10/24 at 10:32 A.M., showed the resident did not receive his/her Ativan 0.5 mg on 6/8/24. Physician made aware. 4. Review of Resident #7's medical record, showed: -Diagnoses included fracture of the left arm; -An order dated 6/6/24, for oxycodone (narcotic pain medication) 5 mg every 12 hours as needed for pain related to fracture of the left arm; -A narcotic medication run sheet, showed LPN A pulled oxycodone 5 mg on 6/8/24 at 3:07 P.M.; -A progress note dated 6/10/24, showed the resident did not receive oxycodone on 6/8/24. Physician made aware. 5. Review of Resident #9's medical record, showed: -Diagnoses included injury at the cervical (neck) of spinal cord and anxiety disorder; -An order dated 4/9/24, for hydrocodone-acetaminophen (Norco, narcotic pain medication that also includes Tylenol) 5-325 mg, one tablet four times a day for pain related to cervical injury: -Scheduled administration times 9:00 A.M., 12:00 P.M., 5:00 P.M., 9:00 P.M.; -An order dated 4/22/24, for clonazepam (used to treat anxiety) 1 mg at bedtime for insomnia related to anxiety disorder: -Scheduled administration time liberalized at bedtime; -A narcotic medication run sheet, showed: -LPN A pulled hydrocodone/acetaminophen 5-325 mg on 6/8/24 at 3:06 P.M.; -LPN A pulled clonazepam 1 mg on 6/8/24 at 3:06 P.M.; -A progress note dated 6/10/24 at 10:38 A.M., showed the resident did not receive his/her clonazepam or Norco on 6/8/24. Physician made aware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265775	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center of Lemay Inc	9353 South Broadway Saint Louis, MO 63125

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #8's medical record, showed: -Diagnoses included anxiety disorder; -An order dated 4/2/24, for diazepam (Valium, used to treat seizures, can also treat anxiety) 5 mg two times a day related to anxiety disorder: -Scheduled administration times 9:00 A.M. and 5:00 P.M.; -A narcotic medication run sheet, showed LPN A pulled diazepam 5 mg on 6/8/24 at 10:21 A.M. and 3:08 P.M.; -A progress note dated 6/10/24 at 10:19 A.M., showed the resident did not receive his/her Valium on 6/8/24. Physician made aware. 7. Review of Resident 10's medical record, showed: -Diagnoses included chronic pain; -An order dated 4/28/24, for Ultram (tramadol) 50 mg two times a day for chronic pain: -Scheduled administration times liberalized in the AM and PM; -A narcotic medication run sheet, showed LPN A pulled tramadol 50 mg on 6/8/24 at 10:22 A.M. and 3:08 P.M. -A progress note dated 6/10/24 at 10:21 A.M., showed the resident did not receive his/her tramadol 50 mg on 6/8/24. Physician made aware. 8. Review of Resident #1's medical record, showed: -Diagnoses included dementia and agitation; -An order dated 6/9/24, for Ativan 0.5 mg two times a day for agitation: -Scheduled administration times 9:00 A.M. and 5:00 P.M.; -A narcotic medication run sheet, showed LPN A pulled lorazepam 0.5 mg on 6/8/24 at 3:06 P.M.; -A progress note dated 6/10/24 at 10:36 A.M., showed the resident did not receive his/her Ativan 0.5 mg on 6/8/24. Physician made aware. 9. Review of Resident #12's medical record, showed: -Diagnoses included diabetes, stroke, and osteoarthritis; -An order dated 8/3/23, for tramadol 50 mg two times a day for osteoarthritis: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265775	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center of Lemay Inc	9353 South Broadway Saint Louis, MO 63125

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Scheduled administration times liberalized in the AM and PM; -A narcotic medication run sheet, showed LPN A pulled tramadol 50 mg on 6/8/24 at 3:08 P.M.; -No progress note to show that the resident did not receive this medication. 10. Review of the Medication Destruction Log, showed on 6/10/24, narcotic medications for Residents #4, #5, #11, #7, #9, #8, #10, #1, and #12 that were pulled on 6/8/24 and not given were wasted. 11. During an interview on 6/21/24 at 9:50 A.M., LPN A said nurses and Certified Medication Technicians (CMT) are not supposed to pre-pop medications, especially narcotic medications. Medications are to be given after they are removed and signed out. All narcotic medications are signed out on the computer. The facility does not have paper narcotic count or sign out sheets. LPN A said he/she does not pre-pop medications. 12. During an interview on 6/21/24 at 10:45 A.M., the Director of Nursing (DON) said approximately two weeks ago, on 6/8/24, Agency Nurse C was scheduled to work overnight. Around 4:00 A.M. on 6/9/24, he/she came across a cart that had what appeared to be narcotics not given. Agency Nurse C called to report this to her. Agency Nurse C also sent text messages and pictures of his/her concern. The picture showed 11 medication cups sat on top of a medication cart. Each medication cup contained one pill. Names written on the bottoms of the cups and visible through the cup included Residents #4, #5, #11, #7, #9, #8, #10, #1, and #12. The name of the pill not identified. The DON said she came to the facility later that morning. Agency Nurse C did not pass his/her 6:00 A.M. medications due to his/her concern with the medications left on the cart. The DON said nurses and CMTs have different medication records. A nurse is not supposed to give another nurse or a CMT their medications to pass, especially narcotics. On nights, there are no CMTs and the nurse is to pass all medications. The nurse should have passed those medications on the evening shift but he/she popped the medications and gave to CMT B to pass. CMT B never gave the medications but they were marked as given by LPN A. They called the doctor and destroyed the medications. They also completed medication error reports on each medicine. The DON said she talked to CMT B and informed the CMT that he/she should have notified management. The CMT said that he/she did not report the incident initially because he/she was worried about conflict and felt intimidated. 13. During an interview on 6/21/24 at 11:22 A.M., CMT B said LPN A asked him/her to pass the medications on the medication cart. CMT B said when he/she told LPN A no, LPN A laughed like he/she did not believe that he/she would not pass the medications. CMT B said this is an ongoing behavior from LPN A. LPN A just left them on the medication cart when he/she left the facility. CMT B said he/she has not been asked to do that since the incident. CMT B said the DON talked to him/her and asked CMT B to notify the DON if this happens again. 12. During an interview on 6/21/24 at 1:43 P.M. with the Administrator, DON, and Corporate Nurse, they said they would expect staff to follow facility policies. Staff should document accurately and should not document a medication as administered if it was not. Staff should not pull medications and ask another staff person to administer the medications. Medications should be administered at the time they are pulled. MO00237365