

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265838	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Lakeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Garden Plaza Drive Florissant, MO 63033	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>See the SOD cited at F602, Event ID# ISJ412</p> <p>Based on observation, interview and record review, the facility failed to prevent the diversion (the unauthorized removal) of Schedule II controlled medications (medication with higher potential of dependency and abuse) for one resident (Resident #194). The census was 89.</p> <p>The Director of Nursing (DON) was notified on 12/13/24, of the past non-compliance which began and ended on 11/12/24. The facility began an investigation, interviewed staff and the pharmacy delivery person, performed medication carts review on each hall, notified the police, in-serviced staff on abuse and misappropriation of resident property (including drug diversion), and terminated Licensed Practical Nurse (LPN) A.</p> <p>Review of the facility's Identifying Exploitation, Theft and Misappropriation of Resident Property Policy, revised April 2021, showed:</p> <ul style="list-style-type: none"> <li>-Policy Statement: As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property;</li> <li>-Policy Interpretation and Implementation:</li> <li>-Exploitation, theft and misappropriation of resident property are strictly prohibited;</li> <li>-It is understood by the leadership in this facility that preventing these occurrences requires staff education and training;</li> <li>-Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent;</li> <li>-Examples of misappropriation of resident property include:</li> <li>-Identity theft;</li> <li>-Theft of money from bank accounts;</li> <li>-Unauthorized or coerced purchases on the resident's credit card;</li> </ul> <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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Coercion to provide gifts in exchange for ongoing care;</p> <p>-Manipulating the resident into providing monetary support or assistance;</p> <p>-Drug diversion (taking the resident's medication); and</p> <p>-Theft of personal belongings;</p> <p>-Staff and providers are expected to report suspected exploitation, theft or misappropriation of resident property;</p> <p>-The QAPI committee reviews and creates plans of action to address quality deficiencies that may lead to exploitation, theft or misappropriation of resident property.</p> <p>Review of the facility's investigation, showed:</p> <p>-Date and Time of Alleged Incident: 11/12/24 at 7:30 A.M.;</p> <p>-Summary of Alleged Incident, showed drug diversion identified on the morning of 11/12/24 on 200 hall unit, and was committed by night shift LPN A. He/She was terminated.</p> <p>Review of the Police Department report, dated 11/12/24 at 5:16 P.M., showed:</p> <p>-Reporter: Former Administrator;</p> <p>-Incident Code: Felsteal: Felony Stealing</p> <p>-Offense: Stealing - controlled substance from building;</p> <p>-LPN A was identified in the report;</p> <p>-Resident #194 was identified as the victim;</p> <p>-Witness: LPN B and Former Administrator.</p> <p>Review of the video footage sent by the facility, showed a staff, LPN A, retrieved a medication card from a medication cart. He/She appeared to be taking some medication and placed the medication card in a backpack which was on the desk at the nurse station.</p> <p>Review of Resident #194's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/9/24, showed:</p> <p>-Cognitively intact;</p> <p>-No impairment to upper and lower extremities;</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included heart disease, kidney disease, septicemia (blood poisoning), and COPD (chronic obstructive pulmonary disease, a group of lung diseases that block airflow and make it difficult to breathe);</p> <p>-Takes opioid medication.</p> <p>Review of the resident's electronic health record showed:</p> <p>-An order of Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) (Norco, contains opioid used to relieve moderate to severe pain), give 1 tablet every 8 hours for pain, start date of 11/4/24;</p> <p>-The Medication Administration Record showed LPN A administered the medication to the resident on 11/11/24 at 10:00 P.M. and on 11/12/24 at 6:00 A.M</p> <p>During an interview on 12/12/24 at 10:59 A.M., LPN A said he/she worked the 3:00 P.M.-11:00 P.M. shift, but was unable to recall the exact date. He/She was a new staff and only worked for three days before he/she was terminated. The facility terminated him/her because he/she looked very tired and looked under the influence. The DON notified him/her over the phone about the termination. LPN A said he/she did not take any of the residents' medications. He/She was taking prescription medications for high blood pressure and Xanax (used to treat anxiety). He/She had prescriptions for those medications. LPN A said he/she had no issues or history of controlled substance use. LPN A took his/her own Tylenol (used to treat minor pain and fever) that night, but did not take his/her Xanax. He/She took Xanax before bedtime. LPN A added that he/she was asked to come to the medication room by another nurse and was told he/she looked tired, fumbled the keys, and was told to go home. He/She then received a call from the DON the next morning and was told he/she was terminated. The DON did not mention any missing medications.</p> <p>During an interview on 12/12/24 at 12:23 P.M., LPN B said he/she worked on the 200 hall on the 11/12/24 day shift to relieve LPN A from working the night shift, 7:00 P.M. to 7:00 A.M He/She clocked-in around 7:15 A.M. LPN B said LPN A told him/her that he/she was going to be orientating LPN A. LPN B observed LPN A to be confused and somewhat disoriented. He/She told LPN A they were going to wait for the night shift nurse. After a few minutes, LPN A told LPN B he/she was the night shift nurse and was just confused. Both LPNs proceeded with providing change-of-shift report and LPN B continued to observe LPN A to look very tired and had slow speech. LPN B said when they counted the narcotic medications, there were a couple of medication counts that were off. LPN A then said he/she administered those medications during his/her shift, then signed out the medications to correct the count. After LPN A left, LPN B checked and cleaned the medication cart and observed a narcotic count sheet that was stuck in one of the drawers of the cart. The sheet contained Resident #194's information. LPN B looked for the medication card that matched with the count sheet, but was unable to find the medication. He/She contacted the pharmacy who verified the medication for the resident was delivered and was received by LPN A. LPN B reported the missing medication to the former Administrator. They found the medication label, the top part of the medication card that was torn, in the shred box.</p> <p>During an interview on 12/18/24 at 9:20 A.M., the resident said he/she received Norco medication, while at the facility. He/She did not recall the specific time and date of receiving the medication, including 11/11/24 and 11/12/24. But, there were a few times he/she did not receive it at the requested time.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/12/24 on 11:37 A.M., the Administrator said he was not at the facility when the drug diversion incident occurred. The former Administrator provided the investigation information and all the in-services provided to the staff regarding receiving narcotic medications. The Administrator said the facility did not offer drug-testing.</p> <p>During an interview on 12/18/24 at 9:33 A.M., a Florissant Police Department dispatch receptionist said LPN A was issued a warrant for questioning and was arrested on 12/5/24. The case was sent for prosecution.</p> <p>MO00245100</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> See deficiency cited at event id #ISJ412</p> <p>This deficiency is uncorrected. For previous examples, see the Statement of Deficiencies dated 10/21/24.</p> <p>Based on observation, interview and record review, the facility failed to ensure call lights were in working order, including visible notification at the nurses station for four of 23 sampled residents (Residents #32, #46, #64, and #60). The census was 89.</p> <p>Review of the facility's Call System, Residents policy, revised September 2022, showed:</p> <ul style="list-style-type: none"> <li>-Policy Statement: Residents are provided with a means to call staff for assistance through communication systems that directly calls a staff member or a centralized work station;</li> <li>-Policy Interpretation and Implementation;</li> <li>-Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor;</li> <li>-The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional;</li> <li>-The resident call system is routinely maintained and tested by the maintenance department.</li> </ul> <p>1. Review of Resident #32's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/7/24, showed:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-No behaviors.</li> </ul> <p>During an interview on 12/11/24 at 1:08 A.M., the resident said he/she had not had a functional call light for a month. The facility staff were aware and it had not been fixed. The facility provided a bell, but staff would not answer the bell.</p> <p>Observation and interview on 12/11/24 at 1:43 P.M., showed the resident's call light did not stay on when pressed. The lights from the wall and from the hall turned on for approximately two seconds. There was no audible sound. The resident said the facility wanted to move him/her to a different room, but he/she refused due to being in the same room for six years. He/She did not want to move or change anything in his/her home.</p> <p>2. Review of Resident #46's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-Mild cognitive impairment;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Rejection of care occurred four to six out of seven days.</p> <p>Observation and interview on 12/9/24 at 9:00 A.M., showed the resident lay in bed. He/She said when the call light was pressed the light would not stay on. The resident pressed the call light. The light in the room lit up red and stayed on for a few seconds then the light went off. The light did not light up in the hallway.</p> <p>Observation and interview on 12/9/24 at 11:45 A.M., showed the resident lay in bed. Certified Nurse Aide (CNA) E was in the room, trying to turn the resident's television on. The resident pressed the call light inside the room, which turned red then went off. CNA E said he/she was not aware the call light was not working.</p> <p>During an interview on 12/9/24 at approximately 1:00 P.M., the Director of Nursing (DON) said Resident #46 and Resident #64 were being moved to another room.</p> <p>Observation and interview on 12/11/24 at 12:20 P.M., showed the resident lay in bed in the same room. The resident said the facility said they would move him/her today, but he/she did not know if he/she was going to move or not. Maintenance Worker D was in the room working on the call lights. He/She said the call lights were not working. The problem was the call light cords were pulled out of the wall and they needed to be rewired.</p> <p>Observation on 12/12/24 at 2:56 P.M., showed the resident pushed his/her call light, which did not light up.</p> <p>3. Review of Resident #64's quarterly MDS, dated [DATE], showed:</p> <p>-Mild cognitive impairment;</p> <p>-No behaviors;</p> <p>-Required maximal assistance for toileting;</p> <p>-Required supervision for personal hygiene.</p> <p>Observation and interview on 12/9/24 at 11:45 A.M., showed CNA E pressed the resident's call light and it did not light up inside the room. Then he/she checked the call light in the hall and said the light did not light up. CNA E said if the resident needed anything, he/she would have to catch staff as they walked by the room. They needed maintenance to fix it.</p> <p>During an interview on 12/12/24 at 2:56 P.M., the resident sat in his/her chair in his/her room. The resident said maintenance was working on the call light the day before yesterday, but he/she did not know if the call light was working or not.</p> <p>4. Review of Resident #60's care plan, revised 10/15/24 and in use during the time of the survey, showed:</p> <p>-Focus: The resident is at risk for fall with or without injury related to altered balance while standing and/or walking and altered mental status;</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Goal: Will minimize risk for falls to extent possible;</p> <p>-Interventions: Provide verbal reminders/cues to ask for assistance as needed.</p> <p>Observation on 12/12/24 at 3:00 P.M., showed the resident was in his/her room with a bell within reach. The call light was plugged into the wall, but the cord was cut just before where the cord was inserted into the wall. The resident said his/her call light had not worked for a little while. If he/she needed something he/she would use his/her roommate's call light. Or he/she would walk out into the hall and tell staff himself/herself.</p> <p>5. During an interview on 12/12/24 at 11:20 A.M., Licensed Practical Nurse (LPN) F said he/she was aware of only one resident's room with a call light which was not working. The resident was given a bell.</p> <p>During an interview on 12/12/24 at 3:05 P.M., Certified Medication Technician (CMT) G said he/she was not aware of any rooms where the call lights were not working. If he/she saw a room where the call light did not work, he/she would tell the supervisor.</p> <p>During an interview on 12/12/24 at 3:10 P.M., CNA H, said he/she just saw Resident #46's and Resident # 32's call lights were not working. He/She was aware that some of the rooms' call lights were not working, and those residents were given a bell.</p> <p>During an interview on 12/12/24 at 10:10 A.M., the Maintenance Director said currently there were 10 call lights that did not work. The call lights were wrapped around the bed rail and when the beds were moved, the cords were getting ripped out of the wall. This resulted in the call lights needing to be rewired and replaced. A bell was the only alternative the facility had for rooms where the call lights were not working. The facility ordered 20 call lights a couple of months ago, but they have not come in yet.</p> <p>During an interview on 12/12/24 at 3:15 P.M., the DON said Resident #32 was offered to move to another room, but he/she refused. Maintenance had been working on the call lights in Resident #46's and Resident #64's room. The residents were moved earlier this week, but they wanted to move back. The DON would expect all call lights to be working.</p> <p>MO00245656</p> <p>MO00244495</p> <p>MO00246314</p>