STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265881	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Dardenne Prairie	7275 State Highway N Dardenne Prairie, MO 63368

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify one resident's (Resident #1) physician, in a review of three sampled residents, that ordered medications were not available for administration. The census was 36. Review of the facility policy, Notification of Changes, last revised 4/2025 showed the following: -The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification; -The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification; Circumstances requiring notification include those that potentially may require physician intervention including circumstances that require a need to alter treatment. 1. Review of Resident #1's facility medical record showed the resident admitted to the facility on [DATE] at 6:30 P.M. Review of the resident's Physician Order Sheet (POS), dated 5/2025, showed the following: -Diagnoses included hypertension (high blood pressure), hyperlipidemia (elevated cholesterol), anxiety disorder, acid reflux and diabetes mellitus type II (uncontrolled blood sugar); -Gabapentin (medication to treat nerve pain, often caused by diabetes) 100 milligrams (mg) capsule, one capsule three times daily (5/27/25); -Pepcid (medication to help reduce stomach acid and treat conditions like heartburn, acid indigestion and ulcers) 40 mg, one tablet at bedtime (5/27/25); -Rosuvastatin (medication to treat high cholesterol) 10 mg, one tablet by mouth at bedtime (5/27/25); -Extra Strength (ES) Tylenol (pain medication) 500 mg, two tablets by mouth two times daily for pain (5/27/25). (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Medication Administration Record (MAR), dated May 2025, showed the following: -On 05/27/25 at 7:00 P.M., the administration boxes for the resident's ordered gabapentin, Pepcid and rosuvastatin were initaled by Licensed Practical Nurse (LPN) A, along with the code number nine (other: see progress notes); -The ES Tylenol box was marked with an X, indicating not due and the medication was not administered. Review of the resident's progress notes, dated 05/27/25 at 9:09 P.M., showed LPN A documented medications not available. The note did not show LPN A notified the physician. Review of the resident's MAR, dated May 2025, showed the following: -On 05/28/25 at 7:00 A.M., the administration box for the resident's ordered gabapentin was initaled by LPN A along with the number nine (other: see progress notes); -The ES Tylenol box was not initialed and marked with an X, indicating not due and the medication was not administered. Review of the resident's progress notes, dated 05/28/25, showed no documentation the resident's physician was notified staff did not administer the resident's 7:00 A.M. medications as ordered. Review of the resident's MAR, dated 5/2025, showed On 05/28/25 at 11:00 A.M., the administration box for the resident's ordered gabapentin was initialed by LPN D along with the number the number nine (other: see progress notes). Review of the resident's progress notes, dated 05/28/25 at 3:21 P.M. showed staff documented, medications coming from pharmacy. No documentation to show staff notified the resident's physician the resident's medications were not available for administration. During an interview on 06/12/25 at 11:48 A.M., LPN A said the following: -The physician should be notified if medications were not administered; -He/She had not notified the physician. During an interview on 06/11/25 at 3:05 P.M. LPN C said if staff was unable to locate medications or administer medications, the physician/on-call physician should be notified to change the order; -He/She would chart meds to be delivered by pharmacy, notify the physician, and document his/her actions in the progress notes. The resident missed three ordered doses of gabapentin, one ordered dose of Pepcid, one ordered dose of rosuvastatin and two ordered doses of ES Tylenol. The resident missed seven total doses of medications. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/25 at 12:29 P.M., the Director of Nursing (DON) said the following: -She would expect medications to be given as ordered; -If medications were not administered, the physician should be notified. It would be the responsibility of the nursing staff, including agency staff, to notify the physician; -Notifications should be documented in the progress notes; -She was not aware of the missed medications; -Some of the medications were available in the Pyxis and some were available from stock supply. MO255076

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician orders for one resident (Resident #1), in a review of three sampled residents, when staff did not administer medications or complete assessments as ordered. Further review showed the medications not administered were available through the facility Pyxis (emergency medication supply available for the facility to pull medication from and use for resident administration) system and as stock medications. The census was 36. Review of the facility policy, Medication Administration, last revised 7/2024, showed: 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 of practice; Policy Explanation and Compliance Guidelines: 9. Review Medication Administration Record (MAR) to identify medication to be administered; 10. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time; 16. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. 1. Review of the Pyxis medication list, showed the following medications available for staff to pull from the system as needed: -Gabapentin (medication for neuropathy pain, a type of pain from nerve damage, usually in the hands and feet) 100 milligram (mg) capsules; -Pepcid (medication for acid reflux) 20 mg tablet; -Rosuvastatin (medication for high cholesterol) 10 mg tablets. 2. Review of Resident #1's facility medical record showed the resident was admitted to the facility on [DATE] at 6:30 P.M. Review of the resident's Physician Order Sheet (POS), dated 5/2025, showed the following: -Diagnoses included: hypertension (high blood pressure), hyperlipidemia (elevated cholesterol), anxiety disorder, acid reflux and Diabetes Mellitus II (uncontrolled blood sugar): -Gabapentin 100 mg capsule, one capsule three times daily (5/27/25); -Pepcid 40 mg, one tablet at bedtime (5/27/25); -Rosuvastatin 10 mg, one tablet by mouth at bedtime (5/27/25); -Extra Strength (ES) Tylenol 500 mg, two tablets by mouth two times daily for pain (5/27/25); (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Complete and document pain assessment using numeric pain scale every shift (5/27/25). Review of the resident's Medication Administration Record (MAR), dated 5/2025, showed the following: -On 05/27/25 at 7:00 P.M., the administration boxes for the resident's ordered gabapentin, Pepcid and rosuvastatin were initaled by Licensed Practical Nurse (LPN) A along with the code number nine (other: see progress notes); -On 05/27/25 at 7:00 P.M., the ES Tylenol box was marked with an X, indicating not due and that the medication was not administered. Review of the resident's Treatment Administration Record (TAR), dated 05/2025, showed the following: -Complete and document pain assessment using the numeric pain scale every shift, day and night; -On 05/27/25 for the night shift, the box was marked with the numeral two (on a scale of 1 - 10 with 10 being the worst pain), indicating the resident had identified pain and initialed by LPN A. Review of the resident's progress notes, dated 05/27/25 at 9:09 P.M., showed LPN A documented meds not available. No documentation to show staff utilized the facility Pyxis to obtain gabapentin, Pepcid or rosuvastatin. ES Tylenol was available in the medication cart as stock medication. Review of the resident's MAR, dated May 2025, showed on 05/28/25 at 7:00 A.M., staff marked the ES Tylenol box with an X, indicating not due and the medication was not administered. Review of the resident's TAR, dated 05/2025, showed the following: -Complete and document pain assessment using the numeric pain scale every shift, day and night; -On 05/28/25 for the day shift, the box was left blank for pain number, indicating staff had not obtained or documented the resident's pain score. Review of the resident's MAR, dated 05/28/25 for 7:00 A.M. showed the administration box for the resident's ordered gabapentin was initaled by LPN A along with the number nine (other: see progress notes). Review of the resident's progress notes, dated 05/28/25, showed no documentation why the resident's 7:00 A.M. gabapentin had not been administered as ordered. No documentation to show staff utilized the Pyxis to obtain gabapentin. Review of the resident's MAR, dated May 2025, showed on 05/28/25 at 11:00 A.M., the administration box for the resident's ordered gabapentin was initialed by LPN D along with the number nine (other: see progress notes). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, dated 05/28/25 at 3:21 P.M. showed staff documented, medications coming from pharmacy. There was no documentation to show staff utilized the Pixis to obtain gabapentin for administration. During an interview on 06/11/25 at 3:05 P.M., LPN C said the following: -The pharmacy delivered medications daily, mid morning to noon and again in the evenings; -Medications should be administered when they are due on the same day; -If an admission comes in after 4:00 P.M. - 5:00 P.M., the medications may not get delivered the day of admission. During an interview on 06/12/25 at 11:48 A.M., LPN A said the following: -If medications were not available for a resident, he/she would check the Pyxis for the needed medications so they would not be missed; -He/She was an agency nurse and did not have access to the Pyxis; -When medications were not available, as a trained nurse, the best practice would be to verify the order and pull the needed medications from the Pyxis; -He/She did not administer medications as they were not available on the medication cart and he/she did not have access to the Pyxis; -He/She did not administer ES Tylenol. During an interview on 06/11/25 at 4:39 P.M., the Director Of Nursing said the following: -She would expect medications to be given as ordered; -If medications were not available, nursing should check the Pyxis to see if medications were available through the Pyxis; -The facility pharmacy delivered two times daily; -The facility had the ability to have medications delivered to them around the clock and within four hours. More than one pharmacy may be used; -If a resident was admitted after 4:00 P.M. - 5:00 P.M., they could call for a stat delivery, which meant medications would be delivered within four hours/24 hours a day; -She would expect nursing to utilize stock medications, if the resident's medications were unavailable, until the resident's medications were available; -ES Tylenol was available as a stock medication. (continued on next page)

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