Missouri Department of Health and Senior Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 28191 | A. BUILDING: _____ B. WING _____ | C 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLONY POINTE-ASSISTED LIVING BY AMER | 1510 CHAPEL HILL ROAD COLUMBIA, MO 65203 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A4798 | 19 CSR 30-86.047(47)(A) Physicians Orders Followed<br><br>Medication Orders.<br>(A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III<br><br>This regulation is not met as evidenced by:<br>Class II*<br><br>Based on interview and record review, facility staff failed to follow physician's orders to obtain a urinalysis for one resident (Resident #1) out of six sampled residents. The facility census was 43.<br><br>1. Review showed the facility did not provide a policy for following physician's orders.<br><br>2. Review of Resident #1's face sheet showed staff documented as follows: showed the resident admitted to the facility on 01/16/25 with diagnoses of dementia and behavioral disturbance.<br><br>Review of the resident's Individual Service Plan, dated 01/16/25, showed staff documented the resident admitted to the facility on 01/16/25 with a diagnosis of unspecified dementia with behavioral disturbance. Review showed the ISP did not contain documentation related to the urinalysis.<br><br>Review of the resident's physician order sheets (POS), dated 07/04/25, showed a physician ordered for an urinalysis.<br><br>Review of the resident's progress notes, dated 07/01/25 through 07/28/25, did not contain | A4798 | | |

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| A4798 | Continued From page 1<br>documentation staff obtained the resident's urinalysis or notified the physician staff were unable to obtain the urinalysis.<br><br>Review of the progress notes, dated 07/01/25 through 07/28/25, did not contain documentation of the residents refusal for a urinalysis. .<br><br>During an interview on 08/29/25 at 12:15 P.M., the administrator said the resident had a physician order in the medical record for a urinalysis to be obtained, dated 07/04/25, but he/she did not see any additional documentation regarding the urinalysis. He/She said the resident had discharged to the hospital on 07/21/25. The administrator said the Director of Nursing (DON) is responsible to ensure physician's orders are followed to include urinalysis orders.<br><br>During an interview on 08/29/25 at 1:19 P.M., the DON said the resident discharged to the hospital on 07/21/25. The DON said the resident had been experiencing increased confusion, aggression and resistance to care for several weeks prior to discharge. The DON said there was a physician order received on 07/04/25 to get an urinalysis due to increases in aggression and confusion which was not obtained. He/She said the staff did not document why the physician order was not followed to obtain urine for testing, and he/she said staff did not document any follow up with the physician about the urinalysis request. The DON said he/she was unsure what caused the failure to follow the physician order and said he/she would need to investigate what had occurred. He/She said the facility had started with a new laboratory on 07/01/25 and he/she would need to investigate if that change impacted any processing of following the | A4798 | | |

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| A4798 | Continued From page 2<br>physician order to obtain the urinalysis. He/She said he/she is responsible to make sure staff follow physician's orders to include urinalysis ordered. The DON said he/she believes this one "got missed" because they had switched laboratory's.<br><br>During an interview on 08/29/25 at 2:08 P.M., Licensed Practical Nurse (LPN) A said he/she did not follow the physician order to obtain the urine ordered on 07/04/25 because of the resident's resistance to care and confusion after a couple attempts he/she did not try again. He/She said he did not follow up on attempts. LPN A said he/she did not consider sending the resident out for the testing of urine. He/She said when the resident was admitted to the hospital on 07/21/25, the resident was diagnosed with a urinary tract infection. LPN A said he/she did not document the attempts to collect the urinalysis and did not reach out to the physician. He/She said said he/she did not attempt to send him/her out because he/she did not feel like the behaviors were related to a urinary tract infection.<br><br>*Higher class is merited due to the extent of the violation.<br><br>MO00257864 | A4798 | | |

Lindsey Teel - Administrator 9/26/25

# PLAN OF CORRECTION

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| **Provider/Supplier Name:** | Colony Pointe Assisted Living by Americare |
| **Street Address, City, Zip:** | 1510 Chapel Hill Rd, Columbia, MO 65203 |
| **Date of Survey:** | 08/29/2025 |

| PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 28191 |
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| A4798 | In response to 19CSR 30-86.047 (47)(A) Physician Orders<br><br>**Immediate Action:**<br>Director of Nursing, Licensed Nurses and Nursing Care staff will be in-serviced on the following policies and procedures:<br><br>1. Physician Orders<br>2. **Physicians Communication Follow up Protocol**<br>• Including steps to take when a resident refuse or cannot follow physician orders<br>3. Change of Condition<br>• Including immediately notifying Director of Nursing or supervising licensed nurse, the resident's physician and responsible party of the change of condition.<br>Administrator will complete in-servicing with all nursing staff on or before 10/3/2025.<br><br>Director of Nursing conducted review of all resident's physician orders to assure all orders are current and followed as directed by the physician.<br><br>All new orders received will be added to the 24-hour Nursing Communication log and reviewed in the morning meeting to assure orders are followed and completed. If unable to complete or follow orders the Director of Nursing or designee in absence of will communicate and advise residents physician to obtain additional orders.<br><br>**Ongoing Compliance:**<br><br>Director of Nursing or designee in absence of will assure ongoing compliance through adding all new orders to 24-hour Nursing Communication Log and reviewing the log at each morning during stand-up meeting to assure orders added to ISP if indicated and are completed as ordered as well as any identified change of condition is addressed with the resident's physician and responsible party. If for any reason staff are | 10/03/2025 |

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| | unable to follow the physicians order the Director of Nurses or other licensed nurse in absence of will notify the physician and responsible party for further directives, and document in the residents chart the notification and further orders received.<br><br>Areas of non-compliance will be addressed immediately and staff will receive additional training and additional interventions may be added to assure ongoing compliance.<br><br>Compliance Date: 10/3/2025 | |
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**The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.**