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
	18030C	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ST CHARLES ASSISTED LIVING APART	45 HONEY LOCUST LANE SAINT CHARLES, MO 63303

(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
A4817	19 CSR 30-86.047(51)(A)(1) Schedule II Meds-Reconcile Each Shift, Record Records shall be maintained upon receipt and disposition of all controlled substances and shall be maintained separately from other records, for two (2) years. (A) Inventories of controlled substances shall be reconciled as follows: 1. Controlled Substance Schedule II medications shall be reconciled each shift; II This regulation is not met as evidenced by: Class II Based on record review and interview, the facility failed to ensure inventories of Schedule II controlled substances (medications which have a high potential for addiction and abuse) were reconciled each shift when staff failed to sign the Controlled Substance Shift Change Count log every change of shift for four of seven sampled residents (Residents #1, #2, #3, and #4) over a three month period. The facility census was 22. 1. Review on 2/2/23 of the Controlled Substance Shift Change Count log showed the following for November, 2022: - The form design included sign on/sign off staff initials for three 8-hour shifts per day to show counts were completed; - Shift changes documented on this form were scheduled at 7:00 A.M., 3:00 P.M., and 11:00 P.M.; - No initials for oncoming staff at 7:00 A.M. on 11/11/22; - No initials for off-going staff at 7:00 A.M. on 11/7/22 and 11/23/22;	A4817		

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
	18030C	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ST CHARLES ASSISTED LIVING APART	45 HONEY LOCUST LANE SAINT CHARLES, MO 63303

(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
A4817	Continued From page 1 - No initials for oncoming staff at 3:00 P.M. on 11/8/22 and 11/11/22; - No initials for off-going staff at 3:00 P.M. on 11/11/22, 11/26/22, and 11/30/22; - No initials for oncoming staff at 11:00 P.M. on 11/10/22 and 11/30/22; and - No initials for off-going staff at 11:00 P.M. on 11/8/22, 11/11/22, 11/25/22, and 11/30/22. Review on 2/2/23 of the Controlled Substance Shift Change Count log showed the following for December, 2022: - No initials for oncoming staff at 7:00 A.M. on 12/9/22; - No initials for off-going staff at 7:00 A.M. on 12/25/22; - No initials for oncoming staff at 3:00 P.M. on 12/8/22, 12/24/22, and 12/29/22; - No initials for off-going staff at 3:00 P.M. on 12/9/22; - No initials for oncoming staff at 11:00 P.M. on 12/24/22 and 12/25/22; - No initials for off-going staff at 11:00 P.M. on 12/8/22, 12/17/22, and 12/24/22. Review on 2/2/23 of the Controlled Substance Shift Change Count log showed the following for January, 2023: - No initials for off-going staff at 7:00 A.M. on 1/18/23 and 1/19/23; - No initials for oncoming staff at 3:00 P.M. on 1/4/23, 1/5/23, 1/11/23, 1/15/23, 1/18/23, and 1/21/23; - No initials for off-going staff at 3:00 P.M. on 1/11/23; - No initials for oncoming staff at 11:00 P.M. on 1/18/23 and 1/27/23; and - No initials for off-going staff at 11:00 P.M. on 1/4/23, 1/5/23, 1/11/23, 1/15/23, 1/18/23, 1/20/23, and 1/21/23.	A4817		

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
	18030C	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ST CHARLES ASSISTED LIVING APART	45 HONEY LOCUST LANE SAINT CHARLES, MO 63303

(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
A4817	Continued From page 2 2. Review of resident records showed there were four residents whose Schedule II controlled medications were documented in the physician order sheets and the controlled substance logs. 3. Review of Resident #1's face sheet and records showed the following: - The resident was admitted to the facility on 4/16/20; - The resident's diagnoses included cellulitis of the lower limb (infection and inflammation in the skin of the leg), malignant neoplasm of breast (cancer of the breast), osteoarthritis (inflammation and pain in bones and joints), and pain. Review of the resident's physician orders for 1/25/23 through 2/7/23 showed the following: - An order for 5 milligrams (mg) of hydrocodone (a Class II controlled medication used to control pain with a high potential for addiction and abuse) administered in a tablet with 325 mg of acetaminophen (a non-addictive medication to control pain), to be administered every 4 hours by mouth as needed (PRN); - On 1/31/23, the resident's physician changed this order to be administered every 8 hours by mouth PRN. 4. Review of Resident #2's face sheet and records showed the following: -The resident was admitted to the facility on 12/21/20; -The resident's diagnoses included acute gout (painful inflammation of the foot and toes), hip pain, and abdominal paint. Review of the resident's physician orders for 11/8/22 through 1/7/23 showed the following:	A4817		

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
	18030C	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ST CHARLES ASSISTED LIVING APART	45 HONEY LOCUST LANE SAINT CHARLES, MO 63303

(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
A4817	Continued From page 3 - An order for 0.25 milliliters (ml) of morphine sulfate (liquid form of a Class II controlled medication used to control pain with a high potential for addiction and abuse), to be administered by mouth every 4 hours PRN for pain; and - An order for 5 mg of hydrocodone to be administered in a tablet with 325 mg of acetaminophen by mouth every 8 hours PRN for pain. 5. Review of Resident #3's face sheet and records showed the following: -The resident was admitted on 12/23/21; -The resident's diagnoses included chronic shoulder pain. Review of the resident's physician orders for 11/8/22 through 12/7/22 showed the following: - n order for 5 mg of hydrocodone to be administered in a tablet with 325 mg of acetaminophen by mouth three times per day at 6 A.M., 2:00 P.M., and bedtime; -The order was changed on 11/22/22 to a dosage of 10 mg of hydrocodone and 325 mg of acetaminophen to be administered by mouth three times per day. Review of the resident's physician orders for 12/8/22 through 1/7/23 showed the following: -The order for 10 mg of hydrocodone and 325 mg of acetaminophen three times per day was discontinued on 12/20/22; -An order for 5 mg of oxycodone (a Class II controlled medication used to control pain with a high potential for addiction and abuse) to be administered in a tablet with 325 mg of acetaminophen by mouth three times per day at 6:00 A.M., 1:00 P.M., and bedtime.	A4817		

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
	18030C	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ST CHARLES ASSISTED LIVING APART	45 HONEY LOCUST LANE SAINT CHARLES, MO 63303

(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
A4817	Continued From page 4 Review of the resident's physician orders for 1/8/23 through 2/7/23 showed the order for 5 mg of oxycodone and 325 mg of acetaminophen was changed to 7.5 mg of oxycodone with 325 mg of acetaminophen on 1/24/23. 6. Review of Resident #4's face sheet showed the following: - The resident was admitted on 6/5/21; - The resident's diagnoses included low back pain. Review of the resident's physician orders for 11/8/22 through 2/7/23 showed an order for hydrocodone 5 mg to be administered in a tablet with 325 mg of acetaminophen by mouth at bedtime. 7. During interview on 2/2/23 at 2:12 P.M., the director of nursing (DON) said the following: - The director of nursing expected certified staff to perform and document a count of all controlled medications at the change of each shift; - There was no process in place to audit the completion of the Controlled Substance Shift Change Count log by certified staff. During interview on 2/2/23 at 2:12 P.M., the administrator said that she would expect certified staff to perform and document a count of all controlled medications at the change of each shift.	A4817		

PLAN OF CORRECTION

Provider/Supplier Name:	Lake St Charles Assisted Living Apartments
Street Address, City, Zip:	45 Honey Locust Lane Saint Charles, MO 63303
Date of Survey:	2/2/2023

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4817	Due to the regulation not being met because facility did not ensure inventories of Schedule 11 controlled substances were not signed off according to facility policy, the facility plans to correct this situation by: 1. The nursing managers will conduct an all-nursing staff in-service specifically regarding Controlled Medication Protocols (**see attached in-service**). The in-service will discuss what controlled medications are, control medication tracking systems, and discuss specific count sheets, log sheets, and shift change records regarding controlled medications. Each nursing assistant will sign that they understand the Controlled Medications Protocols	2/28/2023
A4817	2. The nursing managers will review the Controlled medications tracking systems outlined in this in-service weekly for 3 months making sure it continues to go as protocol is set	Ongoing
A4817	3. The nursing managers will review Controlled Medications tracking systems monthly making sure it continues to be correctly documented and maintained	Ongoing