

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Cedar Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 White Columns Drive Rolla, MO 65401	

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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interview and record review, facility staff failed to ensure one resident (Resident #1) out of one sampled resident did not receive a chemical restraint (medications used to sedate or control behavior) as a convenience to treat behaviors. The facility census was 62.</p> <p>The administrator was notified on 04/04/25 of past Non-Compliance which occurred on 03/28/25. Staff immediately suspended Licensed Practical Nurse (LPN) A, assessed the resident for injuries, and notified the required parties and agencies. The administrator immediately in-serviced all staff on medication administration and abuse and neglect policies and procedures. The deficiency was corrected on 03/31/25.</p> <p>1. Review of the facility's policy, Administering Medications, dated 03/07/22, showed medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director Nursing Services.</p> <p>Review of the facility's policy, Policy on Restraints, 04/01/25, showed staff are directed as follows:</p> <ul style="list-style-type: none"> -Residents have the right to be free from chemical and physical restraints; -Chemical Restraint involves using medication, including prescribed, as needed, or over-the-counter drugs, to control a patient's behavior or restrict their movement, when the medication is not a standard treatment for their condition; -In Missouri nursing homes, as part of the Nursing Home Reform Act, chemical restraints are only permissible to treat a resident's medical symptoms and not for convenience or discipline and such use of medication must be documented in the clinical record and ordered by the physician or practitioner. <p>Review of the facility's Investigation Report, dated 03/31/25, showed LPN A admitted to administering 0.25 milliliters (ml) of Lorazepam (medication used to treat anxiety) solution on 03/28/25 to Resident #1 without a physician order or contacting the physician. Staff documented LPN A administered the medication to calm the resident. Review of LPN A's signed statement showed he/she documented the resident was yelling and keeping others awake, so he/she used his/her judgment to administer 0.25 ml of Lorazepam to calm the resident.</p> <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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Five Day Scheduled Assessment Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/21/25, showed staff assessed the resident as severely cognitively impaired.</p> <p>Review of the resident's Physician Order Summary (POS), dated 03/01/25 through 03/31/25, did not contain a physician order for Lorazepam 0.25 milligram/milliliter (mg/ml) oral concentration.</p> <p>During an interview on 04/01/25 at 9:51 A.M., LPN A said he/she heard Resident #1 yelling, checked on him/her, and an hour later, the resident was still yelling. LPN A said he/she administered a 0.25 dose of Lorazepam to the resident. He/She said the resident had a scheduled order for Lorazepam, but he/she gave the resident an additional dose. He/She took the medication from Resident #2. He/She said staff are directed to call the physician to get an order for a medication if a resident had behaviors. He/She did not contact the physician for an order because there was a sign in the facility, not to contact the physician after 7:00 P.M. unless it was an emergent situation. He/She took it upon himself/herself to administer the medication. He/She said nurses were not allowed to administer medications without a physician order. He/She did not document the administration of the Lorazepam in the resident's medical record.</p> <p>During an interview on 04/01/25 at 1:27 P.M., the Director of Nursing (DON) said staff are not allowed to administer medications due to behaviors without an order. He/She said staff were directed to contact the physician to obtain orders before administering medications to a resident without an order. He/She said it would be considered a chemical restraint to administer Lorazepam for behaviors.</p> <p>During an interview on 04/01/25 at 1:28 A.M., the administrator said administering medications to residents because of behaviors would be considered a chemical restraint.</p> <p>MO00252040</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, interview, and record review, facility staff failed to provide services to meet professional standards when staff failed to document the controlled substance administered for one resident (Resident #2) and failed to complete shiftily controlled drug counts on the memory care unit. The facility census was 62.</p> <p>1. Review of the facility's policy, Narcotics Count Change of Shift Policy dated 01/04/23, showed staff are directed as follows:</p> <p>-Narcotics must be counted with the Nurse/Certified Medical Technician (CMT) at the change of shift. The Nurse/CMT must count the total number of cards/packages and note total on count sheet. Each card/package must be counted to ensure that the total number of narcotics is accurate and matches the total number of narcotics in the card/package. The Nurse/CMT arriving for their shift and leaving their shift must initial the change of shift count sheet;</p> <p>-If any discrepancies are noted at change of shift Nurse/CMT is to notify Director of Nursing (DON) or Nursing Management immediately.</p> <p>Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/02/25, showed staff assessed the resident as:</p> <p>-Severely cognitively impaired;</p> <p>-Diagnosis of anxiety;</p> <p>-Received an anti-anxiety medication.</p> <p>Review of the resident's Physician Order Sheets (POS), undated, showed a physician order for Lorazepam two milligram/milliliter (mg/ml) oral concentration administer 0.25/1 ml sublingually (underneath tongue) every four hours.</p> <p>Review of the resident's Lorazepam's Count form, dated 03/31/25, showed staff documented 10.50 ml Lorazepam remained.</p> <p>Observation on 04/01/25 at 11:16 A.M., showed the resident's Lorazepam bottle contained 8.50 ml in the bottle.</p> <p>Review of the facility's Controlled Substance Shift Change Form, dated 03/01/25 through 03/31/25, showed:</p> <p>-03/04/25-03/05/25, one staff signature for the 6:00 A.M. and 6:00 P.M. shift;</p> <p>-03/06/25, did not contain staff signatures for the 6:00 A.M. or 6:00 P.M. shift;</p> <p>-03/07/25, one staff signature for the 6:00 A.M. and 6:00 P.M. shift;</p> <p>-03/10/25, one staff signature for the 6:00 P.M. shift;</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-03/11/25, did not contain staff signatures for 6:00 A.M. shift;</p> <p>-03/12/25-03/14/25, did not contact staff signatures for the 6:00 A.M. or 6:00 P.M. shift;</p> <p>-03/15/25, one staff signature for the 6:00 A.M. and 6:00 P.M. shift;</p> <p>-03/16/25, did not contain staff signature for the 6:00 A.M. shift;</p> <p>-03/17/25, one staff signature for the 6:00 P.M. shift;</p> <p>-03/18/25, one staff signature for the 6:00 P.M. shift;</p> <p>-03/19/25, did not contain staff signatures for the 6:00 A.M. or 6:00 P.M. shift;</p> <p>-03/20/25, one staff signature for the 6:00 P.M. shift;</p> <p>-03/24/25, one staff signature for the 6:00 P.M. shift;</p> <p>-03/25/25, one staff signature for the 6:00 A.M. shift;</p> <p>-03/26/25, one staff signature for the 6:00 A.M., shift;</p> <p>-03/27/25 - 03/30/25, one staff signature for the 6:00 A.M. and 6:00 P.M. shift;</p> <p>-04/01/25, did not contain staff signatures for the 6:00 A.M. or 6:00 P.M. shift.</p> <p>During an interview on 04/01/25 at 10:10 A.M., CMT B said narcotic medications are counted each shift by two nurses.</p> <p>During an interview on 04/01/25 at 1:27 P.M., the DON said staff are directed to count narcotics at the end of the each shift or nurse change by two staff members. The DON said he/she was responsible to ensure the narcotic medications were counted and documented, but he/she had been busy with other responsibilities and was not told there was an issue.</p> <p>During an interview on 04/01/25 at 1:28 P.M., the administrator said two staff members should count the narcotic medications at the beginning and end of each shift and document they completed the task.</p> <p>MO00252040</p>		