STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265864	A. Building B. Wing	12/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Independence	19200 E 37th Terrace S Independence, MO 64057

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on observation, interview and record review, the facility failed to ensure a controlled drug (medications that fall under the US Drug Enforcement Agency (DEA) of Schedules II through V, having a potential for abuse ranging from low to high and the potential to lead to physical or psychological dependence) card of 30 pills was accounted for and locked up and immediately reported as missing after documenting delivery of the medication from the pharmacy for one sampled resident (Resident #1) out of three sampled residents who received controlled medications. The facility census was 37 residents. On 12/26/23 the Administrator was notified of the past noncompliance which took place between 11/29/23 and ended on 12/2/23 when the facility discovered the resident's card of 30 oxycodone tablets, delivered by pharmacy on 11/29/23 were missing. On 12/2/23 one employee suspected of taking the resident's narcotic medication was suspended. Nurses were educated on 12/2/23 on expectations related to documentation and procedures related to controlled medications, ensuring medications were accounted for, and contacting the pharmacy to ensure residents had medications as ordered. The deficiency was corrected on 12/2/23. Review of the facility's Medication Storage policy, implemented 7/2021 and revised 6/2023 showed: Narcotics (opioids - opium, opium derivatives and semi-synthetic compounds resembling opium) and Controlled Substances will be stored under double lock and key, including: -Schedule II drugs (narcotics/opioids - drugs having a high potential for abuse which may lead to severe psychological or physical dependence). -Back up stock of: --Schedule IV medications (drugs having a low potential for abuse relative to substances in Schedule III medications). -Any discrepancies which cannot be resolved must be immediately reported as follows: --Notify the Director of Nursing (DON), charge nurse or designee and the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Complete an incident report detailing the discrepancy, steps taken to resolve it, and names of all licensed staff working when the discrepancy was noted. --The DON, charge nurse or designee must also report any loss of controlled substances where theft is suspected to appropriate authorities such as law enforcement, Department of Health and Senior Services (DHSS) and any other applicable agency. -Staff may not leave the area until discrepancies are reported as unresolved discrepancies. 1. Review of Resident #1's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 11/28/23 showed the resident was admitted to the facility on [DATE]. Review of the resident's Physician Order Report dated 11/28/23 through 12/2/23 showed the resident was prescribed: -Oxycodone (generic for OxyContin) - Schedule II oral tablet (a semi-synthetic narcotic/opioid used as an analgesic (pain reliever), 5 milligrams (mg). One to two tablets every four hours pro re nata (PRN - as needed) for pain starting 11/28/23. -Tramadol - Schedule IV oral tablet (an opioid/narcotic used as an analgesic), 50 mg. One tablet every six hours PRN for pain control starting 11/28/23. Review of the resident's Medication Administration Record (MAR), dated 11/28/23 through 12/2/23 showed: -Oxycodone - Schedule II oral tablet, 5 mg. One to two tablets every four hours PRN for pain starting 11/28/23. -The resident did not receive oxycodone PRN from 11/28/23 through 12/2/23. Review of the resident's progress notes from 11/28/23 through 12/2/23 showed: -A physician note, dated 11/29/23 showed a list of the resident's medications to include oxycodone 5 mg every four hours PRN. One to two tablets orally for pain starting 11/28/23. -A Nurse Practitioner (NP) note, dated 12/1/23 showed a list of the resident's medications to include oxycodone 5 mg every four hours PRN. One to two tablets orally for pain starting 11/28/23. -There were no other progress notes mentioning oxycodone and no progress notes showed oxycodone was not available at the facility as ordered for the resident during the 11/28/23 through 12/2/23 admission. Review of the resident's Discharge MDS, dated [DATE] showed the resident: -Was cognitively intact. -Had occasional pain and took pain medication(s). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had not received opioid medications during the 11/28/23 through 12/2/23 stay. Review of the resident's Facility Investigation Report, dated 12/2/23 showed the following summary: -On 12/2/23 at 3:12 A.M. Licensed Practical Nurse (LPN) A texted the DON and reported a missing card of oxycodone 5 mg, quantity 30 for Resident #1. LPN A reported he/she looked in both medication carts and called the pharmacy. -The DON saw the text on 12/2/23 at 4:46 A.M. and called LPN A who reported that Pharmacy informed him/her the medication had been delivered at approximately 6:00 P.M. on 11/29/23 and the Unit Manager, a Registered Nurse (RN) signed off for the medication. The DON asked LPN B to send a copy of the Controlled Medication Card Inventory sheet which LPN B completed. -The DON noted the resident's oxycodone had not been added to the Controlled Medication Card Count sheet. -The DON reviewed camera footage from 11/29/23 which showed: --The Unit Manager signed in the narcotics from the pharmacy at 6:41 P.M. and was seen giving LPN B five narcotic cards. --At 6:42 P.M. LPN B took the medication cards to the medication cart. --At 6:42:47 P.M. LPN B opened the narcotic box and placed one card in the box. --At 6:43:25 P.M. LPN B put a second medication card in the box. --LPN B then grabbed the narcotic book, slid a narcotic card under the book and walked to the side of the medication cart. LPN B bent down out of camera view and appeared to pull the trash with the narcotic box open. --At 6:44:18 P.M. LPN B returned to the front of the medication cart. --At 6:44:29 P.M. LPN B added a narcotic medication card to the narcotic box and at 6:44:44 P.M. LPN B added another narcotic medication card for a total of four cards added to the narcotic drawer box. --At 6:45 P.M. LPN B and RN B counted the narcotic box drawer. After the two finished counting, they walked to the nurses' station where LPN B before exiting the building at 6:49 P.M. -On 12/2/23: --A call was placed at 5:41 A.M. to the Administrator, informing him/her of the missing oxycodone. --The DON arrived at the building at 5:45 A.M. to suspend LPN B pending investigation. --LPN B called the DON at 6:36 A.M. to inform the DON he/she would be late. The DON informed LPN B he/she was not to report to work as he/she was suspended pending investigation. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--The DON called the local police department at 8:38 A.M. and filed a report. The on-call Nurse Practitioner (NP) was notified at 8:40 A.M. of the resident's missing narcotic. --At 9:08 A.M. the resident was notified of the missing narcotic and pharmacy was notified the medication needed to be refilled at facility cost. An authorization form was sent to the pharmacy and a replacement card of oxycodone arrived at the facility on 12/2/23 at 6:05 P.M. Review of supporting documentation in the facility investigation, dated 12/2/23 showed: -A Pharmacy Delivery Receipt, dated 11/29/23 which showed five controlled medications were delivered to the facility the evening of 11/29/23 and signed for by the Unit Manager. Two of the controlled drugs were for the resident and included a card of Oxycodone Immediate Release, 5 mg containing 30 tablets and a card of Tramadol HCL, 50 mg containing 20 tablets. -The Controlled Medication Card Inventory sheet with dates ranging from 11/25/23 through 11/30/23 showed LPN B's initial on 11/29/23 documenting he/she added + 4 to indicate four controlled medication cards had been added to the controlled medication box. The names of the medications added and the names of the residents whose cards were being added were not documented on the Controlled Medication Card Inventory sheet for the evening of 11/29/23 as they were on other dates. -The Controlled Medication Count for November, 2023 was signed by the off-going nurse, LPN B and on-coming agency nurse, RN A. -Documentation of authorization for replacement of the resident's Oxycodone Immediate Release 5 mg tablets, 30 count was signed 12/2/23. -Documentation of education by the DON with facility nurses on 12/2/23 related to procedures for identifying and reporting missing narcotics included who needed to be notified and when. -Documentation of education by the DON with facility nurses on 12/2/23 related to procedures for adding and subtracting controlled medication cards on the count sheet, including documenting the medication added or subtracted and the resident's name; procedures for totaling the controlled medications to ensure accuracy and clarity and what to do when there were discrepancies or errors. Observation on 12/21/23 of two video recordings showing the nursing station and medication cart from different angles on 11/28/23 between 6:40 P.M. and 6:45 P.M. showed: -RN A set five objects the size of medication cards one at a time in front of LPN B. -LPN B took the five medication cards or objects directly to the medication cart. -LPN B looked frequently in the direction of the Unit Manager and RN A while he/she was at the medication cart. The Unit Manager and RN A were not at the medication cart when LPN B put what appeared to be two medication cards in the narcotic box. -The objects LPN B placed in the narcotic box were the size of medication cards; however, due to the video being fuzzy no details such as the pill shapes or writing could be seen. The video was clear enough that staff members could be identified. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One object the size of a medication card was observed placed by LPN B under the narcotic count book and was taken out of camera sight to the side of the medication cart. When LPN B was back in front of the medication cart what looked like two additional cards were placed into the narcotic drawer for a total of four cards. LPN B did not put what looked like a fifth medication card into the controlled drug medication drawer. During interview on 12/21/23 at 12:15 P.M. LPN A said: -The resident had been at the facility a number of times. He/She knew from his/her first admission the resident liked to have his/her oxycodone at bedtime. He/She noticed the evening of 2/1/23 the resident did not have his/her oxycodone in the medication cart, but had a physician order for it. He/She thought the drug should have been at the facility from the pharmacy by then. -The resident's oxycodone did not come when pharmacy made their early morning delivery on 12/2/23 between 2:00 A.M. and 3:00 A.M. so he/she called the pharmacy and was told they had already delivered the resident's medication the evening of 11/29/23. -He/She had been off for a few days and thought the medication might have been misplaced. He/She looked on the medication cart for the other hall in case it had been placed there by mistake, but did not find it. -He/She texted the DON on 12/2/23 around 3:12 A.M. -The resident had an order for Tramadol PRN and had that medication available. -The evening of 2/1/23 he/she asked the resident if he/she wanted Tramadol and the resident said yes. The resident never asked for his/her oxycodone the evening of 12/1/23 or morning of 12/2/23. During an interview on 12/21/23 at 12:57 P.M. the Unit Manager said: -He/She remembered signing for medications on 11/29/23 around 6:30 P.M. -LPN B came to the nurses' desk and he/she (the Unit Manager) separated the cards for the hall LPN B was working and gave them to LPN B. He/She gave the rest of the medication cards to the nurse working the other hall. -LPN B was staying over until Agency Nurse RN A could get there. -The DON called him/her in the middle of the night right after talking to LPN A and asked if he/she remembered signing in the resident's medications. He/She told the DON there had been a number of medication cards delivered and he/she didn't know if the resident's was one of them. He/She was told there was an oxycodone, 5 mg card of 30 tablets missing. The DON could pull up the facility's video surveillance on his/her phone. -He/She (the Unit Manager) also watched the video coverage himself/herself which showed he/she had a stack of medication cards. The footage showed he/she handed LPN B five medication cards. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-In the video it showed LPN B opening his/her narcotic drawer and putting first one, then two medication cards in. -LPN B then picked up the narcotic count book with both hands and went to the side of his/her medication cart, disappearing from view and then messed with the trash bag from the treatment cart. Then LPN B put two more medication cards into the medication cart narcotic drawer, but he/she never put the fifth medication card in the narcotic drawer. -When LPN B documented +4 on the Controlled Medication Card Inventory sheet for the evening of 11/29/23, he/she never put the names of the residents who got newly delivered medication cards or the drugs that were delivered. He/She was supposed to write the resident's name, what drug was delivered, how many cards were delivered and also document if medication cards were being taken out of the narcotic drawer, what medication was taken out and for what resident. -Whatever medication cards are signed in as received from pharmacy and what is documented as being added to the Controlled Medication Card Inventory sheet should match. -The off-going and on-coming nurses count the number of medication cards together and do a narcotic count to make sure the correct number of pills are accounted for. During an interview on 12/21/23 at 1:30 P.M. the DON said: -The resident had three different admissions to the facility within the past few months. -The resident's oxycodone card was probably missed because the resident may not have asked for the medication. -The surveillance videos showed the Unit Manager counting the medication cards with the pharmacy employee. One video view showed the pharmacy employee leaving the nurses' station. -The Unit Manager could be seen giving LPN B five medication cards which he/she handed to LPN B one at a time. -LPN B brought the medication cards to the medication cart and flipped through the narcotic book. -First LPN B put one card in the narcotic drawer, then another. -LPN B grabbed a third card and slipped it under the narcotic book and then can be seen pulling trash while the narcotic drawer was still open. -LPN B then added a third and then a fourth medication card to the narcotic drawer. Only four cards were observed going into the medication cart, not five. -LPN B and agency RN A counted the narcotic cards, but since one was not placed in the narcotic drawer and LPN B only documented four added cards the number seemed to match up. -The Controlled Medication Card Inventory sheet did not match up with the pharmacy delivery documentation and they should have matched. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/21/23 at 3:09 P.M. LPN B said: -He/She counted medication cards with the Unit Manager before taking the cards to the medication cart. He/She couldn't remember how many he/she had been given, but thought it was two or three medication cards. -He/She put whatever was given to him/her by the Unit Manager into the narcotic drawer box. -He/She couldn't remember what number of medication cards he/she wrote down on the Controlled Medication Card Inventory sheet or the name of the residents who received the new medication cards. -The only time he/she was aware of he/she went out of camera view was when he/she changed out the medication cart trash bag. -He/She didn't think he/she would have touched the trash with the medication drawer open. -He/She couldn't remember whose medications he/she put in the narcotic medication drawer. -He/She didn't take any resident medication cards or any resident medication. -Whatever medication cards he/she was given by the Unit Manager would have been put into the narcotic medication drawer. If he/she had been given five cards, five cards would have gone into the drawer. During an interview on 12/21/23 at 3:30 P.M. with the Administrator and the DON, the DON said: -Off-going and on-coming staff were expected to count the medication cards and narcotic count sheets together. The Controlled Medication Card Inventory should match the pharmacy receipt description of medications delivered for incoming cards. Medications and resident names should be clearly documented on the forms. Staff were re-educated on 12/2/23 related to protocol. -If the resident had orders for a medication by 3:00 P.M. pharmacy should bring the medication by their early morning medication run. Medications should be delivered by pharmacy no later than within 24 hours of an order. -Staff have been educated to call the pharmacy and let the DON know if the medications are not at the facility within 24 hours. If a resident needs a medication before that time it can be taken from their automated medication dispensing system. MO00228231