STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265647	A. BUILDING _____ B. WING _____	07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN REHAB AND HEALTHCARE CENTER	3001 EAST ELM HARRISONVILLE, MO 64701

(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) COMPLETION DATE
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

X [signature] Admin 9/5/23

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.

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F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		9/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/05/2023

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the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview, and record review, the facility failed to ensure one sampled resident (Resident #64) had a code status upon admission out of 18 sampled residents. The facility census was 88 residents.

Review of the facility's policy, " Advance Directives," dated October 24, 2022 showed:
-The Facility would respect a resident's advance directive and would comply with the resident's wishes expressed in an advance directive.
-Upon admission, the Admission Staff or designee would obtain a copy of a resident's advance directive.
-A copy of the resident's advance directive would have been included in the resident's medical record.
-If the resident did not have an Advance Directive, the Facility would have provided the resident and/or resident's next of kin with information about advance directives upon request.
-An Advance Directive was defined as a resident's written preference regarding treatment options.
-Upon admission, the Admission Staff or designee would have provided written information to the resident concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.
-During the Social Services Assessment process, the Director of Social Services or designee would have also asked the resident whether he or she had a written advance directive, including whether

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the resident had requested or was in possession of an aid-in-dying drug.
-If the resident had an Advance Directive, the Facility would obtain a copy of the document and place it in the resident's medical record.
-If the resident did not wish to complete the Missouri Advance Directive, the Admissions Staff or designee would have notified the Administrator for further review.
-If the resident did not have an Advance Directive, the Admissions Staff or designee would have informed the resident that the Facility could have provided the resident with a copy of the Advance Directive form.

1. Review of Resident #64's face sheet showed he/she had been re-admitted to the facility on 7/8/23 with the following diagnoses:
-Cognitive communication deficit (when a person has difficulty communicating because of injury to the brain that controls the ability to think).
-Acute respiratory failure (an impairment of the gas exchange between the lungs and blood).
-Acute pulmonary edema (a condition caused by excess fluid in the lungs).
-Cardiomegaly (a medical condition in which the heart becomes enlarged that make it work harder).
-Acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood).

Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by the facility staff for care planning) dated 5/29/23 showed his/her Brief Interview for Mental Status (BIMS) score was 15 out of 15 indicating he/she was cognitively intact.

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F 578	Continued From page 3	F 578		

Review of the resident's medical record on 7/18/23 at 1:00 P.M. showed:
-The face sheet did not show a code status.
-The Physician's Order Sheet (POS) did not show a code status.
-The care plan did not show a code status.
-The Admission assessment showed the resident was a full code, dated 7/11/23.

During an interview on 7/19/23 at 9:40 A.M. Licensed Practical Nurse (LPN) C said:
-A resident's code status should have been in the electronic chart.
-The code status should have been on the face sheet.
-The code status should have been on the POS.
-The code status should have been on the resident's care plan.
-The resident did not have a code status on the face sheet, POS, or the care plan.
-The nurse who admitted the resident was responsible for ensuring the code status was done on admission.
-Medical Records checked that the resident's code status was obtained before scanning it into the resident's chart.
-The resident's code status should have been on the face sheet, POS, and care plan the same day the resident had been admitted.

During an interview on 7/19/23 at 10:00 A.M. the Medical Records Director said:
-The code status should be on the resident's chart within 24 hours of admission, ideally the same day they had been admitted.
-Upon admission the nurse who admitted the resident should obtain the code status.
-The code status should have been on the face sheet, care plan, or POS.

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F 578	Continued From page 4 -It was not done. -The resident was a full code (initiate life saving maneuvers if his/her heart stopped). -If there was no Do Not Resuscitate (DNR - do not start life saving maneuvers if the heart stopped) papers signed so the resident was a full code. -The code status for this resident fell through the crack. -The paperwork from the hospital that the resident came from showed he/she was a full code. -The code status should be verified upon admission with the resident if they were their own person or verified with the resident's guardian. -The resident was his/her own person and should have been asked what they wished to do for a code status. -It was his/her responsibility to ensure it was in the resident's medical record. During an interview on 7/21/23 at 12:25 P.M. the Director of Nursing (DON) said: -A resident's Advanced Directives should have been obtained upon admission. -The admission nurse or the charge nurse were responsible for obtaining the code status for new admissions. -They go over new admissions in the morning Department Head meetings and it should have been caught there if it was missed. -The resident should have had a physician's order for advanced directives on the resident's face sheet, POS and care plan.	F 578		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		9/4/23

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F 657	Continued From page 5 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to reassess the effectiveness of individualized resident care and interventions by not reviewing and revising resident care plans (a document that specified health care and supported needs and outlined how the facility met resident requirements) for one sampled resident (Resident #23) out of 18 sampled residents. The facility census was 88 residents. Review of the facility's Care Planning policy,	F 657		

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F 657	Continued From page 6	F 657		

dated 10/24/22, showed:
-The purpose of the policy was to ensure a comprehensive person-centered care plan was developed for each resident based on their individual needs.
-The care plan served to help the resident move toward resident-specific goals which addressed the resident's medical, nursing, mental and psychosocial needs.
-The care plan was updated as indicated for changes in condition, onset of new problems, and resolution of current problems and as deemed appropriate.
-Changes may be made to the care plan on an ongoing basis for the duration of the resident's stay.

1. Review of Resident #23's face sheet, undated, showed the resident had the following diagnoses:
-Senile degeneration of the brain (a decrease in the ability to think, concentrate, or remember), cognitive communication deficit (an impairment in thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and anxiety (mental condition characterized by excessive fear or apprehension about real or perceived threats, leading to altered behavior).

Review of the resident's annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 1/10/23 showed:
-The resident scored a zero on the Brief Interview for Mental Status (BIMS an assessment tool that shows a score between 0 and 15 which shows the resident's mental status. This tool helps determine the resident's attention, orientation and ability to register and recall new information.

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F 657	Continued From page 7	F 657		

These items were crucial factors in care planning decisions).
-This indicated the resident was severely cognitively impaired.

Review of the resident's care plan, most recently dated 2/28/23, showed:
-The resident had a history of low back pain with potential for increase.
--The goal: The resident verbalized relief from pain.
-The resident was admitted to the facility for specialized care.
--The goal: The resident participated in care and decision making.
-The resident had an activities of daily living (ADL) self-care performance deficit.
--The goal: The resident improved current level of functioning.
-The resident had suicidal ideations.
--The goal: The resident identified ways of increasing meaningful relationships by the review date.

Review of the resident's quarterly MDS, dated 7/1/23, showed:
-The resident was totally dependent on staff for bed mobility, transfers, dressing, eating and personal hygiene.
-The resident did not walk.
-The resident was in a Broda chair (a specialized wheel chair that allowed immobile residents the ability to be reclined or tilted).
-The resident was unable to speak.

During an interview on 7/19/23 at 10:29 A.M., Certified Nurse Assistant (CNA) C said:
-He/she checked on the resident every two hours for position and continence.

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-The resident was very contracted (occurs when your muscles, tendons, joints, or other tissues tighten or shorten causing a deformity).
-The resident was non-verbal.
-The resident did groan on occasion.

During an interview on 7/19/23 at 12:04 P.M., CNA A said:
-He/she got the resident up and put him/her to bed and provided cares to the resident.
-The resident was on Hospice (end of life care)
-He/she checked for incontinence and positioning between times of getting the resident up and laying him/her down.
-The resident did not do any activities.
-The resident required total care.

During an interview on 7/19/23 at 2:46 P.M., Licensed Practical Nurse (LPN) B said:
-The resident had incontinence brief changes as needed and checked every two hours for positioning.
-The resident had no way to communicate.

During an interview on 7/21/23 at 8:47 A.M., the MDS coordinator said:
-The computer program provided pop-up messages when a care plan was due.
-The resident's care plan was last updated on 7/3/23.
-He/she had not revised the section regarding the resident's contractures.
-Last time he/she went through the assessment the resident was more mobile.
-ADL's were updated 7/20/23
-He/she had not removed the section regarding the resident was combative.
-He/she was aware the resident was full assist on all ADL's.

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F 657	Continued From page 9 During an interview on 7/21/23 at 12:25 P.M., the Director of Nursing (DON) said: -The charge nurse was responsible for updating care plans. -The resident's decline was gradual but had started a faster decline about six months ago. -It was at that time the resident was moved to the Broda chair. -The resident had contractures since February of 2022. -He/she expected the care plan focus areas, goals and interventions to be updated to reflect decline. -He/she expected to see dates of the updates on the care plan. -There should be dates on all relevant areas of the care plan.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete labs as ordered for one sampled resident (Resident #31) out of five residents sampled for unnecessary medications. The facility census was 88 residents. Review of the facility's laboratory, diagnostic and radiology services policy dated 10/24/22 showed: -The facility was to ensure they provided laboratory services to meet the residents' needs.	F 658		9/4/23

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F 658	Continued From page 10	F 658		

-The facility would coordinate lab services based on orders from an appropriate practitioner.
-The facility was responsible for the timeliness of the lab services.

1. Review of Resident #31's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 5/15/23 showed the following staff assessment of the resident:
-Moderately cognitively impaired.
-Some of his/her diagnoses included anemia (when the red blood cell or hemoglobin is below normal so there aren't enough healthy red blood cells to carry adequate oxygen to the body's tissues), heart failure (condition in which the heart cannot pump enough blood to all parts of the body) , hyperlipidemia (high cholesterol), Alzheimer's disease (a progressive loss of brain cells that leads to memory loss and the decline of other thinking skills), dementia (a progressive mental disorder characterized by memory problems, impaired reasoning and personality changes) and depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life).

Review of the resident's medical records showed the following most recent lab results:
-Vitamin D (contributes to healthy bones, has a role in nerves, muscles, immune system and mental health) dated 11/9/22.
-Comprehensive Metabolic Panel (CMP-a panel of labs that give information regarding the functioning of one's kidney, liver, electrolytes, acid/base balance and blood sugar and blood protein levels) dated 2/8/23.
-Complete Blood Count (CBC-a test that gives information about blood cells) with differential

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F 658	Continued From page 11 (CBCD-gives the percentages of the types of blood cells) dated 2/8/23. -There were no additional Vitamin D, CMP or CBCD labs completed after the above lab results. Review of the resident's July 2023 Physician's Order Sheet (POS) showed the following lab orders: -5/28/23: Vitamin D every six months (should have been done in May 2023). -5/28/23: CMP (should have been done in June 2023) and CBCD (should have been done in June 2023) every four months. During an interview on 7/21/23 at 12:25 P.M. the Director of Nursing (DON) said: -The resident's recurring labs were not done. -They switched labs on 6/7/23. -He/she called the lab within two weeks of switching to check to make sure re-occurring labs were still entered. -He/she was doing an audit to see if all lab orders were in correctly.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nail care for one sampled resident (Resident #83) and failed to respond promptly to one supplemental resident's (Resident #27) call bell/light out of 18 sampled residents. The facility census was 88	F 677		9/4/23

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F 677	Continued From page 12	F 677		

residents.

Review of the facility's policy titled "Communication - Call System" dated 10/24/22 showed:
-The call system was used to provide a mechanism for residents to promptly communicate with nursing staff.
-The facility would provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities.
-Nursing staff should answer call bells promptly.
-When answering a request, nursing staff will return with the item or reply promptly.

Review of the facility's Care and Services policy dated 10/24/22 showed residents were to receive the necessary care and services based on an individualized comprehensive assessment process.

1. Review of Resident #27's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 5/3/23 showed the following staff assessment of the resident:
-Moderately impaired cognitive skills.
-Totally dependent upon one staff for toileting.

Review of the resident's care plan updated 5/4/23 showed:
-The resident had an activities of daily living (ADLs-dressing, grooming, bathing, eating, and toileting) self-care performance deficit related to a fracture.
-The resident was totally dependent on two staff for repositioning and turning in bed as necessary.
-The resident was totally dependent on one to two staff for dressing.

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-The resident was on diuretic therapy (any medication that elevates the rate of urination) related to edema (swelling).

Review of the resident's July 2023 Physician's Order Sheet (POS) showed a physician's order for Furosemide (a diuretic) 40 milligrams (mg), one tablet by mouth one time a day.

Continuous observation on 7/17/23 beginning at 9:24 A.M. showed:
-The resident's call light was on.
-At 9:54 A.M., the resident said he/she had his/her call light on because he/she needed to use the bed pan and he/she was waiting a long time for it.
-At 9:54 A.M., staff entered the resident's room.

Continuous observation on 7/17/23 beginning at 11:48 A.M. showed:
-At 11:48 A.M., the resident's call light was on.
-At 12:15 P.M., the resident's call light was still on and staff entered the resident's room.

Observation on 7/17/23 at 12:25 P.M. showed:
-Staff were not in the resident's room and the resident said he/she still needed the bed pan, they never brought it to him/her and he/she was going to turn his/her call light back on.
-The resident pressed his/her call light pad and it turned on.
-At 12:26 P.M., two staff went into the resident's room.

During an interview on 7/21/23 at 8:56 A.M., Graduate Practical Nurse (GPN) A said:
-The call bells have a station at the nurses' station that light and beep to alert them a call bell is on.

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-He/she was not aware of any issues with time of response to call lights.
-They worked together to get the call lights answered.
-They were not given guidance on how soon they should respond to a call light but he/she preferred they were respond to within 10 minutes or less.

During an interview on 7/21/23 at 9:10 A.M., Certified Nursing Assistant (CNA) D said:
-They tried to respond to the call light as soon as they came on.
-The resident stays in bed.
-They kept the resident's bed pan in his/her bathroom.
-The resident used the call light when he/she needed to use the bed pan.

During an interview on 7/21/23 at 12:25 P.M., the Director of Nursing (DON) said:
-Call light response should be as timely as possible.
-The resident's call light should have been answered in less than 30 minutes.
-He/She would expect staff to return as soon as possible or leave the call light on if the staff were unable to provide what the resident needed.

2. Review of Resident #83's quarterly MDS dated 7/1/23 showed the following staff assessment of the resident:
-Moderately cognitively impaired.
-Had clear speech.
-Usually understood others and was usually understood by others.
-Had no behaviors.
-Did not refuse cares.
-Required extensive assistance with personal hygiene.

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-Did not walk.
-Had impaired range of motion in arms and legs on one side.
-Used a wheelchair.
-Did not have a diagnosis of diabetes (a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).

Observation and interview on 7/20/23 at 11:20 A.M. showed:
-The resident's toe nails were long.
-Licensed Practical Nurse (LPN) D said if the resident doesn't see the podiatrist, he/she should.

Observation and interview on 7/20/23 at 2:33 P.M. showed:
-The resident's toe nails were long, thick and yellow.
-The resident's first through fourth toe nails on his/her right foot were approximately 1/2" long from the top of his/her toe.
-The resident's first toe nail on his/her left foot was about 1/2" long from the top of his/her toe.
-The resident's second toe nail on his/her left foot was about 3/4" long from the top of his/her toe and curved over the top of his/her toe and went down the bottom side of his/her toe.
-The resident said yes when asked if he/she thought his/her toenails were long and needed to be cut.

Review of the resident's medical records showed no podiatry notes for 2023.

Review of the resident's care plan revised 6/11/23 showed:
-The resident had an ADL self-care performance deficit limited mobility.
-Instructions to nursing staff to check the

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F 677	Continued From page 16 resident's nail length and trim and clean on bath day and as necessary and to report any changes to the nurse. During an interview on 7/21/23 at 8:56 A.M., GPN A said: -CNAs normally did nail care. -CNAs would be responsible for nail care since the resident was not diabetic. During an interview on 7/21/23 at 9:10 A.M., CNA A said: -He/she was not sure who was responsible for trimming the resident's toe nails. -He/she thought whoever did the resident's bath would do them at that time. During an interview on 7/20/23 at 1:09 P.M., the Social Services Director said: -He/she had worked at the facility for two months. -The podiatrist had their own list of residents who they were going to see. During an interview on 7/21/23 at 12:25 P.M., the DON said: -Social Services was responsible for podiatry. -They made a list from who Social Services said needed to see the podiatrist as well as the podiatrist maintained a list. -Whenever it was identified that a resident needed to see the podiatrist, they should notify Social Services. -The resident was on hospice (end of life care) so hospice staff could take care of the resident's toe nails as well.	F 677		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		9/4/23

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F 755	Continued From page 17 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the narcotic count sheet was signed by both the on-coming and the off-going nurses to verify the correct count of narcotics. The facility census was 88 residents.	F 755		

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Review of the facility's policy, "Controlled Medication Storage," dated 11/2017 showed:
-Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances were subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations.
-The Director of Nursing (DON) and the consultant pharmacist monitor for compliance with federal and state laws and regulations in the handling of controlled medications.
-The medication nurse on duty maintains possession of the key to the controlled medication storage areas.
-At each shift change or when keys were surrendered, a physical inventory of all Scheduled II, including refrigerated items, was to have been conducted by two licensed nurses and was to have been documented on the controlled substances accountability record for verification of controlled substances count report.
-The nursing care center may elect to have counted all controlled medication at shift change.
-Current controlled medication accountability records were to have been kept in the Medication Administration Record (MAR) or narcotic book.
-When completed, accountability records were to have been submitted to the DON and maintained on file at the nursing center.
-The consultant pharmacist, or pharmacy designee was to have routinely reviewed a sampling audit of the controlled medication storage, records, and expiration dates during the medication storage inspections.

1. Review of the North side Certified Medication Technician's (CMT) medication cart narcotic count sheet on 7/17/23 at 6:07 A.M., showed the

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off going Licensed Practical Nurse (LPN) pre-signed the narcotic count sheet before the day shift CMT came on and counted.

Review of the North side CMT medication cart narcotic count sheet dated 6/1/23 at 6:00 A.M., through 7/20/23 at 6:00 A.M., showed the following number of missing signatures out of the required four signatures a day:
-On 6/4/23 there was one missing signature.
-On 6/5/23 there was one missing signature.
-On 6/6/23 there was one missing signature.
-On 6/7/23 there was one missing signature.
-On 6/9/23 there was one missing signature.
-On 6/30/23 there was one missing signature.
-On 7/2/23 there was one missing signature.

2. Review of the North side Nurses medication cart narcotic count sheet on 7/17/23 at 6:51 A.M., showed the off going LPN pre-signed the narcotic count sheet before the day shift nurse came on and counted.

Review of the North side Nurses medication cart narcotic count sheet dated 5/31/23 at 6:00 A.M., through 7/19/23 at 6:00 A.M., showed the following number of missing signatures out of the required four signatures a day:
-On 5/31/23 there was one missing signature.
-On 6/1/23 there was one missing signature.
-On 6/6/23 there was one missing signature.
-On 6/7/23 there were three missing signatures.
-On 6/9/23 there were two missing signatures.
-On 6/10/23 there was one missing signature.
-On 6/14/23 there was one missing signature.
-On 6/23/23 there was one missing signature.
-On 7/13/23 there was one missing signature.

Review of the North side Nurses medication cart

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narcotic count sheet on 7/19/23 at 9:00 A.M., showed the on-coming LPN pre-signed the narcotic count sheet when he/she came on for the off going shift.
3. Review of the CMT medication cart (100/200 hallway) narcotic count sheet on 7/17/23 at 6:07 A.M., showed:
-The off going LPN pre-signed the narcotic count sheet before the day shift CMT or LPN came on and counted with him/her to verify the count was correct.
-Signing signified all doses were recorded on the MAR, count sheets matched inventory on hand, and package log matched actual package count.
-There were to have been two nurses' signatures per shift, one on coming and one off going.
-There were two shifts per day.
-July 1st to July 17th 2023 the narcotic count log showed.
-12 out of 33 shifts had only one signature.
-One shift out of 33 shifts did not have any signatures.
-Seven out of 33 shifts the number of narcotic packages were blank.

4. Review of the North side Nurses' medication cart, (100/200) narcotic count sheet on 7/17/23 at 6:08 A.M. showed:
-The off going LPN pre-signed the narcotic count sheet before the day shift nurse came on and counted with him/her to verify the count was correct.
-Signing signified all doses were recorded on the MAR, count sheets matched inventory on hand, and package log matched actual package count.
-There were to have been two nurses' signatures per shift, one on coming and one off going.
-There were two shifts per day.
-July 1st to July 17th 2023 the narcotic count log

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showed.
-15 out of 33 shifts had only one signature.
-Five out of 33 shifts did not have any signatures.
-10 out of 33 shifts the number of narcotic packages were blank.

5. Review of the 300/400 hallway CMT cart narcotic count sheet on 7/17/23 at 6:10 A.M. showed:
-The off going LPN pre-signed the narcotic count sheet before the day shift nurse came on and counted with him/her to verify the count was correct.
-Signing signified all doses were recorded on the MAR, count sheets matched inventory on hand, and package log matched actual package count.
-There were to have been two nurses' signatures per shift, one on coming and one off going.
-There were two shifts per day.
-July 1st to July 17th 2023 the narcotic count log showed.
--Four out of 33 shifts had only one signature.

6. During an interview on 7/17/23 at 6:20 A.M. LPN E said:
-No one should have pre signed the narcotic count sheet.
-Two nurses were to have counted the narcotics together and signed when they were done counting confirming the count was correct.
-There should not have been any blank spaces for the signatures or the count of medications.
-The DON was ultimately responsible for ensuring the narcotic count was done correctly.

During an interview on 7/21/23 at 8:49 A.M., LPN A said:
-When he/she comes on shift, he/she would go through report with the off going nurse on

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residents and what needed to be done.
-Signed the narcotic count sheet coming on.
-Counted how many narcotic cards were in drawers of both medication carts and any refrigerated meds with off going nurse.
-Made sure the total number of narcotic cards were accurate and correct on count sheet.
-Would put total amount of narcotic cards on the count sheet add or subtract amount as medication cards are gone or new added from pharmacy.
-The night shift added amount to count sheet when meds came in at night.
-Signed that the count was correct.
-Night nurse signed off when leaving shift that the count was correct.
-Night shift and day shift nurses shouldn't sign before counting they needed to be sure amount of narcotics were correct.
-Anytime exchanging keys with another nurse both should count and sign narcotic count sheet for accuracy then sign the sheet.
-Let the DON and the Assistant Director of Nursing (ADON) know what meds needed to be destroyed and subtract those when meds were gone from cart or refrigerator.

During an interview on 7/21/23 at 12:55 P.M. the DON said:
-Narcotics should have been counted by both the on coming and off going nurses at the same time.
-Both nurses should have signed the narcotic count sheet at the same time.
-The nurses count the number of cards and the number of pills on each card.
-The nurses sign the count sheet verifying the count was correct.
-The nurses should not have signed the sheet before the other shift was there to count with

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F 755	Continued From page 23 them. -If the count was not correct or done correctly the staff would have been expected to notify the DON. -The charge nurse was responsible for ensuring the count was done correctly.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications	F 761		9/4/23

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were stored securely; failed to ensure other objects were not in with the residents' prescribed medications; failed to ensure refrigerators that store residents' prescribed medications and supplements were kept within the required temperatures; failed to ensure the sink in the medication room was kept clean and hand soap and towels were available to wash hands, and failed to ensure medication carts were not left unlocked while nursing staff was not in attendance of the medication cart. The facility census was 88 residents.

Review of the facility's policy, "Storage of Medication," dated 1/2021 showed:
-Medications and biologicals were to have been stored properly, following the manufacturer's recommendation, to maintain their integrity and to support safe effective drug administration.
-The medication supply was to have been accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.
-Medication rooms, cabinets and medication supplies should have remained locked when not in use or attended by persons with authorized access.
-Medications that required refrigeration or temperature between 36 degrees Fahrenheit (F) and 46 degrees F were kept in a refrigerator with a thermometer to allow temperature monitoring.
-A temperature log or tracking mechanism was maintained to verify that the temperature had remained within accepted limits.
-The temperature of any refrigerator that stored vaccines should have been monitored and recorded twice daily.
-Medication storage should have been kept clean, well lit, organized and free of clutter.

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-Medication storage conditions were to have been monitored on a regular basis as a random quality assurance check.
-As problems were identified, recommendations would have been made for corrective action to have been take.

1. Continuous observation on 7/17/23 from 6:00 A.M. to 6:15 A.M. of the medication room located behind the Central Nurses' station showed:
-The medication room door was propped open with a trash can.
-There were no nursing staff in the medication room.
-Three male residents passed by the open medication room door within two feet of the door and looked inside the medication room as they passed by it.

During an interview on 7/17/23 at 6:20 A.M. Licensed Practical Nurse (LPN) E said:
-The medication room door should never have been propped open.
-It would get hot in there but the door should have been closed and locked if a nurse was not in the medication room.

2. Observation on 7/17/23 at 6:30 A.M. of the Nurse's cart on 300/400 hall with LPN E showed:
-Three loose AA batteries were in with a resident's prescribed medication, Acetycsteine (medication used to treat thick mucus in individuals with chronic lung disorders) two 30 milliliters (ml) vials.

3. Observation and review on 7/17/23 at 6:30 A.M. of the Medication Refrigerator Temperature Log with LPN E in the central medication room for July 2023 showed:

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-The log was taped to the front of the refrigerator.
-The refrigerator temperature was checked four out of 17 opportunities.
-Once the temperature was 35 degrees F.
--There was no documentation staff did anything to correct the temperature in the refrigerator.
-Once the temperature was 33 degrees F.
--There was no documentation staff did anything to correct the temperature in the refrigerator.
-The nurse verified there was no documentation staff had taken any steps to correct the temperature of the refrigerator when it was less than 36 degree F.

Observation and review of the South Medication Refrigerator and Temperature Log on 7/17/23 at 6:40 A.M. with LPN E in the south medication room for July 2023 showed:
-The temperature of the refrigerator for health shakes and supplements was 32 degrees F.
-The temperature was verified by the nurse.
-The log was taped to the front of the refrigerator.
-The following residents' physician's prescribed supplements were in the refrigerator;
-A box of Acidophilus (a supplement used to promote the growth of good bacteria in the stomach) 200 milligram (mg) capsules, the box showed refrigeration was recommended.
-A box of Acidophilus 100 mg capsules, the box showed to refrigerate after opening.
-The refrigerator temperature was checked twice out of 17 opportunities.
-The temperature both times was 35 degrees F.
-There was no documentation the staff did anything to correct the temperature in the refrigerator.
-The nurse verified there was no documentation staff had taken any steps to correct the temperature of the refrigerator when it was less

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F 761	Continued From page 27 than 36 degree F. During an interview on 7/17/23 at 6:40 A.M. LPN E said: -Medication vaccines, and other biological product that must be refrigerated require a constant temperature, usually in the range of 36 degrees F to 46 degrees F. -If the medication refrigerator's temperature was lower than 36 degrees F or higher than 46 degrees F, the effectiveness of a drug or biological may have been damaged, became ineffective or possibly even toxic and harmful to the resident. -Daily as assigned by the Director of Nursing (DON), staff would check the medication refrigerator temperature to verify the proper range. -The temperature was to have been recorded on the temperature log. -If the medication refrigerator was below or above the accepted range of 36 degrees F to 46 degrees F, designated staff would have taken the following steps; -Remove all medicines and biological's from the refrigerator and inspect them for change in consistency, clarity or color. -Check the manufacturer's storage recommendation on the package, label or drug insert. -Separate those medications and biological's in question from the other items pulled from the medication refrigerator. -Readjust the medication refrigerator temperature to reset it to the 36 degrees F to 46 degrees F range. -Recheck the temperature in 30 minutes. -If there was still a problem check with the Maintenance staff.	F 761		

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-Document the steps you took to resolve the problem.

4. Observation of the South Medication room on 7/17/23 at 6:45 A.M. with LPN E showed:
-The only sink in the medication room was rusty.
-There was no soap in the soap dispenser to wash hands with.

5. Observation on 7/17/23 at 7:20 A.M. of the Nurses' medication cart with LPN E showed:
-He/she had left the medication cart unlocked for three minutes while he/she went inside a resident's room to obtain a blood sugar level.
-The medication cart was pointing outward in the hallway.
-No nursing staff was in attendance of the cart.
-A male resident walked by the cart within two feet.

6. During an interview on 7/19/23 at 9:30 A.M. LPN E said:
-You should never leave the medication cart opened unless you were getting medications out of it.
-The door to the medication room should not have been propped open.
-The night nurse should have checked the temperature on the refrigerators.
-They should have signed that they checked the refrigerator temperatures.
-He/she did not know what the correct temperature for the medication refrigerators was supposed to have been.
-If the temperature of the medication or supplement refrigerator was out of range the nursing supervisor should have been informed.
-There was only one sink in the medication room to wash your hands and it was rusty.

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-Housekeeping should have ensured the sink was clean and there was hand soap and towels available.
-There should not have been batteries in the residents' medications.
-He/she did not know who was ultimately responsible for ensuring the refrigerator temperatures were kept within range, the medication carts were locked when not in use, the medication room was kept clean, and ensuring there were no objects such as the batteries in the medication carts, maybe the DON.

During an interview on 7/19/23 at 9:35 LPN C said:
-Medication rooms and medications carts should always have been locked unless you were in front of the cart using it.
-The medication and supplement refrigerator's temperature should have been checked at night by the night nurse.
-If the refrigerator was out of range he/she would have told the nursing supervisor.
-There should not have been any batteries in the cart with the residents' prescribed medications.
-Whoever used the cart should have ensured it was clean.
-Housekeeping was responsible to go into the medication room to clean it and ensure there was hand soap and towels so you could wash your hands.
-Housekeeping should have had the nurse let them into the medication room to clean the sink, while the nurse watched them.

During an interview on 7/21/23 at 8:40 A.M. LPN B said:
-The medication cart and medication room should

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never have been left unlocked while unattended.
-The night nurse was responsible for checking the temperature of the medication refrigerators.
-He/she was not sure what the temperature of the medication/supplement refrigerators should have been.
-The temperature of the medication/supplement refrigerators should have been checked daily.
-If the temperature was out of range he/she would have adjusted the temperature and rechecked it again later.
-There should not have been any blanks on the refrigerator log.
-He/she was not sure who was responsible for ensuring the medication/supplement refrigerators were kept within an acceptable range.

During an interview on 7/21/23 at 12:25 P.M. the DON said:
-The temperature of the medication refrigerators should have been checked every shift.
-The temperature should have been documented on the sheet that was on the refrigerator.
-The temperature should have been within the perimeters that was on the temperature log sheet.
-If the temperature was outside of the perimeters staff should have notified the maintenance department.
-It was the responsibility of the night nurse to have been checking the temperatures of the medication refrigerators.
-The nurse manager was responsible for ensuring the temperatures of the refrigerator had been checked.
-It was not critical if the temperature of the medication refrigerator was up or down a few degrees.
-The sink in the medication room should not have

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F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within	F 791		9/4/23

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3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;

§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure two sampled residents (Residents #13 and #16) received dental services out of 18 sampled residents. The facility census was 88 residents.

Review of the facility's dental policy showed:
-The facility would assist residents with referrals for dental services, including coordinating transportation within three business days or less from the time of damage or loss to dentures.
-If a referral was not made within three days, the facility had to provide documentation of they did to ensure the resident could still eat and drink adequately while awaiting dental services.

1. Review of Resident #16's entry tracking form showed he/she admitted to the facility on 1/27/21.

Review of the resident's significant change

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Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 4/1/23 showed the following staff assessment of the resident:
-Cognitively intact.
-Understands others and was understood by others.
-Had clear speech.
-Required set-up assistance and supervision with personal hygiene.
-Had natural teeth or dentures.
-Did not have broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable or loose).

Review of the resident's dental exam dated 5/30/23 showed:
-The resident had no teeth.
-The resident wanted a new set of dentures.
-The resident was informed he/she needed to go through the process of signing up for a dental plan or going through State sponsored insurance.
-The resident would need impressions for new dentures.

Review of the resident's care plan updated 7/5/23 showed:
-The resident was independent with oral care.
-The resident had no teeth and did not wear dentures.
-No interventions regarding obtaining dentures.

Observation and interview on 7/17/23 at 8:36 A.M. showed:
-The resident's breakfast was on a tray on an overbed tray table.
-On his/her tray were eggs, bacon and toast that had not been eaten.
-An empty carton of whole milk.

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-The resident said:
--He/she could not eat well because he/she didn't have any teeth.
--Facility staff keep telling him/her that he/she could get new dentures but they never did anything about it.
--His/her current dentures didn't fit.
--The facility staff kept promising and promising him/her that they would help him/her get dentures that fit.

During an interview on 7/20/23 at 1:04 P.M., the Social Services Director said:
-He/she had worked at the facility two months.
-Currently there was not a system for keeping track of residents who needed dentures.
-There should be a follow-up process after a resident saw the dentist and determined to need dentures.
-He/she goes to nursing staff to see who needed dental services.
-He/she sent an application for the dental insurance program through an application they use to communicate with families to the resident's responsible party on 6/9/23.
-He/she had not spoken to the resident's responsible party about the dental program or getting dentures for the resident.

During an interview on 7/20/23 at 1:42 P.M., the resident's responsible party said:
-At the time of admission (1/27/21), the resident had a pair of dentures but they did not fit properly and had tried multiple times to get them adjusted.
-The resident was not on the State sponsored insurance prior to admission but went on it upon admission to the facility.
-Someone at the facility spoke to the resident last summer about a dental plan.

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-No one talked to him/her about the dental plan other than the resident.
-The resident told him/her the dental plan was free but it was actually $159.00 per month.
-He/she canceled the dental plan because it cost more than what the resident received every month on the state sponsored insurance.
-The resident told him/her that somebody from the facility told the resident they were going to get him/her dentures but they never did.
-The resident had not been measured for impressions.
-He/she just received something from the facility regarding a document that needed to be signed but he/she didn't know what it was.
-The resident said all the time that he/she wished he/she had dentures so he/she could eat everything he/she wanted.
-The facility staff have told him/her for two years they were going to get the resident dentures and they never have.

During an interview on 7/21/23 at 8:56 A.M., Graduate Practical Nurse (GPN) A said:
-He/she was not aware of any issues with the resident's dentures.
-If there were issues with his/her dentures he/she would contact the family to see what dentist they wanted to use.

During an interview on 7/21/23 at 9:10 A.M., Certified Nursing Assistant (CNA) D said:
-The resident hadn't spoken about his/her dentures.
-He/she didn't know if the resident wore dentures.

During an interview on 7/21/23 at 12:25 P.M., the Director of Nursing (DON) said:
-Social Services coordinated dental services.

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-He/she's talked to the resident's responsible party and they've never heard anything about the resident needing dentures.
-The charge nurses were responsible for setting up appointments if a resident had to go out of the facility for denture impression.
2. Review of Resident #13's face sheet showed he/she was admitted on 4/5/19 with the following diagnoses:
-Need for physical assistance with personal care.
-Age related physical debility (a physical decline).

Review of the resident's Dental Note dated 6/16/20 showed:
-He/she presented with teeth 5 through 8, 10 through 13, 22 through 28, and 31 that remain as fragments in hopeless state.
-Edentulation (without teeth) and dentures as possible option.
-Referral for extractions (pulling teeth) then denture fabrication process.
-Nursing was to have inspected his/her mouth for lesions, sores or excessive bleeding as needed.
-Nursing was to have monitored for chewing problems and adjusted diet as needed.
-Social Services was to have scheduled appointments with the dentist as needed.
-Social Services was to have to assisted with making appointments to have teeth pulled and dentures made.

Review of the resident's dental exam dated 10/27/21 showed:
-Root tips present (on the following teeth; 5, 6, 7, 8, 9, 11,12, 13, 20, 21, 22, 24, 25, 26, 27, 28, 29, 31, and 32.
-The resident had frequent discomfort on his/her upper and lower teeth.
-The resident was not able to chew all food.

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-The resident reported some pain through out his/her mouth.
-Previous dental evaluation recommended full mouth extraction then full upper and lower dentures.
-Dentist extracted all remaining maxillary (upper jaw) teeth today.
-Dentist would extract lowers at next visit.
-Dentist recommended a soft diet.
-Recommendation for follow up appointment; extraction of lower teeth and reevaluate.

Review of the resident's quarterly MDS dated 6/7/23 showed:
-The resident's Brief Interview for Mental Status (BIMS) score was 13 out of 15 indicating he/she was cognitively intact.
-He/she needed the assistance of one staff member to guide his/her hand during eating.
-No natural teeth or tooth fragments was not checked.
-Obvious broken teeth was not checked.

Observation and interview on 7/17/23 at 12:56 P.M. the resident said:
-He/she had issues eating because some of his/her teeth were gone.
-The dentist pulled his/her top teeth a couple of years ago.
-He/she only had slivers of teeth on the bottom.
-Pieces of teeth had worked their way out and it hurt to eat.
-He/she was supposed to have had the bottom teeth pulled and had dentures made.
-He/she would have like to have dentures so he/she could eat regular food.
-He/she had talked to the Administrator in the past about getting dentures.
-Staff did not look in his/her mouth.

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CROWN REHAB AND HEALTHCARE CENTER	3001 EAST ELM HARRISONVILLE, MO 64701

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F 791	Continued From page 38	F 791		

-He/she had several broken teeth on the bottom of his/her mouth.
-He/she did not have any teeth on the top of his/her mouth.

Review of the resident's undated care plan showed:
-The resident needed his/her bottom teeth pulled and was to get dentures.
-The resident's teeth have all broken off to nubs with constant pain/discomfort, which was worse when he/she chewed.
-He/she would have dental problems addressed during review period.
-The resident had no teeth and was waiting on dentures to be made.
-The resident had difficulty chewing some harder foods.
-His/her problem with his/her teeth would be recognized and addressed by the dentist through the next review period.

During an interview on 7/19/23 at 9:30 A.M. Licensed Practical Nurse (LPN) C said:
-He/she did not know if the resident had teeth.
-The resident had not told him/her that he/she wanted dentures.
-The nurse verified the resident had last been seen by the dentist on 10/27/21 for teeth extraction.
-There were no notes in the medical record showing that the resident had seen the dentist since 2021.
-The resident had lost seven pounds since January.
-Staff should have looked at why there was a weight loss.
-The resident should have been seen by the dentist annually.

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F 791	Continued From page 39 -The resident should have been seen by the dentist to have dentures made for him/her. -Social Services was responsible for setting up the dental appointments. During an interview on 7/19/23 at 9:45 A.M. the Social Services Designee (SSD) said: -He/she was responsible for scheduling dental appointments for the residents. -The dentist came to the facility to see residents every two months. -The residents should have been seen by the dentist at least annually. -The SSD verified the resident had not seen a dentist since 10/27/21 for teeth extraction. -The resident should have been seen since then so he/she could have obtained dentures. -He/she had been in the SSD position for two months, the previous SSD should have ensured that the resident had been added to the list to see the dentist, but that was not done. During an interview on 7/21/12 at 12:25 P.M. the DON said: -The residents should have seen a dentist once a year and as needed. -The SSD was responsible for ensuring the resident has an appointment at least annually to see the dentist. -The resident should have had his/her remaining teeth pulled. -The resident should have had dentures made if he/she wanted them. -The SSD was responsible to audit the residents' chart to ensure they were seen by a dentist at least annually.	F 791		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		9/4/23

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F 803	Continued From page 40 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow pre-prepared menus to ensure they met the nutritional adequacy needs of residents, in accordance with established national guidelines and professional standards for food service. This deficient practice potentially affected all residents who ate food from the kitchen. The facility's census was 88 residents with a licensed capacity for 118 residents at the time of the survey.	F 803		

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F 803	Continued From page 41	F 803		

1. Review of the pre-prepared menus for the current month provided by the Dietary Manager (DM) showed the following:
-The menus had the facility's food vendor name at the top left.
-The lunch for Monday the 17th was listed as bacon wrapped beef, country mashed potatoes, and mixed vegetables.
-The lunch for Tuesday the 18th was listed as a hot dog on a bun, crispy French fries, cucumber salad, and a cottage cheese/pineapple salad.
-The lunch for Wednesday the 19th was listed as Frito chili pie, buttered corn, and jello salad.

During an interview on 7/17/23 at 9:08 A.M. the DM said the following:
-Their food vendor delivered every Wednesday.
-Just because he/she ordered foods to match the menus did not mean they got them.
-He/she tried to follow the menus, but occasionally had to make substitutions.
-Most of the dietary staff were new hires.

Observation on 7/17/23 at 11:47 A.M. showed the lunch served was beef goulash, mashed potatoes, and a vegetable blend.

Review of the menu board posted in the hall outside the Main Dining room on 7/18/23 at 9:57 A.M. showed the lunch was going to be a hamburger patty, mashed potatoes, and mixed vegetables.

During an interview on 7/18/23 at 10:03 A.M. the DM said he/she made up a "week at a glance" for meals ahead of time going by what foodstuffs were on hand and then seeing what the cook was able to make out of that.

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F 803	Continued From page 42 Review of the "week at a glance" menus for the current week provided by the DM showed the lunch for Wednesday the 19th was listed as chicken cordon bleu casserole, tossed salad, and honey glazed carrots. During an interview on 7/19/23 at 1:58 P.M. the DM said the following: -Menus were not followed and other foods were substituted because they had issues with their food vendor providing certain items for dishes. -Some recipes were also too difficult for the current cooks.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		9/4/23

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F 812	Continued From page 43	F 812		

Based on observation, interview, and record review, the facility failed to keep the Dry Storage (DS) room, walk-in refrigerator, and walk-in freezer floors clean; to maintain sanitary beverage dispensers; to maintain plastic plate covers and utensils in good condition to avoid food safety hazards (cross-contamination); and failed to separate damaged foodstuffs, in accordance with professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 88 residents with a licensed capacity for 118 residents at the time of the survey.

1. Observation on 7/17/23 between 8:29 A.M. and 9:26 A.M. during the initial kitchen inspection showed the following:
-There was a 6 pound (lb.) 12 ounce (oz.) can of chili with beans on a can dispenser rack in the DS area that was dented on one side toward the top rim.
-There were several crumbs and two strips of plastic under the racks in the DS area.
-There was plastic, paper, an onion skin, and a butter pod under the racks in the walk-in refrigerator.
-There was plastic, two unwrapped frozen beef patties, and a piece of garlic bread under the racks in the walk-in freezer, and a bottom rack had a Ziploc bag of garlic sticks ripped open at the bottom which allowed them to spill out.
-There was a scoop in the sugar bin under a food preparation table in the kitchen.
-In an upright plastic utensil container on a food preparation table there were two white plastic scoop spatulas that were chipped on their edges.
-The two coffee dispenser nozzles were crusty

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F 812	Continued From page 44 around the inner edges and the multi-juice soda gun (a soda gun system allows you to stream multiple beverage types through a single hose) dispenser had dried liquid streaks. -On a shelf under the steam table there were two teal and four maroon plate warmer covers that were chipped around their edges. During an interview on 7/17/23 at 9:08 A.M. the Dietary Manager (DM) said the staff was usually pretty good about not putting the scoop in the sugar bin, but they were mostly all newly hired. During an interview on 7/19/23 at 1:58 P.M. the DM said the following: -The dishwasher was responsible for cleaning the floors at night. -Damaged food stuff items were "tossed out" when found. -Dietary staff knew they could dispose of damaged food preparation items. -The soda gun was cleaned nightly and the coffee nozzles soaked; if the nozzles were too stained they were replaced.	F 812		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-	F 825		9/4/23

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F 825	Continued From page 45 §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide restorative care (a program to maintain a person's highest level of physical, mental, and psychosocial function in order to prevent declines that impact quality of life) following discharge from therapy services for one sampled resident (Resident #77) out of 18 sampled residents. The facility census was 88 residents. Review of the facility's Restorative Nursing Program Guidelines policy, dated 10/24/2022, showed: -The program focused on achieving and maintaining physical, mental and psychosocial functioning. -Residents were started on the Restorative Nursing Program: --Upon admission to the facility with restorative needs, but was not a candidate for formalized rehabilitation therapy; --When restorative needs arose during the course of a longer-term stay; --When a resident was discharged from formalized physical, occupational or speech rehabilitation therapy. -The Director of Nursing (DON) managed and directed the Restorative Nursing Program with	F 825		

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consultation from rehabilitation professionals.
-General restorative nursing care did not require the use of qualified professional therapists to render such care. The basic restorative nursing categories included, but not limited to:
--Active range of motion (AROM)
--Walking
-Residents were reviewed by the Interdisciplinary Team (IDT) upon admission, readmission and quarterly to identify any decline in activity of daily living (ADL) function.
-If a decline was identified the IDT evaluated whether the resident was an appropriate candidate for restorative services.
-If a potential to benefit from rehabilitation therapies (either skilled or unskilled) was identified, the attending physician ordered a relevant therapy evaluation.
-The care plan reflected the restorative needs for each resident.
-The Restorative Aide (RA) carried out the restorative program according to the care plan and documented daily as well as a written weekly summary of the resident's services.

1. Review of Resident #77's face sheet, undated, showed the resident was diagnosed with heart failure, lack of coordination, and depression (an illness characterized by persistent sadness).

-Review of the resident's care plan, dated 3/28/23, showed:
-The resident had a self-care deficit related to impaired mobility and arthritis.
--The goal was to maintain current level of function in bed mobility.
--The resident required extensive assistance by one staff when transferred.
--Restorative care was not part of the resident's

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F 825	Continued From page 47	F 825		

care plan.

Review of the resident's Therapy Request Form, dated 5/16/23, showed the resident wanted to walk.

Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 5/24/23, showed:
-The resident scored a 13 on the Brief Interview for Mental Status (BIMS an assessment tool that shows a score between 3 of 15 which shows the resident's mental status. This tool helps determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in care planning decisions).
--The resident's score indicated the resident was cognitively intact.
-The resident had no days of restorative services.

Record review of the resident's Physical Therapy (PT) Evaluation and Plan of Treatment, dated 5/18/23 through 5/31/23, showed the resident discontinued PT on 5/26/23

Review of the Notice of Continuation/Discontinuation of Rehabilitation Services, dated 5/27/23, showed:
-The resident's last day of therapy was 5/26/23.
-The resident was able to receive services from non-skilled personnel to carry out a restorative or maintenance program.

Review of the resident's Physician Order Summary, undated, showed on 6/22/23 the physician ordered restorative services for three times a week for 12 weeks for bed mobility and

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F 825	Continued From page 48	F 825		

leg exercise and Range of Motion (ROM).

During an interview on 7/17/23 at 9:30 A.M., the resident said:
-He/she was unable to walk due to severe back pain.
-He/she wanted to be able to walk and believed a walker would assist him/her.
-He/she experienced pain when in the sitting position making a wheel chair very uncomfortable.
-He/she requested a walker from therapy to help with mobility.
-He/she spoke to the facility physician and the nurse practitioner about getting a walker but no one had gotten back to him/her.
-He/she used a bed pan for urine and bowel movements but wanted to be able to use a bathroom.
-He/she was not in any rehabilitation services or restorative care.

During an interview on 7/19/23 at 10:29 A.M., Certified Nursing Assistant (CNA) C said:
-The resident did not say anything to him/her about wanting a walker.
-The resident was self-sufficient and did not like to accept help.
-The resident got distraught easily and preferred to do his/her own care.
-The resident mentioned frequently he/she wanted to move into an apartment.

During an interview on 7/19/23 at 12:04 P.M., the Restorative Aide (RA) said:
-The resident said in the past he/she was interested in getting out of bed and relearning how to go and do more.
-The resident had orders for restorative but

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nothing actually was ordered by the physician yet.
-The resident wanted to get out of the facility and get back into own environment.
-Therapy could evaluate the resident and see what he/she was able to do on his/her own.

During an interview on 7/19/23 at 1:29 P.M., the Social Services Director (SSD) said:
-He/she was not aware the resident wanted to go out and live in the community.
-The resident could have left against medical advice (AMA).
-He/she planned to go the resident's room and talk to him/her.

During an interview on 7/19/23 at 2:46 P.M., Licensed Practical Nurse (LPN) B said:
-The resident was in therapy but not anymore.
-He/she provided encouragement to the resident regarding getting out of bed and out of the room.

During an interview on 7/19/23 at 2:53 P.M., LPN C said:
-The resident had mentioned about getting out of the facility and living in the community.
-The resident understood he/she needed to manage own ADL's first.
-The resident had therapy but was no longer in therapy.
-The SSD was aware of the resident's goal to be out of the facility.
-He/she was unaware of why the resident was not in therapy.

During an interview on 7/20/23 at 1:50 P.M., the RA said:
-He/she was unsure if the resident had an order for restorative services.
-The resident had not received any restorative

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F 825	Continued From page 50 services in the last month. During an interview on 7/21/23 at 12:25 P.M., the DON said: -Therapists wrote orders for residents who were on skilled and were discharged from skilled therapy services. -They then gave the orders to the facility physician. -The physician then wrote the restorative services orders. -The therapists communicated to the RA when a resident was eligible for restorative services. -The RA was responsible for implementing the restorative services plan. -If a resident had an order for restorative services he/she would expect to see the resident on restorative services.	F 825		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		9/4/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN REHAB AND HEALTHCARE CENTER	3001 EAST ELM HARRISONVILLE, MO 64701

(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) COMPLETION DATE
F 880	Continued From page 51	F 880		

staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 52 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow their policy to complete testing to screen residents upon admission for tuberculosis (TB- a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) for two sampled residents (Resident #83, and #75) out of five sampled residents; the facility failed to follow infection control protocols during wound care for three sampled residents (Residents #23, #25 and #35), and to clean/sanitize scissors properly before and after use between residents for two sampled residents (Residents #25 and #35) out of 18 sampled residents. The facility census was 88 residents. Review of the facility's Tuberculosis Screening policy dated 10/24/22 showed: -All residents were to be screened upon admission to the facility. -Any resident without documented negative TB skin tests (TST) or chest x-ray within the previous 12 months would receive a baseline TST. -When the first TST was negative, a follow-up TST would be administered one to three weeks after the initial TST was read. Review of the "Long Term Care Infection	F 880		

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Prevention and Control Manual," Chapter 5, Vaccinations and TB testing, created by the Quality Improvement Program for Missouri (QIPMO), dated February 2022 and the Missouri Department of Health rule 19 CSR 20-20.100 dated 2/28/22 showed:
-Paragraph two:
--Within one month prior to or one week after admission, all residents new to long-term care are required to have the initial test of a Mantoux (a test for immunity to tuberculosis using intradermal injection of tuberculin) purified protein derivative (PPD) two-step TSTs.
---The results of the TSTs should be read within 48-72 hours from administration.
--If the initial test is negative, zero to nine millimeters (mm), the second test, which can be given after admission, should be given one to three weeks later.
--Documentation of chest X-ray evidence ruling out TB disease within one month prior to admission, along with an evaluation to rule out signs and symptoms compatible with infectious TB, may be accepted by the facility on an interim basis until the Mantoux PPD two-step TST is completed.

Review of the facility's Hand Hygiene policy, dated 10/24/2022, showed:
-The facility considered hand hygiene the primary means to prevent the spread of infections.
-Facility staff are trained and in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.
-Facility staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents and visitors.
-Facility staff perform hand hygiene procedures in the following circumstances:

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--When hands are soiled with visible dirt or debris.
--After contact with intact or non-intact skin, clothing and environmental surfaces of residents even if gloves were worn.
--In between gloves changes.
-Alcohol based hand hygiene products can and should be used to decontaminate hands:
--Before putting on sterile gloves for the purpose of performing aseptic procedures.
-The use of gloves does not replace hand hygiene procedures.

Review of the facility's Clean and Disinfection of Resident Care Equipment dated 10/24/2022 showed:
-Resident-care equipment, including reusable items are cleaned and disinfected per current CDC (Center for Disease Control) recommendations for disinfection.
-Reusable items (equipment that is designated reusable by more than on resident) are cleaned and disinfected or sterilized between residents.

1. Review of Resident #83's entry tracking form showed he/she was admitted to the facility on 12/16/22.

Review of the resident's immunization tab showed:
-No documentation of any TSTs prior to May 2023.
-A TST was documented as administered and read on 5/2/23 and the results were 0 mm/negative.
-A TST was documented as administered and read on 5/12/23 and the results were 0 mm/negative.

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2. Review of Resident # 75's entry tracking form showed he/she admitted to the facility on 8/19/22.

Review of the resident's immunization tab showed:
-No documentation of any TSTs prior to May 2023.
-A TST was documented as administered and read on 5/2/23 and the results were 0 mm/negative.
-A TST was documented as administered and read on 5/10/23 and the results were 0 mm/negative.

During an interview on 7/21/23 at 8:56 A.M., Graduate Practical Nurse (GPN) said the Infection Preventionist usually put in the orders for the TSTs and did them.

During an interview on 7/21/23 at 12:25 P.M., the Director of Nursing (DON) said:
-The admitting nurse should administer the TST for a newly admitted resident.
-They reviewed new admissions daily and if the admitting nurse did not administer the first TST for a new resident, the Infection Preventionist or the Assistant Director of Nursing (ADON) did it.
-The charge nurses read the TSTs.
-The infection Preventionist put in the orders so the second TST was scheduled.
3. Review of Resident #25's admission record showed he/she admitted on 6/20/23 with the following diagnoses:
-Fracture of the right femur (thigh bone).
-Sepsis (a bacterial infection in the blood), unspecified organism.
-Local infection of the skin and subcutaneous tissue (the layer of tissue that underlies the skin), unspecified.

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Observation of wound care on 7/19/23 at 12:27 P.M., showed Licensed Practical Nurse (LPN) A:
-Put supplies on the resident's table without cleaning it or placing a barrier down first.
-Did not sanitize scissors before use.
-The wound care company's Nurse Practitioner (NP) and LPN A washed their hands and donned (put on) gloves.
-He/she handed the NP the items he/she needed.
-He/she removed gloves, did not wash/sanitize his/her hands and re-gloved.
-He/she applied Santyl (ointment that helps remove dead skin tissue and aid in wound healing) to the bed of the wound.
-He/she then applied Gentamicin (antibiotic used to treat infection) on top.
-He/she did not change gloves and wash/sanitize hands and re-glove.
-He/she cut Hydrofera (an antimicrobial foam dressing) with the scissors to fit the wound bed and placed on the wound.
-He/she did not change gloves and wash/sanitize hands and re-glove.
-He/she placed a boarder dressing over wound.
-He/she placed scissors on treatment cart.
-He/she did not clean/sanitize scissors.
-He/she removed gloves and sanitized hands.
-He/she went to another resident's room.

4. Review of Resident #35's Admission record showed he/she admitted on 11/4/22 with the following diagnoses:
-Cellulitis (a common and potentially serious bacterial skin infection) of right lower limb.
-Diabetes Mellitus II [condition that affects the way the body processes blood sugar (glucose)] with Diabetic Nephropathy (affects the kidneys' ability of removing waste products and extra fluid

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from the body).
-Sepsis (a bacterial infection in the blood), unspecified organism.

Observation of wound care on 7/17/23 at 11:04 A.M., showed LPN A:
-He/she put supplies on the resident's table without cleaning it or placing a barrier down first.
-He/she sanitized hands and donned gloves.
-He/she did not clean/sanitize scissors.
-He/she cut gauze dressing from right leg with scissors, resident's right leg had two open blisters, one medial (middle) and one posterior (back).
-He/she cleaned areas with wound cleaner.
-He/she did not change gloves, wash/sanitize hands and re-glove.
-He/she applied Santyl to both areas with an applicator.
-He/she did not change gloves, wash/sanitize hands and re-glove.
-He/she did not clean scissors.
-He/she cut calcium alginate (CaAlg-a type of dressing that can absorb 20 times its weight in exudate and soak up loose debris from a wound bed) to fit areas and placed over the two spots.
-He/she wrapped with bulky gauze wrap.
-He/she removed gloves did not wash/sanitize hands.
-He/she re-gloved to do left leg.
-He/she cut gauze dressing off left leg with same scissors without cleaning from the right leg.
-He/she cleaned leg with wound cleanser, posterior open blister and opened blister on anterior (front) near ankle area.
-He/she applied Santyl to areas.
-He/she cut the alginate without cleaning scissors.
-He/she wrapped leg with the bulky gauze.

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-He/she removed gloves and washed hands.
-He/she removed unused supplies from room to nurse's treatment/medication cart.
-He/she placed scissors on top of treatment cart without sanitizing/cleaning scissors.
-He/she took cart back to nurses station.
-His/her scissors still laying on top of the treatment cart.
-He/she went to pass meds to other residents.

During an interview on 7/19/23 at 1:45 P.M., LPN A said:
-He/she should have cleaned the bedside tray table or placed a barrier before laying the wound care supplies on it.
-He/she should have changed his/her gloves and washed/sanitized hands:
--After cleansing the wound and before applying the medication.
--After applying the medication.
-He/she should have cleaned/sanitized the scissors before and after each use and between residents.
-He/she should not have left uncleaned scissors on top of the treatment cart.
5. Review of Resident #23's face sheet, undated, showed:
-The resident had the following diagnoses:
--Senile degeneration of the brain (a decrease in the ability to think, concentrate, or remember).
--Cognitive communication deficit (an impairment in organization/ thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).

Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 7/1/23, showed:

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-The resident scored a 00 on the Brief Interview for Mental Status (BIMS an assessment tool that shows a score between 3 and 15 which shows the resident's mental status. This tool helps determine the resident's attention, orientation and ability to register and recall new information. These items were crucial factors in care planning decisions).
--This showed the resident was severely cognitively impaired.
-The resident had a stage I (Intact skin with non-blanchable redness of a localized area usually over a bony prominence) or greater pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure) on his/her coccyx (tail bone).

Observation on 7/20/23 at 11:00 A.M., of wound care showed LPN A:
-He/she put the supplies on a bedside tray table without cleaning the table or providing a clean barrier.
-He/she had donned gloves to remove the resident's clothes and disposable brief.
-He/she cleansed the wound with wound cleanser.
-He/she did not cleanse his/her hands or change gloves before applying Calmoseptine (a multipurpose moisture barrier that protects and helps heal skin irritations).
-He/she reapplied the resident's clothes.
-He/she remembered that he/she was to apply an abdominal pad (extra thick dressing to care for wounds that were draining).
-With the same gloves on he/she removed the resident's clothes.
-With the same gloves on he/she smeared the Calmoseptine around the wound.
-He/she then placed the abdominal pad over the

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F 880	Continued From page 60 wound. During an interview on 7/20/23 at 11:20 P.M., LPN A said: -He/she should have changed his/her gloves and washed hands after cleansing the wound and before applying the medication. -He/she should have changed his/her gloves and washed hands after removing the resident's clothes before smearing the medication and applying the abdominal pad. -He/she should have cleaned the bedside tray table or placed a barrier before laying the wound care supplies on it. 6. During an interview on 7/21/23 at 12:25 P.M., the DON said: -While wound care was performed the nurse should remove gloves and wash/sanitize hands after touching or removing soiled dressing. -There should be a barrier on the bedside tray table if used for wound care. -The bedside tray table should be cleaned or have a barrier prior to putting anything on it for wound care. -The bedside tray table should have been cleaned following the procedure. -Gloves should be removed anytime they were soiled. -Hands should have been washed anytime the gloves were removed. -Gloves should be changed and hands washed/sanitized and new gloves put on when more than one wound treatment product is being applied. -Scissors should be cleaned: --Before and after use. --Between treatments on different areas of same resident.	F 880		

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F 880	Continued From page 61 --Between each resident wound cares.	F 880		

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A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II 1. Refer to F755.	A4055		
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III This regulation is not met as evidenced by: Class III 1. Refer to F761.	A4064		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II.	A4075		

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A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II 1. Refer to F755.	A4055		9/4/23
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III This regulation is not met as evidenced by: Class III 1. Refer to F761.	A4064		9/4/23
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II.	A4075		9/4/23

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A4075	Continued From page 1 1. Refer to F658. 2. Refer to F677. 3. Refer to F791.	A4075		
A4077	19 CSR 30-85.042(68) Res Groomed/Dressed Appropriately Taking into consideration the resident's preferences, residents shall be well-groomed and dressed appropriately for the time of day, the environment and any identified medical conditions. II/III This regulation is not met as evidenced by: Class III. 1. Refer to F677.	A4077		9/4/23
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II. 1. Refer to F880.	A4086		9/4/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN REHAB AND HEALTHCARE CENTER	3001 EAST ELM HARRISONVILLE, MO 64701

(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
A4099	Continued From page 2	A4099		
A4099	19 CSR 30-85.042(90) Rehab Service Documentation Staff shall include the following in documentation of rehabilitation services: physician's written approval for proposed plan of care; progress notes at least every thirty (30) days by the therapist; daily record of the procedure(s) performed; summary of therapy when rehabilitation has been reached and, if applicable, recommendations for maintenance procedures by restorative nursing. III This regulation is not met as evidenced by: 1. Refer to F825.	A4099		9/4/23
A4100	19 CSR 30-85.042(91) Social Service Program The facility shall designate a staff member to be responsible for the facility's social services program. The designated staff person shall be capable of identifying social and emotional needs, knowledgeable of methods or resources, or a combination of these to use to meet them and services shall be provided to residents as needed. II/III This regulation is not met as evidenced by: Class III. 1. Refer to F791.	A4100		9/4/23
A5016	19 CSR 30-85.052(16) Special Diets-Menus Reviewed/Approved Menus for special prescribed diets shall be reviewed and approved in writing by either a	A5016		9/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21031	A. BUILDING: _____ B. WING _____	07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A5016	Continued From page 3 qualified dietitian, a registered nurse or a physician. II/III This regulation is not met as evidenced by: Class III 1. Refer to F803.	A5016		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class III 1. Refer to F812.	A7015		9/4/23

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CROWN REHAB AND HEALTHCARE CENTER	3001 EAST ELM HARRISONVILLE, MO 64701

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A7048	Continued From page 4	A7048		
A7048	19 CSR 30-87.030(46) Safe Plastic/Rubber Items, Food Contact Safe plastic or safe rubber or safe rubber-like materials that are resistant under normal conditions of use to scratching, scoring, decomposition, crazing, chipping and distortion, that are of sufficient weight and thickness to permit cleaning and sanitizing by normal dishwashing methods, and which meet the general requirements of this rule, are permitted for repeated use. III This regulation is not met as evidenced by: 1. Refer to F812.	A7048		9/4/23
A7065	19 CSR 30-87.030(63) Food-Contact Surfaces Washed/Rinsed/Sanitized Where equipment and utensils are used for the preparation of potentially hazardous foods on a continuous or production-line basis, utensils and the food-contact surfaces of equipment shall be washed, rinsed and sanitized at intervals throughout the day on a schedule based on food temperature, type of food and amount of food particle accumulation. III This regulation is not met as evidenced by: 1. Refer to F812.	A7065		9/4/23
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care,	A8010		9/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN REHAB AND HEALTHCARE CENTER	3001 EAST ELM HARRISONVILLE, MO 64701

(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
A8010	Continued From page 5 of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III This regulation is not met as evidenced by: Class III 1. Refer to F578.	A8010		

PLAN OF CORRECTION

Provider Name:	Crown Rehab and Healthcare
Street Address, City, Zip:	3001 East Elm Street Harrisonville, MO 64701
Date of Survey:	July 17, 2023
Provider number:	265647

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F803	**Menus Meet Resident Needs/Prep in Advv/ Followed**	9/4/23
	There was no negative impact on the resident:	
	The residents, employees, visitors in the facility have the potential to be affected.	
	Issue Identified:	
	The facility failed to follow pre-prepared menus to ensure they met the nutritional adequacy needs of residents, in accordance with established national guidelines and professional standards for food services.	
	What measures will be put into place of system changes to ensure that the deficient practice will not recur?	
	The Dietary Manager and Staff will be educated by the Dietician and Administrator on the importance of following the menu.	
	How will the facility monitor its performance to make sure that solutions are sustained?	
	The Dietary Manager/ Administrator will audit 3 random meals 3Xs weekly for a month then 1 random meal weekly for 60 days. All results will be reviewed during QAPI for evaluation and further recommendations.	

Administrator 9/9/23

PLAN OF CORRECTION

Provider Name:	Crown Rehab and Healthcare
Street Address, City, Zip:	3001 East Elm Street Harrisonville, MO 64701
Date of Survey:	July 17, 2023
Provider number:	265647

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 812	**Food Procurement Store/ Prepare/ Serve- Sanitary**	9/4/23
	There was no negative impact on the resident:	
	The residents, employees, visitors in the facility have the potential to be affected.	
	Issue Identified:	
	The facility to keep the dry storage, walk-in refrigerator, and walk-in freezer floors clean. The facility failed to maintain sanitary beverage dispensers. The facility failed to maintain plastic plate covers and utensils in good condition to avoid food safety hazards and failed to separate damaged foodstuffs in accordance with professional standards for food service safety.	
	What measures will be put into place of system changes to ensure that the deficient practice will not recur?	
	The dry storage, walk-in refrigerator, and walk-in freezer floors were clean. The beverage dispenser was clean. The overused dishware was discarded. The Dietary Manager and Staff will be educated by the Administrator on the following: Cleanliness (Floors, Beverage Dispensers), Disposing worn items, Removing dented food cans, Food Storage	
	How will the facility monitor its performance to make sure that solutions are sustained?	
	The Dietary Manager/ Administrator will complete an audit tool 4xs a week for a month then 2xs a week for 60 days. All results will be reviewed during QAPI for evaluation and further recommendations.	

PLAN OF CORRECTION

Provider Name:	Crown Rehab and Healthcare
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Date of Survey:	July 17, 2023
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F 578	**Request/ Refuse/ Discontinue Treatment; Advance Directives**	9/4/23
	There was no negative impact on the resident:	
	All residents that reside in this facility have the potential to be affected.	
	Issue Identified:	
	The facility failed to ensure resident #64 had a code status upon admission.	
	What measures will be put into place of system changes to ensure that the deficient practice will not recur?	
	Resident #64 code status was inputted.	
	DON/ Medical Records were educated by the Administrator on the importance of inputting code statuses on all residents upon admissions and readmissions.	
	How will the facility monitor its performance to make sure that solutions are sustained?	
	Medical Records/Designee will complete an audit 3xs a week for a month then weekly for a month. All results will be reviewed during QAPI for evaluation and further recommendations.	

PLAN OF CORRECTION

Provider Name:	Crown Rehab and Healthcare
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Date of Survey:	July 17, 2023
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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 791	**Routine/ Emergency Dental Services**	9/4/23
	There was no negative impact on the resident:	
	All residents that reside in this facility have the potential to be affected.	
	Issue Identified:	
	The failed to ensure Residents #13 and #16 received dental service.	
	What measures will be put into place of system changes to ensure that the deficient practice will not recur?	
	Dentist came to the facility on 8/2/23	
	Resident #13 saw the dentist 8/2/23	
	Resident # 16 will see the dentist on 8/10/23.	
	The DON/Social Service Designee were educated by the Administrator on providing outside service for the residents.	
	How will the facility monitor its performance to make sure that solutions are sustained?	
	All results will be reviewed during QAPI for evaluation and further recommendations.	

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PLAN OF CORRECTION

Provider Name:	Crown Rehab and Healthcare Center
Street Address, City, Zip:	3001 East Elm Street Harrisonville, MO 64701
Date of Survey:	7/21/2023
Provider number:	21031

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F657	Resident #23's care plan will be updated to reflect current resident care needs. Current residents who reside at the facility have the potential to be affected. MDS or designee will audit current residents care plans to ensure ADL needs are accurate to include any contractures and any current resident behaviors are care planned. DON or designee will in-service MDS coordinator on ensuring care plans are updated to reflect current ADL needs to include any contractures if applicable and resident behaviors. Admin or designee will in-service the SSD on ensuring behavior care plans are updated. DON/ADON or designee will audit 10 residents care plans weekly to ensure they accurately reflect current ADL needs, contractures if applicable and any behaviors. If any issues are identified 1:1 education will be completed by the DON or designee. Results will be reviewed during QAPI for evaluation and further recommendations.	
F658	Resident #31 will have standing lab orders drawn per physician orders. Current residents who reside at the facility have the potential to be affected. DON/ADON or designee will audit current residents to identify standing orders to ensure they were drawn and completed per physicians' orders. Any issues identified will be clarified with physician and drawn if needed.	

	DON/ADON or designee will in-service licensed nurses on ensuring standing orders are placed in the lab portal. DON/ADON or designee will audit 5 residents with standing labs weekly to ensure they were drawn as ordered. If issues are identified 1:1 education will be completed and labs will be drawn per orders. Results will be reviewed during QAPI for evaluation and further recommendations.	
F677	Resident #83 podiatry services will be offered to the resident. Resident #27 will have their call light responded to in a timely manner. Current residents who reside at the facility have the potential to be affected. DON/ADON or designee will audit current residents' toenails to identify residents who are needing toenail care completed. If able to complete in house toenail care will be completed, if needing to see a podiatrist the resident will be placed on the list to see podiatrist. DON/ADON or designee will in-service facility staff on prompt response to call lights. DON/ADON or designee will in-service facility nursing staff on toenail care and referring residents to podiatry services if needed. DON/ADON or designee will audit 10 residents weekly to ensure toenail care was completed. If any residents toenails were identified that need addressed, toenail care will be provided or resident will be placed on the podiatrist list. Any issues identified will have 1:1 in-service completed by the DON or designee. DON/ADON or designee will audit 5 call lights 3x/week to ensure they were answered in a timely manner. Any issues identified will have 1:1 in-service by the DON or designee. Results will be reviewed during QAPI for evaluation and further recommendations.	
F755	Licensed nurses and CMT's narcotic count sheets will be signed off by the oncoming and off going licensed nurse or CMT. Current residents at the facility have the potential to be affected. DON/ADON or designee will in-service licensed nurses and CMT's on properly signing off on the narcotic count sheet at the beginning and end of each shift. In-service will include to not pre-sign prior to your shift count being completed.	

	DON/ADON or designee will audit 6 narcotic books 5x/week to ensure the narcotic count sheets were signed appropriately and not presigned. If issues are identified 1:1 in-service will be completed. Results will be reviewed during QAPI for evaluation and further recommendations.	
F761	Medications will be stored securely, and other objects will not be stored with medications in the medication carts. Medication fridges will be kept within the required temperatures and documented on a temperature log. Sink in the south medication room was cleaned and soap and towels are present to allow staff to wash their hands. Medication carts will be locked when not attended by staff. Current residents that reside at the facility have the potential to be affected. DON/ADON or designee will audit medication carts to ensure other objects are not stored in the same drawer as medications. DON/ADON or designee will audit medication fridges to ensure working thermometer is present, temperature log is present. Housekeeping or designee will clean the skin in the south medication room and ensure soap and towels are present. DON/ADON or designee will in-service licensed nurses and CMT's on ensure medication room doors are kept closed, objects are not stored in the medication cart drawers with medications, medication fridge temps are documented daily and DON is notified if outside of range, sink in south medication room is clean and soap and towels are present to wash hands. Medication carts will be locked when unattended. DON/ADON or designee audit medication carts and rooms 3x/week to ensure the medication rooms are closed, medication carts are locked if unattended and medication carts do not have other items stored in the same drawer as medications. If issues are identified, they will be corrected and 1:1 in-service will be completed by the DON or designee. DON/ADON or designee will audit medication room fridges 5x/week to ensure temp logs have been completed and no temperatures were outside of normal range and to ensure medication room sink is clean and soap and towels are present. Any issues identified will be corrected and 1:1 in-service will be completed by the DON or designee. Results will be reviewed during QAPI for evaluation and further recommendations.	

F825	Resident #77 will have RA services per order. Current residents who reside at the facility have the potential to be affected. DON/ADON or designee will audit residents with current RA orders to ensure they are being provided the RA services per orders. DON/ADON or designee will in-service the RA on completing RA services and documenting services completed. DON/ADON or designee will in-service DOR on communicating new orders to the RA and DON. DON/ADON or designee will audit 5 residents weekly on RA services to ensure they are getting the RA services per orders and services were documented. Any issues identified will result in 1:1 education by the DON or designee. Results will be reviewed during QAPI for evaluation and further recommendations.	
F880	Residents #83 and #75 will have TB test completed. Residents #23, #25 and #35 will have infection control protocols followed during wound care. Residents #25 and #35 will have wound care completed with clean scissors. Current residents who reside at the facility have the potential to be affected. DON/ADON or designee will audit current residents to ensure they have had a TB test completed. Residents needing TB test will have one completed. DON/ADON or designee will in-service licensed nurses on completing TB tests for new admissions. DON/ADON or designee will in-service licensed nurses on following infection control protocols during wound care and cleaning scissors before and after use. DON/ADON or designee will audit 3 new admissions weekly to ensure TB test was administered. Any issues identified will be corrected and 1:1 in-service will be provided by the DON or designee. DON/ADON or designee will observe wound care 3x/week to ensure infection control protocols are being followed including cleaning scissors before and after use.	

	Results will be reviewed during QAPI for evaluation and further recommendations.	

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A4055	**Refer to F755**	9/4/23
A4064	**Refer to F761**	9/4/23
A4075	**Refer to F658, F677 and F791**	9/4/23
A4077	**Refer to F677**	9/4/23
A4086	**Refer to F880**	9/4/23
A4099	**Refer to F825**	9/4/23
A4100	**Refer to F791**	9/4/23
A5016	**Refer to F803**	9/4/23
A7015	**Refer to F812**	9/4/23
A7048	**Refer to F812**	9/4/23
A7065	**Refer to F812**	9/4/23
A8010	**Refer to F578**	9/4/23

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