STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. BUILDING _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW HEALTH & REHABILITATION	2203 EAST MECHANIC STREET 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 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one sampled resident (Resident #1) with limited range of motion (ROM) received restorative therapy services to prevent further decrease in his/her ROM out of 10 sampled residents. The facility census was 91 residents. Review of the facility's policy titled "Restorative Nursing Services" dated July 2017 showed: -Residents would receive restorative nursing care as needed to promote optimal safety and independence. -Restorative nursing care consisted of nursing interventions that may or may not be accompanied by formalized rehabilitative services. -Residents may be stared on restorative nursing	F 688		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/26/2024

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW HEALTH & REHABILITATION	**2203 EAST MECHANIC STREET HARRISONVILLE, MO 64701**

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F 688	Continued From page 1	F 688		

program upon admission, during the course of stay, or when discharged from rehabilitative care.
-A restorative goal may have included maintaining his/her dignity and self-esteem.

1. Review of Resident #1's face sheet showed he/she admitted to the facility with the following diagnoses:
-Person injured in unspecified motor vehicle accident.
-Fusion of the spine (a surgery performed that joins two or more vertebra (any of the bony or cartilaginous segments that make up the spinal column) together), cervical region (the neck region of the spine).
-Unspecified displaced fracture (when the pieces of the bone move so much a gap forms around the fracture) of sixth cervical vertebra.
-Unspecified displaced fracture of seventh cervical vertebra.
-Unspecified fracture of the thoracic (T- middle section of spine)7-T8 vertebra.

Review of the resident's Restorative Nursing Instruction Form dated 6/11/24 showed:
-The resident was to receive restorative nursing three times a week.
-The resident was to receive active assisted range of motion (AAROM- performed when the patient/resident needs assistance with movement from an external force because of weakness, pain, or changes in muscle tone) to his/her lower extremities.
-The goals of the program were:
--Improve sitting tolerance and balance.
--Maintain functional level.

Review of the resident's Annual Minimum Data Set (MDS- a federally mandated assessment

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MEADOW VIEW HEALTH & REHABILITATION	2203 EAST MECHANIC STREET HARRISONVILLE, MO 64701

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F 688	Continued From page 2	F 688		

instrument completed by facility staff for care planning) dated 8/17/24 showed:
-The resident was cognitively intact.
-The resident had full functional range to his/her upper extremities.
-The resident had full functional range to his/her lower extremities in ROM.
-The resident was fully dependent (helper does all of the effort, resident does none of the effort to complete the activity) for the following:
--Eating.
--Oral hygiene.
--Toileting hygiene.
--Showering/bathing.
--Upper body dressing.
--Lower body dressing.
--Putting on/off footwear.
--Personal hygiene.
--Rolling left and right.
--Going from a sitting to lying position.
--Going from a lying position to sitting on the side of the bed.
--Chair to bed transferring.
--Tub/Shower transferring.
-The resident had zero days of restorative nursing in which active ROM (the ROM that can be achieved when opposing muscles contract and relax, resulting in joint movement) or passive ROM (ROM that is achieved when an outside source exclusively causes movement of a joint and is usually the maximum ROM that a joint can move) in the seven days look back period.

Review of the resident's care plan dated 9/4/24 showed:
-The resident had an Activities of Daily Living (ADLs) self-care performance deficit related to limited mobility due to quadriplegia (paralysis that affects all a person's limbs and body from the

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	265362	A. BUILDING _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW HEALTH & REHABILITATION	2203 EAST MECHANIC STREET 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 688	Continued From page 3	F 688		

neck down).
-The resident had quadriplegia related to his/her spinal injury with a goal for the resident to maintain optimal status and quality of life within limitations.

Review of the resident's response history for the task "Restorative Program" dated 8/13/24 through 9/5/24 showed:
-The resident only received ten minutes of restorative therapy during that time period.
-The task had been documented as not applicable (N/A) 10 times out of 12 opportunities.

During an interview on 9/9/24 at 10:54 A.M. the resident said:
-He/She was supposed to get ROM exercises from the facility's Restorative Aide.
-He/She had not received any restorative therapy in the last three months.
-He/She thought the reason why he/she was not receiving his/her restorative therapy was due to staffing issues.
-He/She had benefited from the restorative therapy.

During an interview on 9/9/24 at 1:23 P.M. Certified Medication Technician (CMT) A said he/she was unsure of what therapy services the resident was supposed to receive.

During an interview on 9/9/24 at 1:50 P.M. Licensed Practical Nurse (LPN) A said:
-The resident used to receive restorative therapy.
-He/She thought there might have been an insurance problem and that was why the resident was no longer on restorative therapy services.

During an interview on 9/9/24 at 2:00 P.M. the

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	265362	A. BUILDING _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW HEALTH & REHABILITATION	**2203 EAST MECHANIC STREET HARRISONVILLE, MO 64701**

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F 688	Continued From page 4	F 688		

Director of Nursing (DON) and Administrator said:
-There was a binder that held the orders for all residents currently on a restorative program.
-The Administrator thought that residents were re-evaluated for restorative therapy monthly.
-He/She thought the resident did not have an active order for restorative therapy.

During an interview on 9/9/24 at 2:08 P.M. Certified Occupational Therapist Assistant (COTA) A said:
-The Restorative Nursing Instruction Form indicated the resident had an active order for restorative therapy.
-The facility had just hired a new Restorative Aide.
-The therapy department was responsible for recommending restorative therapy services.
-Restorative therapy was still beneficial to the resident.
-Residents were re-evaluated for restorative therapy every three months.
-The resident would be re-evaluated for restorative therapy on 9/11/24.

During an interview on 9/9/24 at 2:15 P.M. CMT A said:
-He/She had not been trained on performing restorative therapy.
-He/She had charted not applicable (NA) on the restorative program task because the task was not applicable to him/her.
-He/She was unsure how long the facility had been without a Restorative Aide.

During an interview on 9/9/24 at 2:21 P.M. LPN A said he/she thought the facility had been without a Restorative Aide for a couple months.

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F 688	Continued From page 5 During an interview on 9/9/24 at 2:24 P.M. the Assistant Director of Nursing (ADON) said: -The facility had been without a Restorative Aide for a month. -He/She was unsure of who would be responsible for completing the restorative therapy during the absence of a Restorative Aide. -When N/A was documented on a task that indicated the task was not completed. -He/She was unsure of who was responsible for ensuring the restorative therapy was being completed. During an interview on 9/9/24 at 2:33 P.M. the DON and Administrator said: -The facility had been without a Restorative Aide since July or August. -A Certified Nursing Assistant (CNA)/CMT could perform restorative therapy. -The ADON was responsible for over-seeing the documentation and completion of the restorative therapy. NOTE: After the interview was conducted it was clarified that the facility had been without a Restorative Aide from 7/10/24 until the present. MO00241400	F 688		

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	00968	A. BUILDING: _____ B. WING _____	C 09/09/2024

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A4081	19 CSR 30-85.042(72) Restorative Nursing, Res Out of Bed Facilities shall provide each resident, according to his/her needs, with restorative nursing to encourage independence, activity and self-help to maintain strength and mobility. Each resident shall be out of bed as desired unless medically contraindicated. II This regulation is not met as evidenced by: 1. Refer to F688.	A4081		

PLAN OF CORRECTION

Provider/Supplier Name:	Meadowview Health and Rehabilitation
Street Address, City, Zip:	2203 E. Mechanic St. Harrisonville, MO
Date of Survey:	09/09/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265362

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. This submission of the POC does not constitute an admission on the part of Meadowview Health and Rehab ("the facility") as to the accuracy of the surveyor findings, nor the conclusions drawn there from. The facility's submission of the POC does not constitute an admission on the part of the facility that the findings cited are accurate, or that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction.	
F688 SS=D	**Corrections will include:** Resident #1 is currently in the hospital, upon return the resident will be re-evaluated by the Therapy team to establish an updated Restorative Nursing program. Restorative Nurses Aid was hired on 9/08/2024 Two staff members will be trained as back-up in the absence of the Restorative Nurse Aid. **The facility will identify other residents having the potential to be affected by the same alleged deficient practices as follows:** All residents will be considered at risk for this alleged deficient practice. **The measures that will be put into place or systemic changes made to ensure that the alleged deficient practice will not occur are as follows:**	09/30/2024

	The Vice President of Clinical Services will provide education to the Administrator and the Director of Nursing regarding the Policy and Procedures for the Restorative Nursing Program. The Director of Nursing and the Administrator will provide education to the Clinical team regarding the Policy and Procedures of the Restorative Nursing Program. The Director of Nursing and Therapy designee will provide education and training to the Restorative Nurses Aid and the two-back-up staff members. **The facility will monitor the corrective actions to ensure that the alleged deficient practice will not recur as follows:** The Director of Nursing or designee will monitor the Restorative Nursing program compliance 2 times a week x 4 weeks then weekly ongoing according to CFR (s):483.25(c)(3) QAPI will monitor to ensure continued compliance with and the effectiveness of these corrective measures during monthly and quarterly meetings, respectively.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider Name:	Meadow View Health & Rehabilitation
Street Address, City, Zip:	2203 E Mechanic St Harrisonville, MO
Date of Survey:	09/09/2024
Provider number:	265362

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A4081	Reger to F688	09/30/2024

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