DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265552	A. BUILDING _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWLEY RIDGE CARE CENTER	1204 NORTH OUTER ROAD DEXTER, MO 63841

(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 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff) assessment within 14 days of admission of hospice services for one resident (Resident #50) out of three sampled residents. The facility census was 48. The facility did not provide a policy regarding the completion of significant change MDS assessments. 1. Review of Resident #50's medical record showed: - Admitted to hospice services on 02/26/25; - No significant change MDS dated on or after 02/26/25; - The facility failed to complete a significant change MDS within 14 days of the resident's admission to hospice.	F 637		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danielle Sp. LNHA
TITLE: Administrator
(X6) DATE: 3/31/25

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 637	Continued From page 1 During an interview on 03/20/25 at 10:00 A.M., the MDS Coordinator said he/she would expect a significant change MDS to be completed if a resident was admitted to hospice. He/She would expect the MDS to reflect the resident's current condition. During an interview on 03/20/25 at 12:00 P.M., the Administrator said she would expect the MDS to reflect the resident's current condition.	F 637		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify, assess, and provide supportive interventions for one resident (Resident #47) with a diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of one sampled residents The facility's census was 48. The facility did not provide a policy regarding trauma informed care.	F 699		

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F 699	Continued From page 2	F 699		

1. Review of Resident #47's medical record showed:
- Admission date of 11/01/24;
- Diagnoses of PTSD, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), panic disorder (a long-term anxiety disorder that involved repeated and unexpected panic attacks), generalized anxiety disorder (persistent feeling of worry), unspecified dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), and delusional disorder (a serious mental illness that causes people to have unshakable false beliefs for at least a month).

Review of the resident's Physician Order Sheet (POS), dated March 2025, showed:
- An order for Invega Sustenna (an antipsychotic (medication used to manage psychosis (a mental health condition characterized by a severe loss of touch with reality) medication) 0.75 milliliters (ml) intramuscular (injected into the muscle) injection once a day on the 28th of each month for delusional disorder, dated 02/28/25;
- An order for Seroquel (an antipsychotic medication) 200 milligrams (mg) by mouth at bedtime for panic disorder, dated 02/25/25;
- An order for Xanax (an antianxiety medication) 1 mg by mouth three times a day for generalized anxiety disorder, dated 03/07/25.

Review of the resident's Preadmission Screening and Resident Review (PASARR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 11/07/24, showed:

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F 699	Continued From page 3	F 699		

- Resident with psychotic disorder, major depressive disorder, anxiety disorder, personality disorder, delusional disorder and PTSD;
- The following behavior was documented: adaptation to change;
- Experienced one psychiatric treatment episode that was more intensive than routine follow-up care, had attended partial care/hospitalization, or had received Program of Assertive Community Treatment or Integrated Case Management Services.

Review of the resident's Care Plan, revised 02/05/25, showed:
- Did not identify PTSD as a problem;
- Did not address personalized triggers or interventions associated to the resident or triggers.

During an interview on 03/20/25 at 9:33 A.M., Resident #47 said he/she didn't like loud noises. Lots of noise agitated him/her and made him/her anxious. He/She kept a fan on in the room with the door closed to help block out the noise from the facility.

During an interview on 03/20/25 at 10:00 A.M., the Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff) Coordinator said he/she would expect a resident's care plan to include a diagnosis of PTSD with triggers and the care plan should reflect the resident's current condition.

During an interview on 03/20/25 at 12:00 P.M., the Administrator said she would expect the care plan to reflect the resident's current condition.

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F 759	Continued From page 4	F 759		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) during medication administration. There were 38 opportunities with three errors made, for an error rate of 7.89%, which affected three residents (Residents #37, #38, and #39) out of seven sampled residents. The facility census was 48. The facility did not have a policy for insulin administration. Review of the insulin aspart (medication to lower blood sugar), Novolog (medication to lower blood sugar) insulin, and insulin lispro (medication to lower blood sugar) Pen's Manufacture Guidelines for Priming Before Each Injection and Administration, revised 02/2023, showed: - Turn the dose selector to select two units; - Hold the pen with the needle pointing up; - Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; - Keep the needle pointing upwards, press the push-button all the way in; - The dose selector returns to zero; - A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times;	F 759		

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F 759	Continued From page 5	F 759		

- Select your dose you want to give.

1. Review of Resident #37's Physician Order Sheet (POS), dated March 2025, showed an order for insulin lispro per sliding scale subcutaneous (an injection under the skin) at 7:00 A.M., 12:00 P.M., and 5:00 P.M., with meals every day for a blood sugar (BS) 70 - 130 = zero units; BS 131 - 180 = one unit; BS 181 - 240 = two units; BS 241 - 300 = three units; BS 301 - 350 = four units; BS 351 - 400 = five units; BS greater than 400, call physician, dated 06/03/24.

Observation on 03/18/25 at 11:11 A.M., of the resident's insulin lispro administration showed:
- Licensed Practical Nurse (LPN) A did not prime the insulin lispro pen;
- LPN A administered two units of insulin lispro per the resident's pen for a blood sugar 229.

2. Review of Resident #38's POS, dated March 2025, showed:
- An order for Novolog FlexPen three units subcutaneous at 7:00 A.M., 12:00 P.M., and 5:00 P.M., with meals every day, dated 09/28/24;
- An order for Novolog FlexPen per sliding scale subcutaneous three times a day at 7:00 A.M., 12:00 P.M., and 5:00 P.M., for a BS 70 - 130 = zero units; BS 131 - 180 = two units; BS 181 - 240 = four units; BS 241 - 300 = six units; BS 301 - 350 = eight units; BS 351 - 400 = 10 units; if BS greater than 400 = 12 units and call the physician, dated 09/28/24.

Observation on 03/18/25 at 11:05 A.M., of the resident's insulin administration showed:
- Licensed Practical Nurse (LPN) A did not prime the insulin Novolog pen;
- LPN A administered the nine units of insulin

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F 759	Continued From page 6	F 759		

Novolog per the resident's pen for a blood sugar 254.

3. Review of Resident #39's POS, dated March 2025, showed:
- An order for insulin aspart pen give five units subcutaneous once a day at 12:00 P.M., dated 03/04/25;
- An order for insulin aspart pen per sliding scale subcutaneous with meals and at bedtime at 5:00 A.M., 11:00 A.M., 4:00 P.M., and at 8:00 P.M. If BS less than 60, call the physician, BS 150 - 200 = two units, BS 201 - 250 = three units, BS 251 - 300 = six units, BS 301 - 350 = nine units, BS 351 - 400, 12 units, BS 401 - 450 = 18 units, if BS greater than 450, call the physician, dated 03/04/25.

Observation on 03/18/25 at 11:21 A.M., of the resident's administration showed:
- Licensed Practical Nurse (LPN) A did not prime the insulin aspart pen;
- LPN A administered the 11 units of insulin aspart per the resident's pen for a blood sugar 279.

During an interview on 03/18/25 at 4:15 P.M., LPN A said he/she primed the insulin pens when they were first opened and used.

During an interview on 03/20/25 at 12:10 P.M., the Director of Nursing (DON) and the Administrator said they would expect staff to administer medications according to the manufacturer's guidelines.

Missouri Department of Health and Senior Services

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	12667	A. BUILOING: _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
CROWLEY RIDGE CARE CENTER	1204 NORTH OUTER ROAD DEXTER, MO 63841

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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. Refer to F759.	A4055		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Daniella Spr LNHA

TITLE

Administrator

(X6) DATE

3/21/25

PLAN OF CORRECTION

Provider/Supplier Name:	Crowley Ridge Care Center
Street Address, City, Zip:	1204 N Outer Road Dexter, Mo 63841
Date of Survey:	March 18, 2025- March 20, 2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Crowley Ridge Care Center as to the accuracy of the surveyor's findings, nor the conclusion drawn there from. The facility's submission of this POC does not constitute an admission on the part of the facility that the findings cited are accurate, 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 April 28, 2025.	
F637	The facility will ensure to complete a significant change MDS assessment within 14 Days of admission of Hospice services.	04/28/2025
	Significant change MDS assessment for resident #50 was completed.	
	MDS Consultant/designee will educate MDS Coordinator on MDS Significant change MDS Assessments.	
	DON/Designee will audit monthly X3 to ensure significant changes are completed.	
	Any concerns identified will be corrected immediately and reviewed at the Quarterly QA meeting x 3 months.	
F699	The facility will ensure to identify, assess, and provide supportive interventions for residents with a diagnosis of PTSD.	04/28/2025
	Resident #47 PTSD identified, assessed, and supportive interventions put in place.	
	Admin/designee will educate Social Services Director on identifying, assessing and providing supportive interventions for residents with a diagnosis of PTSD.	

	Admin/designee will conduct an audit of every resident that has a diagnosis of PTSD. Admin/designee will audit all new admissions for a diagnosis of PTSD.	
	Any concerns identified will be corrected immediately and reviewed at the Quarterly QA meeting x 3 months.	
F759	This facility will ensure to maintain an error rate of less than 5% during medication administration.	04/28/2025
	DON/designee will educate nursing staff to prime insulin pens prior insulin administration.	
	DON/designee will monitor nurses for accuracy and competency of insulin administration. DON/designee will ensure nurse gathers appropriate supplies, insulin pen is dated properly, insulin needle is primed with 2 units prior to dialing up residents insulin dose/order, and that proper hand hygiene is performed during insulin administration. Audits will be conducted weekly x4, then monthly x3. Compliance checklist and audit logs will be kept up to date by DON/designee.	
	Any concerns identified will be corrected immediately and reviewed at the Quarterly QA meeting x 3 months.	

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/Supplier Name:	Crowley Ridge Care Center
Street Address, City, Zip:	1204 N Outer Road Dexter, Mo 63841
Date of Survey:	March 18, 2025- March 20, 2025

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A4055	This facility will ensure to maintain an error rate of less than 5% during medication administration.	04/28/2025
	DON/designee will educate nursing staff to prime insulin pens prior insulin administration.	
	DON/designee will monitor nurses for accuracy and competency of insulin administration. DON/designee will ensure nurse gathers appropriate supplies, insulin pen is dated properly, insulin needle is primed with 2 units prior to dialing up residents insulin dose/order, and that proper hand hygiene is performed during insulin administration. Audits will be conducted weekly x4, then monthly x3. Compliance checklist and audit logs will be kept up to date by DON/designee.	
	Any concerns identified will be corrected immediately and reviewed at the Quarterly QA meeting x 3 months.	

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.