STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265255	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Healthcare and Rehabilitation Center	1009 East Ohio Clinton, MO 64735

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 1. Please refer to event ID YO6F12, exit date 03/26/25, for details. Based on observation, record review, and interview, the facility failed to promote and facilitate each residents right to self-determination when staff failed to honor four residents' (Resident #1, #2, #3, and #4) shower preferences. The facility census was 71. Review of the facility's policy titled Bath, Shower/Tub, dated February 2018, showed the following information: -The purpose of the procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin; -Document the date and time the shower/tub bath was performed; -Document the name and title of the individual who assisted the resident; -Document all assessment data obtained during the shower/tub bath; -Document if the resident refused the shower/tub bath and the reason; -Notify the supervisor if the resident refused the shower/tub bath. 1. Review of Resident #1's face sheet (brief information sheet about the resident) showed the following: -admission date of 07/22/20; -Diagnoses included multiple sclerosis (chronic, autoimmune disease that affects the central nervous system (brain and spinal cord)), spastic hemiplegia (paralysis or severe weakness) affecting left dominant side on the left side of the body, chronic pain syndrome, and anxiety disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 03/03/25, showed the following: -Cognitively intact; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident was totally dependent on staff for showering, toileting hygiene, and lower body dressing; -Resident required substantial to maximal assistance of staff for upper body dressing and personal hygiene. Review of the resident's nursing progress notes dated 03/03/25, at 5:26 P.M., showed the resident was totally dependent on staff for toileting and bathing, and substantial assistance to dependent on staff for dressing and grooming. Due to his/her impairment the resident required total assistance for mobility in bed and transfers. He/she was unable to ambulate. Review of the resident's care plan, last updated 03/17/25, showed staff did not care plan regarding the resident's need for shower assistance and his/her shower preferences. Review of the facility's shower sheets titled Skin Monitoring: Comprehensive Certified Nurse Aide (CNA) Shower Review, showed the following: -On 03/05/25, staff documented resident received a shower, fingernail care, and shaved. Staff stripped off the resident's linen, wiped down bedding, and made bed with clean linen. Staff noted no new skin concerns. A CNA and licensed practical nurse (LPN) signed the form. -On 03/18/25 (13 days after prior shower), staff documented resident received a shower and shaved. Fingernail care was not needed. Staff stripped off bed linen, wiped down bed, and made bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form. Review of the resident's record, on 03/26/25, showed no additional showers and no shower refusals. Observation and interview on 03/26/25, at 10:20 A.M., showed the resident was in his/her bed. He/she said Tuesday and Friday were his/her scheduled shower days. His/her last shower was over one week ago. Before last week it had been over two weeks since his/her last shower. He/she felt terrible, dirty, and worried about smell without a shower twice per week. 2. Review of Resident #2's face sheet, showed the following: -admission date 05/08/23; -Diagnoses included atrial fibrillation (condition where the upper chambers of the heart (atria) beat irregularly and rapidly), glaucoma (condition of increased pressure within the eyeball, causing gradual loss of sight), need for assistance with personal care, and muscle weakness. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Resident required partial to moderate assistance of staff for showering, toileting hygiene, lower body dressing, upper body dressing and personal hygiene. Review of the resident's care plan, updated 12/20/24, showed staff did not care plan related the resident's need for assistance with showers or shower preferences. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's shower sheets titled Skin Monitoring: Comprehensive CNA Shower Review, showed the following: -On 03/02/25, staff documented resident received a shower and fingernail care was not provided. Staff stripped off bed linen, wiped down bed, and made bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/05/25, staff documented resident received a shower and fingernail care was not provided. Staff stripped off bed linen, wiped down bed, and made bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/12/25 (seven days after prior shower), staff documented resident received a shower and fingernail care was not provided. Staff stripped off bed linen, wiped down bed, and made bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form. Review of the resident's record, on 03/26/25, showed no additional showers and no shower refusals. Observation and interview on 03/26/25, at 11:25 A.M., showed the resident was seated in his/her recliner. He/she said his/her last shower was over two weeks ago. He/she was offered a shower before his/her leg was broken, but it was going to be done by a man, and he/she did not want a man to complete the shower. He/she wrote dates down when he/she a shower, but was unable to find the last date. He/she felt dirty without being shower routinely. 3. Review of Resident #3's face sheet, showed the following: -admission date 10/04/24; -Diagnoses included rhabdomylosis (medical condition characterized by the breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream), multiple fractures of ribs, muscle weakness, pain, and need for assistance with personal care. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Resident was totally dependent on staff for toileting hygiene; -Resident required staff assistance for set up or clean up of personal hygiene; -Resident required partial to moderate assistance for upper body dressing; -Resident required substantial to maximal assistance for showering and lower body dressing. Review of the resident's care plan, updated 01/21/25, showed the following: -Resident required assistance with activities of daily living (ADL's) related to limited mobility and pain; -Resident required dependent to max assistant with shower transfers and full body showering; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident required max to dependent assist of two staff for transfer to/from toilet, dependent for toilet hygiene and clothing management, and incontinent care of bowels. Resident had Foley catheter (a tube that is inserted into the bladder, allowing urine to drain freely) and dependent for catheter care. Review of the facility's shower sheets titled Skin Monitoring: Comprehensive CNA Shower Review, showed the following: -On 03/03/25, staff documented resident received a shower and fingernail care. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/06/25, staff documented resident received a shower and fingernail care was refused. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/13/25 (7 days after prior shower), staff documented resident received a shower and toenail care was not provided. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form. Review of the resident's record, on 03/26/25, showed no additional showers and no shower refusals. Observation and interview on 03/26/25, at 10:52 A.M., showed the resident was in his/her wheelchair near the nursing station. The resident said he/she usually received a shower twice per week, but was unsure when he/she last received a shower. He/she really liked when he/she did receive a shower twice per week. 4. Review of Resident #4's face sheet, showed the following: -admission date 09/07/18; -Diagnoses included cerebral infarction (stroke), hemiplegia (complete paralysis on one side of the body) and hemiparesis (milder form of weakness on one side) affecting unspecified side, anxiety disorder, and chronic pain syndrome. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Resident was totally dependent on staff for toileting hygiene; -Resident required substantial to maximal assistance for showers and lower body dressing; -Resident required set up or clean up assistance from staff for upper body dressing; -Resident required supervision or touching assistance from staff for personal hygiene. Review of the resident's care plan, updated 01/21/25, staff did not care plan regarding shower assistance or the resident's shower preferences. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's shower sheets titled Skin Monitoring: Comprehensive CNA Shower Review, showed the following: -On 03/03/25, staff documented resident received a shower and fingernail and toenail care provided. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/06/25, staff documented resident received a shower and fingernail care. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/10/25, staff documented resident received a shower and fingernail care not needed. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/17/25 (seven days after prior shower), staff documented resident received a shower and fingernail care not provided with toenail care provided by podiatrist. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form; -On 03/24/25 (seven days after prior shower), staff documented resident received a shower and fingernail care not provided with toenail care provided by podiatrist. Staff stripped the bed linen, bed wiped down the bed, and made the bed with clean linen. Staff noted no new skin concerns. A CNA and LPN signed the form. Review of the resident's record, on 03/26/25, showed no additional showers and no shower refusals. Observation and interview on 03/26/25, at 11:00 A.M., showed the resident in his/her room in a wheelchair. The resident said he/she was only getting one shower per week, but preferred two per week. He/she a shower this Monday, 03/24/25, but felt it was only because he/she had a doctor's appointment. He/she was embarrassed when he/she had not received a shower and especially embarrassed to go to the doctor without a shower. The shower aide was frequently being pulled to work the floor. 5. During an interview on 03/26/25, at 10:00 A.M., CNA E said that there was only one shower aide that was not working this day. He/she said very few residents were receiving two showers per week. During an interview on 03/26/25, at 1:40 P.M., CNA C said that he/she was not told that any residents needed a shower. There was one shower aide and that he/she was not working this day. The shower aide had the shower schedule. During an interview on 03/26/25, at 11:20 A.M., LPN A said residents were not receiving showers twice per week. One shower aide recently quit and there was only one shower aide for the entire facility. During an interview on 03/26/25, at 11:35 A.M., LPN B said there was currently only one shower aide in the facility, but there was no one working as a shower aide this day. The residents were not receiving two showers per week. During an interview on 03/26/25, at 1:55 P.M., LPN D said he/she knew that residents were not (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receiving showers twice per week. There was only one shower aide for the facility and the aide was not working this day. During an interview on 03/26/25, at 2:15 P.M., the Assistant Director of Nursing (ADON) said there was a recent turn over and only one full time shower aide was working. He/she called in on this day. Until another shower aide could be hired or assigned, the home planned to start having the floor aides provide showers as well. During an interview on 03/26/25, at 2:20 P.M., the Director of Nursing (DON) said the expectation was for residents to receive two showers per week and if a resident refused a shower they would have to sign the shower sheet. MO00251410, MO00251648

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 1. Please refer to event ID YO6F12, exit date 03/26/25, for details. Based on record review and interview, the facility failed to protect each resident's right to be free from misappropriation of proper when narcotic pain medications for one resident (Resident #3) went missing while in the possession of the facility staff. The facility census was 71. Review of the facility's policy titled Administering Pain Medications, dated October 2022, showed the following: -Document in the resident's medical record results of the pain assessment, medication, dose, route of administration, and results of the medication; -Report other information in accordance with facility policy and professional standards of practice. Review of the facility's policy titled Medication Orders, dated February 2023, showed the following: -Medications included in the Drug Enforcement Administration (DEA) classification of controlled substances (drug or chemical whose manufacture, possession, and use are regulated by a government), and mediation classified as controlled substance by state law, are subject to special ordering, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations; -Before a controlled drug can be dispensed, the pharmacy must be in receipt of a prescription from a person lawfully authorized to prescribe; -The Director of Nursing (DON) and the contracted consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications; -Only authorized, licensed nursing and pharmacy personnel have access to controlled medications; -Controlled substance medications are dispensed by the provider pharmacy in readily accountable quantities and containers designed for easy counting of contents; -The pharmacy will include an individual resident controlled drug record (count sheet) for each controlled substance medication container dispensed to a resident if the facility so desires; -Alternatively, the facility may utilize a bound book in place of count sheets; -The following information is completed up dispensing or upon receipt of the controlled substance: resident's name, prescription number, drug name, strength, and dosage for of medication, date received, quantity received, and the name of person receiving the medication supply; -If the facility uses a bound book in lieu of the pharmacy count sheets, all of this information will be completed by a licensed nurse at the facility; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At each change of custody (shift change or exchange of keys) all on-hand controlled medication quantities shall be counted by two nurses and reconciled with the count sheets; -This shall be documented by completing a Controlled Drug Count Form indicating the date and time the physical count was completed; -Any discrepancies shall be reported to the charge nurse and the DON immediately; -With the nurse supervisor present, the discovering nurse should place a signed entry on the resident controlled drug record where the discrepancy was detected; -If it is something other than a mathematical error, the DON should provide assistance with the investigation and resolving the discrepancy; -Controlled substance medications are stored at the facility under double lock on the medication cart or medication room separate from all other medications. 1. Review of Resident #3's face sheet (brief information sheet about the resident) showed the following: -admission date of 10/04/24; -Diagnoses included rhabdomyolysis (medical condition characterized by the breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream), multiple fractures of ribs, pain, muscle weakness, and osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down). Review of the resident's care plan, dated 10/18/24, showed the following: -Resident received as needed pain medication therapy related to rhabdoymyolysis, rib fractures, and occasional generalized pain; -Staff should administered analgesic (pain) medications as ordered by physician; -Staff should monitor and document side effects and effectiveness every shift; -Staff should notify physician if medication does not control pain to tolerable level. Review of the resident's Physician Order Sheet (POS), current as of 03/26/25, showed an order, dated 10/04/24, for morphine sulfate ER (drug used to treat moderate to severe pain), oral tablet extended release 30 milligrams (mg), give one tablet by mouth two times per day for multiple fracture of ribs. Review of the resident's March 2024 Medication Administration Record (MAR), showed staff documented administration of morphine sulfate ER 30 mg every day in the morning and at bedtime from 03/01/25 to 03/26/25. Review of the pharmacy consolidated delivery sheets, dated 03/10/25, showed morphine sulfate ER 30 mg tablets, quantity of 60 tablets, received for the resident. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the controlled medication logbook on the medication cart showed the following: -On 03/10/25, staff documented there was 9 tablets of morphine sulfate and the pharmacy delivered 60 tabs. The total at the end of shift was 69 tablets; -On 03/16/25, the resident had 57 tablets of morphine sulfate. When the evening shift completed the change of shift count there were only 27 tablets of morphine sulfate in the cart; -On 03/24/25, the pharmacy delivered 30 tablets of morphine sulfate; -On 03/26/25, at 1:55 P.M., there were 38 tablets of morphine sulfate in the cart when reviewed with nurse. Review of the facility's Investigation Report, dated 03/18/25, showed the following information: -On 03/16/25, at 10:10 P.M., the Administrator received a call from Licensed Practical Nurse (LPN) B that the narcotic count for the resident showed there was 30 tablets of morphine sulfate missing; -Staff searched the medication cart and medication room. The medication was not located; -Police department notified on 03/17/25; -Notified pharmacy to report and request they send replacement for the missing medication and to bill the facility; -LPN F's statement, dated 03/16/25, showed the LPN worked 4 ½ hour shift, from 5:30 P.M. to 10 P.M. The nurse was rushing during the count at the beginning of shift and was unsure if the count was actually correct at that time; -LPN A's statement, dated 03/17/25, showed he/she counted medications on beginning of shift on 03/15/25 evening and end of shift on 03/16/25 morning. The count was correct at those time. When he/she worked the day shift on 03/17/25, he/she was informed by the night shift nurse that the count was off by 30 tablets. During an interview on 03/26/25, at 10:45 A.M., LPN A said the narcotic count was completed at the beginning and end of every shift. If the count was incorrect staff should notify the DON and administrator immediately. During an interview on 03/26/25, at 11:35 A.M., LPN B said the process for narcotics included the off-going nurse taking the narcotic book and the on-coming nurse taking the narcotic drawer to complete the shift count. Staff start by going through all of the tablets and then they count the liquids. If the narcotic count was not correct staff were to immediately contact the supervisor and staff do not leave the facility until the supervisor approved. During an interview on 03/26/25, at 1:55 P.M., LPN D said that if the log and tablets do not match during shift change, staff are to call management and have to stay at the facility until approved to leave. During an interview on 03/26/25, at 2:15 P.M., the Assistant Director of Nursing (ADON) said staff (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should complete a narcotic count during each shift change. If an error was found, staff were to contact management immediately. During an interview on 03/26/25, at 2:20 P.M., the DON said she expected the staff to follow facility policy. During an interview on 03/26/25, at 2:40 P.M., the Administrator said when she was notified of narcotic count discrepancy on 03/16/25 around 10:00 P.M. by LPN B. The medication cart and medication room were searched, and the narcotic was not located. The nursing staff did not have any knowledge of where the narcotics could be. The Administrator expected staff to complete narcotic counts accurately with every shift change. If the count was not accurate the staff were to notify the DON and Administrator immediately for further instructions. MO00251335