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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265807 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/04/2025 |
| NAME OF PROVIDER OR SUPPLIER Crestview Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 1313 South 25th St Bethany, MO 64424 | |
| 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) | | |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the walls, hallways, ceilings and floors in a clean and homelike environment. Furthermore the facility failed to ensure furnishings were in good repair and temperatures in the dining room remained at a comfortable level. This had the potential to effect all residents. The facility census was 40.</p> <p>The facility did not provide a policy for cleaning, maintenance of the facility and care of furnishings, or temperatures.</p> <p>1. Observations on 2/19/25 at 10:30 A.M., showed:</p> <ul style="list-style-type: none"> -Main dining room thermostat read 61 degrees Fahrenheit; -All doors to the main dining room were closed; -Window blinds in the dining room and attached hallways were drawn; -White blankets were rolled up and placed at the threshold of the doors leading to the courtyard. <p>Observation on 2/19/25 at 11:22 A.M., showed:</p> <ul style="list-style-type: none"> -Main dining room thermostat read 60 degrees Fahrenheit <p>During an interview on 2/19/25 at 10:05 A.M., Resident #9 said:</p> <ul style="list-style-type: none"> -He/She did not mind eating in the lobby because it was a comfortable temperature; -The main dining room was too cold to eat there, for a few weeks. <p>During an interview on 2/19/25 at 11:15 A.M., Resident #92 said:</p> <ul style="list-style-type: none"> -The dining room had been too cold to eat meals in for weeks; -He/She missed eating and visiting with her friends in the dining room. <p>During an interview on 2/19/25 at 12:32 P.M., Resident #18's family member said:</p> <p>(continued on next page)</p> | | |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: 265807 | Facility ID: 265807 If continuation sheet Page 1 of 9 |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-The heat in the dining room had not worked for over a week.</p> <p>During an interview on 2/19/25 at 3:00 P.M., the Administrator said:</p> <p>-The facility has not employed a maintenance supervisor for a month or more;The transportation driver assists with maintenance where he/she can;</p> <p>-The heat in the dining room had been checked by the Maintenance Director for the facility management company;</p> <p>-The dining room heater cannot keep up with the cold weather;</p> <p>-Residents eat in their rooms and assist diners eat in the lobby area;</p> <p>-She does not know when the heat will be fixed.</p> <p>2. Observations beginning on 2/25/25 at 12:37 P.M., showed:</p> <p>-The dining room floor tile cracked, with missing pieces, tiles loose with jagged edge;</p> <p>-Dead bugs, dust and debris in light fixtures;</p> <p>-Packaged Terminal Air Conditioner (PTAC: which is a self-contained heating and cooling system designed to be mounted through a wall), in courtyard hall had dust and debris inside the vent, pieces of the plastic vent cover were missing and broken;</p> <p>-Fire doors to 100 hall had chipped covering, with exposed wood underneath and white water damage like staining to lower half of the door;</p> <p>-Fire doors to service hall had large chips in Formica, with exposed wood underneath;</p> <p>-Corner sheetrock at service hall had large slash and gouge in sheetrock with peeling paint.</p> <p>Observation on 02/27/25 at 8:58 A.M., showed:</p> <p>-Television room at the end of the 400 hall had multiple gouges and scratches in the lower 1/3 of the sheetrock.</p> <p>-Glass table lamp had visible layer of dust and debris;</p> <p>-400 hallway had multiple gouges and scratches in the pain and sheetrock along the entire hall;</p> <p>-Hand rail end cap off at room [ROOM NUMBER] caused sharp edge;</p> <p>-Hand rail end cap loose at room [ROOM NUMBER] and opposite end cap was missing causing sharp edge;</p> <p>-Hand rail end cap missing at room [ROOM NUMBER];</p> <p>-Hand rail end cap missing at room [ROOM NUMBER];</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Hand rail end cap loose at room [ROOM NUMBER];</p> <p>-The small handrail at the corner of the dining hall and 400 hall was loose;</p> <p>-The handrail between room [ROOM NUMBER]-410 was loose;</p> <p>-Hand rail end cap was missing at room [ROOM NUMBER], caused a sharp edge;</p> <p>-Hand rail end cap at room [ROOM NUMBER] was missing, and caused a sharp edge;</p> <p>-Hand rail end cap at room [ROOM NUMBER] was off and laying on top of the handrail;</p> <p>-Hand rail at end of 500 hall with red, U shaped, sharp pronged metal piece with exposed two inch screw in the middle, was lying on top of the handrail.</p> <p>Observation on 02/27/25 at 9:06 A.M., showed:</p> <p>-Nurse station TV area had multiple gouges and scratches in the dry wall and paint;</p> <p>-Lobby area light fixtures had dead bugs, dust, and debris in lights;</p> <p>-PTAC unit had dust and debris in the vent and on the unit;</p> <p>-Multiple ceiling can lights had cobwebs;</p> <p>-Second PTAC unit had a broken grate and dust and debris in the vent;</p> <p>-The glass billboard had dried, white drips on the glass;</p> <p>-Long fluorescent lights had exposed bulbs;</p> <p>-The nurses station had scuffed and chipped paint,</p> <p>-The flooring carpet had multiple stained and discolored areas,</p> <p>-The seams of the carpet are approximately 1/4 inch apart with dust and debris in them.</p> <p>-The shower room on the 500 hall had dark, black mold like substance that covered 1/4 of the lower shower wall and grout of the shower and floor, exposed wires with ends capped in outlet cutout by tub, the ceiling had multiple brown water stains, and the lights had dead bugs, dust, and debris in them;</p> <p>-The 500 hall had multiple gouges, scratches, and chips in the paint and drywall along the entirety of the hall;</p> <p>-Treatment cart had rhinestone gems in partial star and curve shapes on the back of the cart, some gems were missing and a sticky/gummy substance was left behind, and had glitter letters half peeled off on the back of the cart and left a sticky/gummy uncleanable surface;</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Hallway from lobby to dining room had black scuff marks along lower third of the wall;</p> <p>-Windows in halls to dining room had cobwebs, dust and debris;</p> <p>-Hallway from lobby to dining room PTAC unit had dirt and debris in the vent, cracked plastic vent cover; the wall above the unit had broken wooden trim, leaving a sharp edge, peeling sheetrock and chipped/flaking paint;</p> <p>-Dining room windows had dirt, dust, debris and cobwebs; lower third of the walls had nicks and scratched paint; the rolling stools (used to sit on to assist resident with meals) had cracked vinyl covering and exposed padding underneath; cabinet doors were sprung and hanging crookedly; the tile grout was black in multiple areas with a thick crusty substance; the small serving bowls/dishes, on the prep cart, had dust and debris in them and on the storage tray, the steam table had white crusty/dusty substance on the bottom shelf; the storage chart had white crusty/dusty substance on the bottom shelf and legs; the white prep table had cobwebs, dirt and debris on it and hanging from the legs and corners.</p> <p>During an interview on 2/19/25 at 12:32 P.M. Resident #18 family member said:</p> <p>-Nothing gets fixed around the facility;</p> <p>-There is no maintenance personnel.</p> <p>During an interview on 02/26/25 02:52 P.M., Housekeeping/Laundry Aide A said:</p> <p>-High dusting (such as lights, and corners) should be completed by any housekeeping staff who have time to get it done.</p> <p>-High dusting was not assigned to anyone specifically.</p> <p>-The staff assigned to the hall were responsible for all cleaning.</p> <p>-There was no deep cleaning list for common areas of the building.</p> <p>-The Dining room was deep cleaned weekly; spot cleaning was done after each meal;</p> <p>-Carpets are vacuumed daily if there was time to do it.</p> <p>-He/She did not know when carpets were shampooed or who was responsible for that.</p> <p>During an interview on 02/19/25 at 3:00 P.M., the Administrator said:</p> <p>-The facility had been without a Maintenance supervisor or staff for over a month;</p> <p>-The transportation driver helps fix things as he/she has time to do it.</p> <p>During an interview on 02/27/25 at 12:28 P.M., the Quality Assurance Nurse said:</p> <p>-The facility was having maintenance struggles and there was no current maintenance staff.</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-The Administrator looks at things as she can.</p> <p>-The part time van driver can work on work orders as time allows;</p> <p>-She would expect communication between the administrator and maintenance to complete work orders.</p> <p>During an interview on 02/27/25 at 3:10 P.M., the Administrator said:</p> <p>-The Maintenance Director is responsible for upkeep and repairs.</p> <p>-There was not a Maintenance Director for over a month;</p> <p>-The van driver completes things as times allows and that he can do;</p> <p>-Staff fill out work order; the van driver picks them up and does what he can to complete them;</p> <p>-High dusting in the dining room would be maintenance; the rooms and halls would be housekeeping;</p> <p>-Carpets would cleaned when there was a stain; the housekeeping supervisor runs a carpet cleaner on different halls on different days.</p> <p>MO#249706</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, or psychosocial well-being for one of three sampled residents (Resident #7) when staff failed to obtain a physician ordered blood transfusion in January 2025 for an anemic resident in a timely manner. The blood transfusion was not carried out until fourteen days after it was ordered. The facility census was 43.</p> <p>Review of facility policy titled Physician Orders, undated, showed physician's orders must be signed by the physician and dated when such order was signed.</p> <p>Review of facility policy titled Lab Reporting Guidelines, undated, showed:</p> <ul style="list-style-type: none"> -Guidelines will be followed to ensure that lab recommendations are completed timely; -Nurse will received the lab for a lab draw; write a telephone order and document the order on the physician order sheet (POS) or note the order on the POS when written by the physician. -The nurse will document on the lab report that the physician had been notified to include how they were notified, when (time and date) and the nurse's signature; -The lab report will be placed in the medical record under the lab section; -When any new orders were received, this will again be documented on the 24 hour report. <p>1. Review of Resident #7's Annual Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 11/22/24, showed:</p> <ul style="list-style-type: none"> -They had moderate cognitive impairment; -They were dependent on a wheelchair; -They took an antiplatelet medication (a medication that prevents blood platelets from sticking together and forming blood clots); -Diagnoses included: Arthritis hypercalcemia (condition where there is high level of calcium in the blood), anemia, and high blood pressure. <p>Review of care plan, dated 12/7/24, showed the resident:</p> <ul style="list-style-type: none"> -had cognitive loss and their DPOA (Durable Power of Attorney) had been invoked by two physicians; -their designated family member directed health care needs. <p>Review of physician's orders showed:</p> <ul style="list-style-type: none"> -Faxed order, dated 1/16/25, Type and cross 2 units PRBC (packed red blood cells) and transfuse, pre-treat with Tylenol 650 mg (milligram) by mouth and Benadryl 12.5 mg 30 minutes prior to start. Give Lasix (a water pill) 40 mg intravenous (IV) x 1 between units, for diagnosis anemia . <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the resident's medical record showed no documentation the physician orders were carried out.</p> <p>Review of progress notes, dated 12/1/25-2/11/25, showed:</p> <ul style="list-style-type: none"> -On 1/17/25, physician ordered a blood transfusion due to low hemoglobin levels; -On 1/27/25, resident returned to the facility from hospital appointment to have blood transfusion. Hospital did not have right blood type in stock so the resident did not receive transfusion. -On 1/30/25, Resident received 1 unit of packed red blood cells (PRBC). <p>During an interview on 2/11/25 at 1:40 P.M., Family Representative A said:</p> <ul style="list-style-type: none"> -Resident had experienced some fatigue that physician had been concerned about; -Resident did not receive a blood transfusion right away in January when it was ordered; -They were unsure why a delay occurred in the resident receiving the blood transfusion. <p>During an interview on 2/11/25 at 11:48 A.M., Licensed Practical Nurse (LPN) A said:</p> <ul style="list-style-type: none"> -Laboratory results went directly to the resident's physician; -The facility staff did not receive the resident's lab results unless they specifically requested them; -There should have been some documentation in the progress notes on the care resident received. <p>During an interview on 2/11/25 at 2:15 P.M., Physician's Registered Nurse (RN) A said:</p> <ul style="list-style-type: none"> - The resident had Complete Blood Count (CBC) (a medical test that measures the number and types of various cells in the blood) drawn on 1/16/25 and their hemoglobin was 7.5 g/dl; -The physician sent an order for blood transfusion to occur and for facility to pre-treat resident with Tylenol and Benadryl; -He/she called the facility to notify them of the orders and faxed the orders on 1/16/25 by 5:00 P.M.; -The hospital outpatient said the facility dropped the resident off on 1/27/25 without an appointment and they did not have the resident's blood type on hand; -The resident did not get the transfusion until 1/30/25; -When the physician's office sends orders to the facility- the facility staff are able to call the hospital to schedule the transfusion; -Without the blood transfusion the resident had a risk of having their hemoglobin levels drop <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>further and experience additional fatigue.</p> <p>During an interview on 2/11/25 at 2:20 P.M., LPN A said:</p> <ul style="list-style-type: none"> -He/she was unsure why resident's blood transfusion was delayed in January. -BOM (Business office manager) was the person who scheduled appointments and arranged transportation to appointments for residents; -When the BOM is out of facility the Human Resources (HR) staff person is supposed to cover for the BOM. <p>During an interview on 2/11/25 at 3:10 P.M., BOM said:</p> <ul style="list-style-type: none"> -Faxes were received on the fax machine located in the main business office of facility; -She takes faxes to the west nurses station; -The nurses were responsible for writing any orders and appointments that need made on the faxed orders received; -Faxes were then brought back to him/her in the front office for scheduling of appointments; -He/she was responsible for scheduling appointments for the residents; -Paperwork and orders did sometimes get missed; -Resident #1's paperwork said family was going to schedule resident's appointment; -He/She contacted Resident #1's family member and they advised they were not taking care of appointment for transfusion; -The facility driver took the resident to his/her transfusion appointment on 1/27/25 and all the pretransfusion mapping was completed at that time but transfusion did not occur because the hospital did not have the resident's blood type on hand; -He/She took resident back to outpatient clinic on 1/30/25 for the transfusion; -When he/she was not working in facility the HR staff was their back up regarding checking faxes and taking phone calls and writing down appointments. <p>During an interview on 2/11/25 at 3:30 P.M., Family Representative B said:</p> <ul style="list-style-type: none"> -They did not agree or tell facility they would take resident to their second blood transfusion due to the extensive time commitment of 3-6 hours that the transfusions took to complete; -There was a communication break between administration and nurses at the facility. <p>During an interview on 2/11/25 at 3:23 P.M., Physician said he/she expected their order for blood</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>transfusion to be carried out within 5-7 days.</p> <p>During an interview on 2/11/25 at 3:50 P.M., Director of Nursing said he/she expected physicians orders to be carried out as soon as possible.</p> <p>During an interview on 2/11/24 at 4:11 P.M., Administrator said:</p> <ul style="list-style-type: none"> -He/she expected facility staff to follow physicians orders; -Physician's orders were received in main office at fax machine and were taken to the west nurses station charger nurse; -The charge nurse took orders off fax and entered them into electronic medical record; -Physician then electronically signed the orders in electronic medical record; -Business Office Manager makes resident appointments; -When BOM was out of facility the Administrator or HR staff made appointments. <p>MO248336</p> | | |