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

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 46555 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. 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.

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46555 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. 1. Review of Resident #47's medical record showed: - admitted [DATE]; - 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: - Resident with psychotic disorder, major depressive disorder, anxiety disorder, personality disorder, delusional disorder and PTSD; - The following behavior was documented: adaptation to change; (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49152 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; - 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; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 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 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.