STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265437	A. Building B. Wing	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon View Health and Wellness	1200 West College Street Liberty, MO 64068

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31100 Based on interview and record review, the facility failed to ensure residents are free from sexual abuse, when four residents (Resident #1, #2, #3 and #4), who are alert and oriented and independent with care, reported that the nurse would touch and rub their genitals using the excuse of providing incontinent care and treatments. The resident's reported that the actions of the nurse made them feel very uncomfortable and they felt violated. The facility census was 100. The Administrator was notified on 1/5/22 at 2:00 P.M. of an Immediate Jeopardy (IJ) which began on 1/2/22. The IJ was removed on 1/6/22 as confirmed by surveyor onsite verification. Review of the facility policy, dated 2021, on abuse, neglect, and exploitation showed: - The facility would provide protection for the health, welfare and the rights of each resident to prohibit and prevent abuse, neglect, and exploitation. - Defined abuse as willful infliction of injury and included sexual abuse. - Willful was defined as acting deliberately. - Sexual abuse was defined as non-consensual sexual contact of any kind with a resident. 1. Review of Resident #1's care plan, dated 11/18/21, showed: - The facility had the right to protect the resident's health and welfare. - The resident self-toileted. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/19/21, showed: - Cognitively intact; - Required supervision for cares; - Always continent of bladder and bowel; (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Diagnoses included kidney failure, diabetes, and arthritis. During an interview on 1/4/21 at 3:00 P.M., the resident said: - One night he/she was in the bathroom. - He/she did not call for help. - Licensed Practical Nurse (LPN) A came into the bathroom. - He/she had never seen LPN A before. - He/she said LPN A only did perineal (peri) care for male residents. - LPN A did not knock on the bathroom door and did not introduce him/herself. - LPN A took all the resident's clothes off and left him/her naked. - LPN A then said he/she was going to get wet wipes. - LPN A told the resident he/she had fecal matter on his/her balls. - LPN A told the resident he/she was going to look for shaving cream to clean the resident. - LPN A sprayed shaving cream on the resident's penis. - LPN A repeatedly stroked the resident's penis and gave up when the resident's penis did not get hard. - LPN A told the resident to get into bed without providing any clothing. - LPN A came back to the resident's room about an hour later. - LPN A patted the resident's penis and said okay. - LPN A made him/her very uncomfortable. - He/she reported the issue to a staff member who reported the issue to the Administrator (ADM). Review of the facility investigation, dated 1/4/22, by the ADM interviewing the resident showed: - The resident was in the bathroom. - LPN A asked the resident what was going on. - The resident told LPN A he/she was having diarrhea, but could handle it. - LPN A removed the resident's shirt and pants and said they were soiled. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- LPN A started to clean the resident with wipes. - LPN A left the room and came back with shaving cream. - LPN A went too far, he/she rubbed the shaving cream on my butt, my penis, my balls, and my pubic hair. - LPN A put the resident in bed naked and covered him/her with a blanket. - LPN A returned a little later and said you're back in bed. - LPN A patted the blanket over the resident's penis and made him/her very uncomfortable. - LPN A told the resident he/she only liked to do peri-care on the male residents. 2. Review of Resident #4's admission MDS, dated [DATE], showed: - Cognitively intact; - Required supervision for cares; - Continent of bowel and bladder; - Diagnoses included kidney failure and lung disease. Review of the resident's care plan, dated 11/16/21, showed: - The resident had the right to privacy. - The resident was able to self-toilet. Review of the facility's investigation of the resident on 1/4/22 by the ADM showed: - LPN A came into the resident's room around 3:00 A.M. - LPN A woke up the resident and said he/she needed to fix the resident's bed, because the resident was laying wrong. - The resident sat up on the side of his/her bed. - The resident was wearing boxers and no shirt with a blanket covering his/her lap. - LPN A grabbed the wipes and brought them to the bedside table. - LPN A kept grabbing at the blankets and tried to grab at the resident. - The resident said I don't know what you are doing, but I want you to get out of my room right now. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- LPN A washed his/her hands and left the room and did not return. During an interview on 1/5/22 at 9:25 A.M., the resident said: - LPN A woke him/her during the middle of the night. - He/she did not put on his/her call light. - LPN A said he/she did not like the way the resident was sleeping. - The resident said he/she normally slept with his/her knees outside the bed. - He/she had never fallen out of bed. - LPN A grabbed his/her blanket. - LPN A walked over to the sink after removing the resident's blanket and put wipes on the sink. - LPN A washed his/her hands. - LPN A grabbed the resident's knees. - The resident told LPN A he/she made him/her uncomfortable. - LPN A told the resident he/she seemed anxious and needed medication for anxiety. - The resident said he/she did not need anything. - LPN A then left the resident's room. 3. Review of Resident #2's care plan, dated 11/29/21, showed: - The resident required staff assistance of one for toileting. - The resident had a urinary catheter (a sterile tube inserted into the bladder to drain urine) and required catheter care. Review of the resident's quarterly MDS, dated [DATE], showed: - Cognitively intact; - Independent for cares; - Always continent of bowels; - Diagnoses included diabetes, dementia, anxiety, depression, and psychotic disorder. Review of the facility investigation, dated 1/4/22, by the ADM showed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The resident stated he/she had a spastic bladder. - LPN A came to clean him/her up. - LPN A kept rubbing the resident's penis to clean it and rubbed it so much it was irritated. During an interview on 1/5/22 at 9:55 A.M., the resident refused to speak to the investigator. 4. Review of Resident #3's care plan,dated 5/13/21, showed: - The resident was dependant upon staff due to cognitive issues. - The resident self-toilets. Review of the resident's quarterly MDS, dated [DATE], showed: - Cognitively impaired; - Independent or required supervision only for cares; - Always continent of bowel and bladder; - Diagnoses included kidney disease, dementia, depression, and psychosis; Review of the facility investigation, dated 1/4/22, by the ADM showed: - LPN A made the resident uncomfortable. - LPN A woke him/her in the middle of the night and gave the resident a bath. - LPN A made the resident feel uncomfortable. During an interview on 1/5/22 at 10:00 A.M. the resident said: - LPN A woke him/her up in the middle of the night. - LPN A removed his/her clothing. - The resident had an infection on their penis. - LPN A treated the infection with a physician ordered cream. - LPN A made the resident feel uncomfortable. 5. During an interview on 1/5/22 at 10:30 A.M., Certified Nurse Assistant (CNA) A said: - He/she worked with LPN A. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- LPN A performed peri care on only male residents that did not require peri care. - LPN A made him/her feel very uncomfortable. - He/she reported the issue to the ADM. During an interview on 1/11/22 at 7:10 A.M., LPN B said: - Staff reported to him/her that Resident #1 told him/her that LPN A inappropriately touched the resident. - He/she immediately reported the incident to the ADM. During an interview on 1/6/22 at 10:00 A.M., the ADM said: - As soon as the issue was reported to him/her, he/she ensured that residents were safe. - He/she ensured LPN A was not in the facility. - He/she notified the staffing coordinator that LPN A was not allowed in the building pending investigation. - He/she called the staffing agency and explained the allegations and stated that LPN A was suspended pending investigation. - He/she called the police and reported the issue. - He/she called the Elder Abuse hotline. - He/she called the Missouri Board of Nursing. - After thorough investigation, he/she banned LPN A from the facility permanently. During an interview on 1/6/21 at 10:30 A.M., LPN A said: - He/she would never inappropriately touch a resident. - He/she provided pericare for residents needing pericare. - Residents asked him/her for pericare. - Resident #4 was in danger of falling out of bed. - He/she repositioned the resident to prevent a fall. - He/she asked a resident if he/she needed a shower and provided the shower. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO195421

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 31100 Based on interview and record review, the facility failed to ensure the proper background checks were performed prior to allowing one Agency staff member, Licensed Practical Nurse (LPN) A, to work in the facility. The facility census was 100. Review of the facility policy, dated 2021, on abuse, neglect, and exploitation showed: - The facility would provide protection for the health, welfare and the rights of each resident to prohibit and prevent abuse, neglect, and exploitation. - Defined abuse as willful infliction of injury and included sexual abuse. - Willful was defined as acting deliberately. - Sexual abuse was defined as non-consensual sexual contact of any kind with a resident. -Review showed the policy did not mention background checks. Review of Licensed Practical Nurse (LPN) A's premployement screens performed by the staffing agency showed: - On 12/9/21 the facility contacted the exclusions search and found LPN A was not currently excluded from working in long term care (LTC). - LPN A was registered with the state of Missouri Family Care Safety Registry (FCSR), a registry that does criminal background checks (CBC), sex offender registry. - The request to the FCSR, dated 11/15/21, showed this was not background screening and background screening could be obtained from the registry. During an interview on 1/4/21 at 2:00 P.M., the Administrator (ADM) said: - LPN A was employed by a staffing agency. - The staffing agency performed all the background checks. During an interview on 1/11/21 at 4:00 P.M., the Staffing Agency (SA) A said: - The staffing agency used a third party to perform background checks on all their employees. - He/she would check to ensure that all the background checks were performed. -They did not have a background screen on LPN A. MO195421