

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/16/2022
NAME OF PROVIDER OR SUPPLIER Senath South Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 East Hornbeck Street Senath, MO 63876	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751</p> <p>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #1) remained free from physical abuse when staff failed to respond appropriately to the resident's behavior. The staff (Nurse Aide A) member struck the resident in the face multiple times. The facility census was 144.</p> <p>The Administration was notified on February 14, 2022, of Past Noncompliance Immediate Jeopardy (IJ) which began on February 6, 2022. On February 6, 2022, the Director of Nursing (DON) responded to a code green (all staff respond to a resident in a behavioral crisis) involving Resident #1. Upon getting the report of the incident, the DON discovered Nurse Aide (NA) A had physically attacked Resident #1. NA A left the premises, staff contacted the police, conducted an investigation, and notified appropriate parties. Facility staff reviewed the abuse and neglect policies and inserviced staff on abuse and neglect. The IJ was removed on February 7, 2022.</p> <p>1. Record review of the facility's Abuse and Neglect Policy, dated 9/17/2021, showed:</p> <ul style="list-style-type: none"> - The definition of abuse as purposefully beating, striking, wounding or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for the resident's proper control, treatment or management. Physical abuse also includes but is not limited to: hitting, slapping, punching, biting and kicking; - The facility is committed to protecting our resident from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals; - It is the policy of the facility that every resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. <p>Record review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 11/11/2021, showed:</p> <ul style="list-style-type: none"> - admitted [DATE]; <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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - The resident was cognitively intact; - The resident was independent with ADL's. <p>Record review of Resident #1's Physician Order Sheet (POS) dated 2/2022, showed diagnoses included intellectual disabilities, substance abuse, anxiety, depression and schizophrenia (a mental disorder with symptoms of hallucinations and delusions).</p> <p>Record review of the facility's abuse investigation, dated 2/6/2022 and completed by the DON, showed:</p> <ul style="list-style-type: none"> - At 9:45 A.M., staff called a code green to the men's unit courtyard to intervene with Resident #1; - Resident #1 became physically aggressive toward NA A; - The resident was placed in a five man CALM (Crisis Alleviation Lessons and Method - a crisis intervention to physically restrain in a safe manner to prevent injury) hold and given an injection of 25 milligram (mg) of Thorazine (a drug used to treat behaviors in mentally ill residents); - While calming the resident, Resident #1 said NA A had struck him/her; - The resident had a laceration to the inner lip; - The DON had responded to the code green and attempted to speak with NA A who responded angrily and aggressively and left the building; - Witness statements were taken and the evidence supported NA A struck Resident #1 after the resident shouted obscenities in regard to wanting a second cigarette. The staff member was terminated. <p>Record review of Resident #1's statement, taken by the DON, showed:</p> <ul style="list-style-type: none"> - On 2/6/2022, the resident sat in the courtyard smoking and heard NA A use obscenities and a racial slur; - NA A then accused the resident of being responsible for getting the NA written up; - The resident then asked for another cigarette and NA A refused saying the resident was not calm; - The resident told NA A that he/she was the one upset and then NA A starting swinging at the resident and hit him/her in the face. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/9/2022 at 9:30 A.M., the DON said she had not been aware of any prior issues with NA A. When she attempted to speak with NA A he/she became aggressive with her and flipped over a table and chair and exited the building. She contacted the police, but no report was made. The DON said Resident #1 is mentally ill and easily agitated against staff. NA A was supervising a smoke break for Resident #1's unit. On 2/6/22 things were said back and forth between Resident #1 and NA A, eventually leading to NA A refusing to give Resident #1 a second cigarette, even when all other residents got one. There was a verbal exchange and there are differing accounts of exactly what was said, however all stories agreed that Resident #1 said something that triggered NA A who then began swinging his/her arms at Resident #1. NA A called a code green and all staff available responded, including the DON.</p> <p>During an interview on 2/9/2022 at 10:15 A.M., Resident #1 said during a smoke break outside, NA A called him/her obscenities and a racial slur. The resident said he/she told NA A to stop calling names. He/she did curse at NA A in return and that is when NA A struck at the resident several times in the face.</p> <p>During an interview on 2/9/2022 at 10:25 A.M., Resident #7 said in the courtyard, during a smoke break NA A cursed at Resident #1. NA A swung at Resident #1 several times and took the resident to the ground.</p> <p>During an interview on 2/9/2022 at 10:30 A.M., Resident #8 said NA A would not give Resident #1 a second cigarette, but gave the other residents a cigarette. Resident #1 said something and NA A swung at the resident three times hitting Resident #1 in the face and then taking him/her to the ground.</p> <p>During an interview on 2/9/2022 at 10:40 A.M., Resident #9 said NA A was talking to another resident when Resident #1 said something and NA A threw the pack of cigarettes on the ground and attacked Resident #1. NA A punched Resident #1 in the face.</p> <p>During an interview on 2/14/2022 at 9:30 A.M., NA A said while on a smoke break, Resident #1 starting yelling and he/she told the resident to calm down or he/she would not get another cigarette. Resident #1 said Fuck your grandmother. NA A said he/she had just lost their grandmother and told Resident #1 again to calm down. The resident kept yelling and a Code Green was called. NA A denied hitting the resident.</p> <p>MO196967</p>		