STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265832	A. Building B. Wing	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senath South Health Care Center	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)
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** 32751 Please see the deficiency at D3JO12. Based on observation, interview and record review, the facility failed to ensure one resident (Resident #70) was free from abuse when a staff member reacted to the resident by pushing him/her to the floor. The facility census was 132. The Administration was notified on 9/8/2022 of a Past Non-compliance Immediate Jeopardy (IJ) which began on 8/30/2022. Upon discovery on 8/30/2022, the administrator identified Environmental Services Staff (EVS) A physically abused Resident #70. EVS A admitted to grabbing the resident's arm and taking the resident to the ground. Staff immediately assessed the resident and conducted an investigation. Facility staff reviewed their abuse and neglect policies and inserviced staff on abuse and neglect. The IJ was corrected on 8/31/2022. 1. Record review of the facility's Abuse and Neglect Policy, dated 9/17/2021, showed: - 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. Record review of Resident #70's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 8/16/2022, showed: - admitted [DATE]; (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Cognitively intact; - Independent with ADL's. Record review of the resident's Physician Order Sheet (POS) dated, 9/7/2022, showed a diagnosis of Schizoaffective Disorders (a mental disorder characterized by abnormal thought processes and an unstable mood). Record review of the facility's abuse investigation, dated 8/30/2022, showed: - During a Code [NAME] (a facility term for a resident who is having a potentially harmful behavior - all staff come to the resident to assist) on the men's unit, a commotion was heard on the women's unit; - Resident #70 had become agitated after requesting orange juice from EVS A; - EVS A had refused to give the resident orange juice due to the cart being used on the COVID isolation hall; - Resident #70 then threw an empty cup at EVS A's face; - EVS A then put his/her hands on the resident's upper arms and took the resident to the floor; - According to EVS A's statement he/she took the resident to the floor using a one man CALM (Crisis Alleviation Lessons and Method - a crisis intervention to physically restrain in a safe manner to prevent injury) take down - EVS A was suspended pending investigation. Record review of EVS A's written statement showed: - A Code [NAME] was called to the men's unit and he/she went and stood in attendance on the women's unit; - Resident #70 requested orange juice from the cart used for COVID isolation residents; - EVS A told the resident he/she could not have the juice on the cart and that EVS A would get he/she some ice water; - Resident #70 became agitated and threw a cup in the face of EVS A; - EVS A said he/she took the resident down. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 9/7/2022 at 10:30 AM, Resident #70 said he/she did recall the incident between him/her and EVS A. Resident #70 said someone called a Code Green. There were a lot of staff all standing around in the hallway. The resident said he/she saw the juice cart and was thirsty. Resident #70 said he/she walked up to EVS A and asked for some juice. EVS A said no that the juice on the cart had just been on the (COVID) positive unit. Resident #70 said that made no sense because the juice was covered and asked again. The resident said EVS A started walking away. Resident #70 said he/she got upset and threw his/her cup at EVS A's face. The resident said EVS A grabbed his/her upper arms, then kind of lifted and put the resident on the floor. The resident said he/she hit her head on the floor and still had a knot and tender area from it. In a telephone interview on 9/15/2022 at 11:30 A.M., EVS A said on 8/30/2022 a Code [NAME] was called. EVS A said when a Code [NAME] is called all staff members are to go to the area and standby. EVS A said he/she stood away from the actual Code [NAME] with EVS B near the hydration cart that had just come from the positive COVID unit. Resident #70 went up to EVS A and asked for some juice. EVS A said he/she told the resident the juice on the cart had just come from the COVID positive unit, but he/she (EVS A) would go to the kitchen and get the resident some juice. Resident #70 became agitated and demanded some juice immediately. EVS A said the resident stepped forward and pinned him/her in against the cart. EVS A said he/she asked for help from his/her coworkers and no one did anything, so he/she slipped from between the cart and Resident #70 and headed to the exit doors. Resident #70 followed and became increasingly agitated and went after EVS A again, this time pinning him/her to a portion of the wall, and increasing his/her threats to EVS A. EVS A said he/she yelled for help again and again, but no one assisted. EVS A said he/she slipped out again and made it to the door off the unit, when Resident #70 caught up to him/her again. EVS A said he/she was panicked by this point and yelled for help multiple times, but no one else moved. Resident #70 grabbed EVS A's top. EVS A said Resident #70 then threw his/her cup in EVS A's face. EVS A said he/she did put his/her hands on the resident and pushed. Both the resident and EVS A fell to the ground, Resident #70 taking EVS A's top off in the process. EVS A then left the unit. EVS A said he/she was aware this facility's population were mentally ill and did receive training regarding handling residents with behaviors by calling a Code [NAME] or walking away. In the moment, EVS A said he/she was frightened and just did what he/she needed to do to get out. In an interview on 9/7/2022 at 12:50 P.M., the Social Service Worker (SSW) said on 8/30/2022 a Code [NAME] was called to the men's unit and all staff had responded. EVS A was standing on the women's unit and Resident #70 had ask EVS A for some juice and when the staff member refused, the resident became agitated and threw a cup at the EVS A's face. EVS A took the resident to the floor. In an interview on 9/7/2022 at 1:10 P.M., Hall Monitor (HM) A said a Code [NAME] had been called to the men's unit. HM A said Resident #70 and EVS A were standing on the women's unit. Resident #70 had asked EVS A for some juice and when the staff member refused, the resident became agitated and threw a cup at EVS A's face. EVS A then grabbed Resident #70 by the arms and in a forward motion physically slung him/her to the floor. HM A said he/she heard Resident #70's head hit the floor. In an interview on 9/7/2022 at 1:20 P.M., EVS B said on 8/30/2022 a Code [NAME] had been called on the men's unit and he/she and EVS A were standing on the women's unit. EVS A had passed orange juice to some COVID isolation residents and Resident #70 had requested orange juice from the cart. EVS A refused, due to the cart being in the isolation rooms. The resident became agitated and threw a cup at EVS A's face. EVS A then grabbed the resident by the arms and slung the resident to the floor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 9/19/2022 at 9:45 A.M., the Business office manager (BOM) said on 8/30/2022 he/she had responded to a Code [NAME] call on the men's unit. While standing on the women's unit, he/she witnessed Resident #70 throw a cup at EVS A and EVS A pick the resident up by his/her upper arms and throw the resident to the floor. In an interview on 9/19/2022 at 10:00 A.M., Certified Nurse Aide (CNA) C said a Code [NAME] had been called to the men's unit. CNA C said Resident #70 and EVS A were standing on the women's unit. CNA C heard yelling. Resident #70 had asked EVS A for some juice and when the staff member refused, the resident became agitated and threw a cup at EVS A's face. EVS A then grabbed Resident #70 by the arms and in a forward motion physically threw him/her to the floor. In an interview on 9/7/2022 at 10:45 A.M., the Director of Nurses (DON) said there is no such thing as a one man CALM take down. Staff are not trained, in any way to do a take down alone. To be done safely it requires a staff member to call for a Code [NAME] and requires 5 people to assist the resident to the floor. EVS A should have walked away from Resident #70 or should have requested assistance to prevent any harm. Complaint #MO206304

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16207 See D3JO12 for 2567 details. Based on observation, interview and record review the facility failed to provide individualized treatment to meet the needs of one resident (Resident #7) out of a sample of 13 residents with a mental disorder. The facility census was 132. Review of Resident #7's medical record showed: - An admitted [DATE]; - Resident #7 is his/her own responsible party; - Diagnoses included Transient Cerebral Ischemic Attack (TIA), recurrent Major Depressive Disorder, Hypothyroidism, Psychotic Disorder with delusions due to known physiological condition, schizoaffective disorder, Schizophrenia, Post-Traumatic Stress Disorder (PTSD) and Bipolar disorder; - Intact cognition as assessed from the most recent 7/4/2022 quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff. Review of Resident #7's most recent care plan, updated 7/4/2022 showed a problem identified as Resident #7 has manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. These behaviors include acting out physically and verbally towards staff and peers. The resident also has a history of anxiety and a diagnosis of PTSD. The care plan did not identify any sources of anxiety or triggers for behavioral episodes. Interventions for the above problem included: - Administer and monitor medications as ordered; - Administer prn (as needed) medications as needed/ordered when non-pharmacological interventions are noneffective; - Assist resident in addressing root cause of change in behavior or mood as needed; - Give positive feedback for good behavior; - If resident is disturbing others, encourage him/her to go to a more private area to voice concerns/feelings to assist in decreasing episodes of disturbing others; - Notify guardian/physician as needed. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No interventions relating to specific triggers to avoid, that would cause increased anxiety and behaviors for the resident. During an interview on 9/7/2022 at 10:00 A.M., Resident #7 said he/she had become more paranoid and nervous recently. The resident said the facility staff has really been upsetting him/her at medication times. Resident #7 said it is very important for him/her to see his/her medications and make sure he/she knows what they are and make sure they are right. Resident #7 said at almost every medication pass, staff just hand over the pills and tell him/her to move on. Resident #7, offered for observation, a set of papers with details and dates of every medication administration. He/she had hand written the notes to help ease his/her anxiety. Resident #7 said he/she could go back and review his/her notes to ease his/her anxiety. Observation during the interview showed the more Resident #7 spoke about the medications and the way they are administered, the more physically agitated he/she became. The resident was twisting his/her hands, visibly trembling and had a shaking voice. During an interview on 9/7/2022 at 1:15 PM, the Director of Nursing (DON) said she was aware of Resident #7's anxiety with medication administration. The DON said staff turnover is very high right now, so it is likely a different or new person administering the medications every day. The DON said she has talked to the staff multiple times regarding this being one of Resident #7's triggers, specifically medication administration. The DON said the anxiety about medication administration and way to prevent the anxiety should be on Resident #7's care plan. Complaint #MO205036