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	11/09/2022

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 32751 Based on observation, interview, and record review the facility failed to ensure staff treated one resident (Resident #3), of seven sampled residents, with respect and dignity when multiple staff entered the resident's room, searched his/her possessions- throwing items on the floor and placing items in trashbags, without regard for the resident's emotional well-being, and then removed the resident's personal belongings from his/her room in trash bags. The facility census was 132. Record review of the facility's policy, Resident Rights dated 4/29/2021 showed: - The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility; - The facility must protect and promote rights of each resident; - The resident has the right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits. Record review of the facility's policy, Room Checks, dated 2/26/2021, showed: - A Certified Nurse Aide (CNA) or Nurse Aide (NA) will check the resident's room every morning and every evening to ensure that the resident's area is clean and free from potentially dangerous items; - Any contraband that is found in the resident's room will be removed and reported to the charge nurse; - Legal Guardian imposed limitations may be set for any contraband found in the resident's room that is not approved by the facility covenant guidelines. 1. Record review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/23/2022, showed: - The resident is cognitively intact; - The resident is independent with all activities of daily living (ADLs); (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident has diagnoses of anxiety, Manic Depression (a chronic mood disorder that causes intense shifts in mood), Schizophrenia (a mental disorder characterized by episodes of psychosis including hallucinations, delusions, disorganized thinking and social withdrawal.) Record review of the resident's Care Plan, dated 9/22/2022, showed: - The resident has a history of verbal aggression and dislike of authority; - The care givers are to provide positive interaction; - If reasonable, staff is to discuss the behaviors and explain why behavior is inappropriate; - Approach and speak in a calm manner when intervening; - Provide physical and verbal cues to alleviate anxiety. Observation on 11/3/2022, at 11:00 A.M., during the initial tour of the Women's Unit showed Resident #3's room as neat, tidy with no clutter and plenty of space. Observation on 11/3/2022 at 4:15 P.M. showed: - From the hallway, Resident #3 could be heard sobbing and screaming Stop!; - Upon entering the room, Resident #3 sat on the bed, crying, asking for mommy and yelling for staff to stop, over and over again; - Registered Nurse (RN) D, Hall Monitor (HM) G, Administrator in Training (AIT) E, and Certified Nurse Aide (CNA) F were in the resident's room going through the resident's personal belongings and personal property; - Four other staff members gathered at the resident's room door watching; - RN D, HM G, AIT and CNA F looked through the resident's toiletry bag, backpack, two plastic totes and a collection of books. The staff threw miscellaneous items from those sources on the floor. Staff threw books onto the floor behind them- with no regard as to how they landed; - The AIT threw personal items such as makeup, books, clothing, and food into large trash bags and tossed them into the hallway; - The resident's room was in disarray and staff continued to throw things in the floor while the resident yelled and cried for staff to stop throughout the incident; - None of the staff present attempted to calm the resident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/3/2022 at 4:15 P.M., observations showed two staff members took the two large, black trashbags out of Resident #3's room. AIT E said the resident was discovered in the bathroom snorting an unknown drug. The staff could not determine for certain what the drug was. Since they assumed the resident had procured this drug outside the facility, the facility would have the right to search the room and make sure there were no more drugs. AIT said the facility did not have to seek the resident's permission. AIT gave no reason for removing the resident's personal effects but did say the facility was removing the food sent to the resident by family members because the guardian did not want the resident to gain weight. The AIT said that if the resident would not give permission, the guardian would, and they would search the room then. During an interview on 11/3/2022 at 4:20 P.M., Resident #3 admitted to snorting a drug in the bathroom, but would not say what drug it was or how he/she acquired it. Resident #3 said he/she told staff there were no more drugs in the room. The resident said he/she did not give permission to search the room. Resident #3 said they took his/her stuff and just threw it around. Resident #3 said they took his/her stuff to throw away, and none of it had any drugs in it. He/She said all those staff members just stood in the doorway and watched him/her scream and cry and did nothing. During an interview on 11/3/2022 at 5:10 P.M., HM G said he/she was sitting in the doorway of the resident's room and noticed resident had gone to bathroom and closed the door. HM G said he/she opened the bathroom door and saw the resident with a book, a white substance on the book and a hollowed ink pen case. The HM then called for assistance and RN D entered the room and found the empty red and white capsule on the bed. RN D began searching the room and going through the resident's drawers, the AIT started taking the personal belongings and food out of the room. During an interview on 11/3/2022 at 5:20 P.M., RN D said he/she was called to the room where two green and yellow capsules were on the bed. RN D said he/she then began to search the resident's drawers for more medications, but found none. RN D said, to his/her knowledge, no one called the police or had the unknown substance tested to determine what it was. Complaint #MO209391

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(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** 31057 Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident when Resident #2 stabbed Resident #1 multiple times with a shard of glass while a staff member slept nearby. The facility census was 132. The Administrator was notified on 11/3/22 at 3:30 P.M., of the Immediate Jeopardy (IJ) which began on 11/3/22. The IJ was removed on 11/5/22, as confirmed by surveyor onsite verification. 1. Policy review: Record review of the facility Abuse and Neglect policy revised 11/3/2002, showed: - Class I neglect- failure of an employee to provide reasonable and necessary services to maintain the physical and mental health of any resident when that failure presents either imminent danger to the health, safety, or welfare of a resident, or substantial probability that death or physical injury would result; - Employees are trained through orientation and ongoing training on issues related to abuse prohibition practices, such as: dealing with aggressive residents, reporting allegations without fear of reprisal, recognizing signs of burnout, frustration or stress that may lead to abuse and the definition that constitutes abuse, neglect and misappropriation of resident property. Review of the facility Intensive Monitoring/Visual Checks policy, updated 3/25/2022, showed: - Residents who are showing poor impulse control including verbal/physical aggression, elopement ideations, suicidal/homicidal ideations, decompensation mentally or medically may also be placed on one to one or two to one (within eyesight of staff at all times) monitoring at the discretion of the Administrative staff. - A one to one (1:1) or two to one (level of monitoring) will be determined at the severity of the behavior or medical condition and at the discretion of the Chief Operating Officer, Regional Director, Administrator, DON, Management Team and Physician. - Residents who require intensive monitoring of one to one will always have a dedicated staff member within eyesight. - One delegated staff member can monitor two residents in the same room if both residents require intensive monitoring related to medical or fall risks. This must be approved by the Administrator. This cannot be implemented for two residents that are behavioral. (continued on next page)

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(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	2. Observation on 11/3/22 showed Residents #1, #2, and #4 resided on the Women's Unit, a locked behavioral unit. The unit included 22 residents, each with mental health disorders, including behaviors that would require a secured setting. The nurse's station is located outside of the unit's locked doors. 3. Record review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 8/17/2022 showed: - Cognition intact; - Diagnoses of schizophrenia (mental disorder of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation); Record review of Resident #1's care plan, updated 8/17/2022, showed: - Requires encouragement to interact with others in a positive manner; - At risk for injury to self and others related to history of verbal and physical aggression; - On 11-2-22 resident broke the window in his/her own room. Record review of the progress notes for Resident #1, showed: - On 11-3-22 Resident #1 became agitated with Resident #4 because of all the commotion Resident #4 was causing on the secure unit. Resident #1 grabbed a chair in his/her room and proceeded to break his/her bedroom window. At 3:36 A.M., Resident #1 received a PRN (as needed) injection of Thorazine (a medication that may sometimes be used to control agitation with a side effect of drowsiness) to calm down. At 4:56 A.M. nurse called to secure unit related to Resident #1 had been stabbed multiple times in the face and hands by Resident #2. Resident #1 sent out to local emergency room (ER) per physician orders. Record review of the ER report for Resident #1, dated 11/3/2022 showed: - Wound on left hand measures 8 centimeters (cm) with 7 sutures in place; - Wound on right side of forehead measures 7 cm with 7 sutures in place; - Wound on right dorsal (back of hand) part of hand measure 3 cm with 4 sutures in place; - Wound below left eye measures 3 cm with Dermabond (a tissue adhesive that forms a strong bond across wound edges) applied; - Wound located left index and middle finger measures 2 cm with Dermabond applied. 4. Record review of Resident #2's quarterly MDS, dated [DATE] showed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Cognition intact; - Diagnoses of schizophrenia; Record review of Resident #2's care plan, updated 9/20/2022, showed: - A reference to Resident #2's PASRR (Pre Admission screening and resident review) (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 8/23/2012, noted the resident had a long history of mental illness and frequent psychiatric hospital admissions related to schizophrenia and borderline personality disorder (a mental health disorder that impacts the way you think and feel about yourself and others, causing problems functioning in everyday life); - Per PASRR, the resident has tendency of verbal and physical aggression towards other when told no, history of suicidal and homicidal ideations. Monitor for elopement. Currently displays aggressive behavior such as kicking doors and yells out. Currently displays physical aggression towards others, which increases with regards to smoking and told no it is not smoke break time; - On 11/3/2022 resident displayed physical aggression towards peer in common area; - Requires encouragement to interact with peers and socialize with others. Record review of Resident #2's progress notes showed on 11/3/2022 the nurse received a call from a Certified Medication Technician (CMT) to report Resident #2 had stabbed Resident #1 in the face multiple times. Upon arrival, assessment of Resident #1 showed Resident #1 had blood coming from right side of face and upper left side of the under eye, left and right hand lacerations noted. CMT reported Resident #2 came up to him/her holding a piece of glass and stated, I stabbed the bitch. During an interview on 11/3/2022 at 11:00 A.M., the Director of Nursing (DON) said staff notified her by phone Resident #4 had broken a window in the common area at around 2:30 A.M. on 11/3/2022. After the staff attended to Resident #4, Resident #1 broke a window in his/her room that is shared with Resident #2. At that time, both Resident #1 and Resident #2 were removed from that room with Resident #2 going to a different room for the rest of the night and Resident #1 going to the common area to sleep on the couch while being placed on 1:1 oversight with Hall Monitor (HM) A. The DON said meanwhile, an unknown staff member cleaned Resident #1 and Resident #2's room of the glass placing it in the trash can in the room. At approximately 3:50 A.M., the DON received another call from staff stating Resident #2 had stabbed Resident #1 with a piece of glass. The police were notified along with the guardians, physicians, and the Administrator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/3/2022 at 11:15 A.M., Resident #2 said Resident #1 and Resident #4 were a couple and broke up last night. Resident #2 said she shared a room with Resident #1. Resident #4 kept complaining the staff were not treating her with care and called people racial slurs and busted the window out in the common area. Resident #1 then came into their room and broke their window disturbing Resident #2's sleep again. Resident #2 said she got mad, starting pacing the hall wanting to sleep, but could not and decided to stab Resident #1 in the eye for bothering her. Resident #2 then went back to his/her room, and found the trash can with all the broken glass. There were no staff on the hall. Resident #2 described the piece of glass she chose from the trashcan as approximately 2-3 inches wide, 6-8 inches in length and shaped like the state of Idaho. Resident #2 said the only staff on the hall was HM A and he/she was about to fall asleep. Resident #2 said she waited until HM A was asleep, walked down the hall to the common area, past the sleeping HM A, and stabbed Resident #1 in the eyes and face. Resident #2 said she had no remorse and Resident #1 got what she deserved. Resident #2 said she retaliated on Resident #1 for what her friend (Resident #4) was saying about people of color. During an interview on 11/3/2022 at 12:30 P.M. HM B said he/she was assigned to the Men's Unit working 1:1 with a resident when a Code [NAME] was called on the Women's Unit due to Resident #4 breaking a window in the common area. HM B said he/she responded, and then returned to the Men's Unit after the incident had settled. Approximately 30 minutes after the first incident a nurse from the Women's Unit opened the Men's Unit door, appeared upset and said he/she needed assistance. HM B said he/she responded again. Upon entering the common area on the Women's Unit, there was blood everywhere. Two nurses where attempting to stop the bleeding on Resident #1. The nurse instructed him/her to call 911 and the DON. HM B said during the initial code for Resident #4, he/she had seen HM A asleep in a chair in the common area after the incident was over. HM B said he/she had previously noted on a couple of occasions HM A would sleep during his/her shift but never reported it to anyone. HM B said none of the Hall Monitors were to sleep while on duty. HM B said when staff is given a 1:1 resident assignment; they are to keep that resident in line of sight at all times. When he/she leaves the assigned resident during a Code Green, at least one other HM or CNA is supposed to stay back and watch those residents. During an interview on 11/3/2022 at 3:25 P.M., HM A said after the incident with Resident #1 busting out the window in his/her room, Resident #1 was moved to the common area to sleep on the couch and Resident #2 was moved to another room. HM A said he/she did not know who cleaned up all of the glass from Resident #4 and Resident #1's incidents. The residents settled down and he/she dimmed the lights on the hall and sat in a chair, facing the hall, about four feet away from the couch where Resident #1 was sleeping in the common area. The next thing he/she knew Resident #1 started screaming and Resident #2 was stabbing Resident #1 in the face with a broken piece of glass. HM A denied seeing Resident #2 come up the hall or having a piece of glass until the incident. HM A denied sleeping as he/she had been in trouble once before for sleeping and was written up for it, but could not account how Resident #2 entered the room without his/her knowing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/3/2022 at 3:40 P.M., HM C said he/she had been assigned a resident to monitor 1:1 on the Women's Unit. HM C said he/she had stayed with his/her resident after Resident #4 broke the first window, and after things had settled checked out in the hall and saw HM A asleep in a chair in the common area. A little while went by and HM C heard Resident #1 break the window in his/her room. HM C said he/she saw staff run down to the room and remove both Resident #1 and #2 out of the room. HM C said he/she had not reported HM A sleeping. HM C said no staff is to be sleeping while on duty. HM C said when assigned a resident to monitor 1:1, he/she is with that resident the entire time while on duty, only switching off for breaks. During the night he/she is with the resident usually with the door shut to encourage a good night. During an interview on 11/3/2022 at 4:00 P.M., the Administrator and the DON said they would have expected the staff to clean up the glass from the residents room and immediately dispose of it. The DON stated she is not aware of Hall Monitor A having been written up for sleeping. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A 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 be taken to address Class I violation(s). Complaint #MO209391

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31057 Based on observation, interview, and record review the facility failed to keep all residents free from hazards and provide the necessary monitoring and supervision for one resident (Resident #1) when Resident #2 stabbed Resident #1. Facility staff failed to dispose of broken glass from a window to ensure residents with a history of physical aggression towards others did not have access. Resident #2 entered an unattended room, chose a shard of glass that had been disposed of in the trash can, walked the length of the unit, and stabbed Resident #1 within four feet of a sleeping staff member, who was assigned to provide one on one supervision to Resident #1. The facility census was 132. The Administrator was notified on 11/3/22 at 3:30 P.M., of the Immediate Jeopardy (IJ) which began on 11/3/22. The IJ was removed on 11/5/22, as confirmed by surveyor onsite verification. 1. Policy review: Record review of the facility Abuse and Neglect policy revised 11/3/2002, showed: - Class I neglect- failure of an employee to provide reasonable and necessary services to maintain the physical and mental health of any resident when that failure presents either imminent danger to the health, safety, or welfare of a resident, or substantial probability that death or physical injury would result; - Employees are trained through orientation and ongoing training on issues related to abuse prohibition practices, such as: dealing with aggressive residents, reporting allegations without fear of reprisal, recognizing signs of burnout, frustration or stress that may lead to abuse and the definition that constitutes abuse, neglect and misappropriation of resident property. Review of the facility Intensive Monitoring/Visual Checks policy, updated 3/25/2022, showed: - Residents who are showing poor impulse control including verbal/physical aggression, elopement ideations, suicidal/homicidal ideations, decompensation mentally or medically may also be placed on one to one or two to one (within eyesight of staff at all times) monitoring at the discretion of the Administrative staff. - A one to one (1:1) or two to one (level of monitoring) will be determined at the severity of the behavior or medical condition and at the discretion of the Chief Operating Officer, Regional Director, Administrator, DON, Management Team and Physician. - Residents who require intensive monitoring of one to one will always have a dedicated staff member within eyesight. - One delegated staff member can monitor two residents in the same room if both residents require intensive monitoring related to medical or fall risks. This must be approved by the Administrator. This cannot be implemented for two residents that are behavioral. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Observation on 11/3/22 showed Residents #1, #2, and #4 resided on the Women's Unit, a locked behavioral unit with 22 residents- all of whom are diagnosed with mental health disorders, including behaviors that would require a secured setting. The nurse's station is located outside of the unit's locked doors. Record review on 11/3/2022 of the staffing list on duty during the time the incident occurred (early morning 11/3/2022) and provided by the Director of Nursing (DON), showed: - The Women's Unit had four assigned staff, two Certified Nurse Aides (CNA) and two Hall Monitors (HM); - Both CNAs were assigned to 1:1 monitoring of residents; - HM C had also been assigned to 1:1 monitoring of a resident; - HM A assigned to the unit in general. 3. Record review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 8/17/2022 showed: - Cognition intact; - Diagnosis of schizophrenia (mental disorder of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation); Record review of the care plan updated 8/17/2022, showed: - Requires encouragement to interact with others in a positive manner; - At risk for injury to self and others related to history of verbal and physical aggression; - On 11-3-22 resident broke the window in personal room. Record review of the progress notes showed: - On 11-3-22 Resident #1 became agitated with Resident #4 because of all the commotion Resident #4 was causing on the secure unit. Resident #1 grabs a chair in his/her room and begins to break his/her bedroom window. At 3:36 A.M., Resident #1 receives a PRN (as needed) injection of Thorazine (a medication that may sometimes be used to control agitation with a potential side effect of drowsiness) to calm down. At 4:56 A.M. nurse called to secure unit related to Resident #1 had been stabbed multiple times in the face and hands by Resident #2. Sent to local emergency room (ER) per physician orders. Record review of the ER report, dated 11/3/2022, showed: - Wound on left hand measures 8 centimeters (cm) with 7 sutures in place; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Wound on right side of forehead measures 7 cm with 7 sutures in place; - Wound on right dorsal (back of hand) part of hand measure 3 cm with 4 sutures in place; - Wound below left eye measures 3 cm with Dermabond (a tissue adhesive that forms a strong bond across wound edges) applied; - Wound located left index and middle finger measures 2 cm with Dermabond applied. 4. Record review of Resident #2's quarterly MDS, dated [DATE] showed: - Admission to facility on 4/1/2020; - Cognition intact; - Diagnoses of schizophrenia; Record review of Resident #2's progress notes showed: - On 10/11/2022 Resident #2 in the dining room, went up to another resident and began hitting him/her and yelling, staff separated the residents. Resident #2 began screaming stating that other resident was going to give him/her a dollar and then did not. Resident #2 removed from the unit temporarily with staff member. Resident #2 received an as needed injection of Thorazine, tolerated well; - On 10/23/2022 Resident #2 went to the nurses' station several times requesting to go out and smoke, get fresh air, and complaints of being hungry. The nurse allowed resident to go outside for air and a cigarette the previous night and explained to the resident this was not to become a nightly request and the resident had to wait two weeks to ask again. Resident #2 agreed at that time. When reminding the resident again of the agreement the resident kicked through the door from the secure unit to the step down unit and went outside to the courtyard. Called Code [NAME] (a code used to secure a resident with use of a CALM technique (five trained staff members physically take the person to the ground) if needed. Notified the Administrator and he/she convinced the resident to return to the unit, the resident then received an as needed injection of Thorazine, the resident tolerated well with no further issues; - On 11/3/2022 the nurse received a call from a Certified Medication Technician (CMT) to report Resident #2 had stabbed Resident #1 in the face multiple times. Upon arrival, assessment of Resident #1 showed Resident #1 had blood coming from right side of face and upper left side of the under eye, left and right hand lacerations noted. CMT reported Resident #2 came up to him/her holding a piece of glass saying, I stabbed the bitch. Record review of the care plan updated 9/20/2022, showed: (continued on next page)

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	265832	A. Building B. Wing	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senath South Health Care Center	300 East Hornbeck Street Senath, MO 63876

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- A reference to Resident #2's PASRR (Pre Admission screening and resident review) (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 8/23/2012, noted the resident had a long history of mental illness and frequent psychiatric hospital admissions related to schizophrenia and borderline personality disorder (a mental health disorder that impacts the way you think and feel about yourself and others, causing problems functioning in everyday life); - Per PASRR the resident has tendency of verbal and physical aggression towards other when told no, history of suicidal and homicidal ideations. Monitor for elopement. Currently displays aggressive behavior such as kicking doors and yells out. Currently displays physical aggression towards others, which increases with regards to smoking and told no it's not smoke break time; - 11/3/2022 resident displayed physical aggression towards peer in common area; - No updates related to the incidents from the progress notes on 10/11/22 or 10/23/22; - Requires encouragement to interact with peers and socialize with others. During an interview on 11/3/2022 at 11:00 A.M., the Director of Nursing (DON) said staff notified her by phone Resident #4 had broken a window in the common area at around 2:30 A.M. on 11/3/2022. After the staff attended to Resident #4, Resident #1 broke a window in his/her room that is shared with Resident #2. At that time, both Resident #1 and Resident #2 were removed from that room with Resident #2 going to a different room for the rest of the night and Resident #1 going to the common area to sleep on the couch while being placed on 1:1 oversight with HM A. The DON said meanwhile, an unknown staff member cleaned Resident #1 and Resident #2's room of the glass placing it in the trash can in the room. At approximately 3:50 A.M., the DON received another call from staff stating Resident #2 had stabbed Resident #1 with a piece of glass. The police were notified along with the guardians, physicians, and the Administrator. The DON said none of the staff present during the incident could recall what happened to the glass from the window, or who cleaned it up. During an interview on 11/3/2022 at 11:15 A.M., Resident #2 said Resident #1 and Resident #4 were a couple and broke up last night. Resident #2 said she shared a room with Resident #1. Resident #4 kept complaining the staff were not treating her with care and called people racial slurs and busted the window out in the common area. Resident #1 then came into their room and broke their window disturbing Resident #2's sleep again. Resident #2 said she got mad, starting pacing the hall wanting to sleep, but could not and decided to stab Resident #1 in the eye for bothering her. Resident #2 then went back to his/her room, and found the trash can with all the broken glass. There were no staff on the hall. Resident #2 described the piece of glass she chose from the trashcan as approximately 2-3 inches wide, 6-8 inches in length and shaped like the state of Idaho. Resident #2 said the only staff on the hall was HM A and he/she was about to fall asleep. Resident #2 said she waited until HM A was asleep, walked down the hall to the common area, past the sleeping HM A, and stabbed Resident #1 in the eyes and face. Resident #2 said she had no remorse and Resident #1 got what she deserved. Resident #2 said he/she retaliated on Resident #1 for what her friend (Resident #4) was saying about people of color. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/3/2022 at 12:30 P.M. HM B said he/she was called to the Women's Unit due to Resident #4 breaking a window in the common area. HM B said he/she responded. HM B said when he/she first arrived on the Women's Unit, HM A was awake. But by the time he/she left and headed back to his/her previous hall, HM A had sat down in a chair and fallen asleep. HM B said he/she had no idea how HM A was able to sleep as the chair was just a few feet away from where staff where still cleaning up the glass from the window Resident #4 shattered. Approximately 30 minutes after the first incident a nurse from the Women's Unit opened the Men's Unit door, appeared upset and said he/she needed assistance. HM B said he/she responded again. Upon entering the common area on the Women's Unit, there was blood everywhere. Two nurses where attempting to stop the bleeding on Resident #1. The nurse instructed him/her to call 911 and the DON. HM B said during the initial code for Resident #4, he/she had seen HM A asleep in a chair in the common area after the incident was over. HM B said he/she had previously noted on a couple of occasions HM A would sleep during his/her shift but never reported it to anyone. HM B said none of the Hall Monitors were to sleep while on duty. HM B said when staff is given a 1:1 resident assignment; they are to keep that resident in line of sight at all times. During an interview on 11/3/2022 at 3:25 P.M., HM A said after the incident with Resident #1 busting out the window in his/her room, Resident #1 was moved to the common area to sleep on the couch and Resident #2 was moved to another room. HM A said he/she did not know who cleaned up all of the glass from Resident #4 and Resident #1's incidents. The residents settled down and he/she dimmed the lights on the hall and sat in a chair, facing the hall, about four feet away from the couch where Resident #1 was sleeping in the common area. The next thing he/she knew Resident #1 started screaming and Resident #2 was stabbing Resident #1 in the face with a broken piece of glass. HM A denied seeing Resident #2 come up the hall or having a piece of glass until the incident. HM A denied sleeping as he/she had been in trouble once before for sleeping and was written up for it, but could not account how Resident #2 entered the room without his/her knowing. Record review of HM A's employee file showed no discipline record for sleeping while on duty. During an interview on 11/3/2022 at 3:30 P.M., the DON said she was not aware of HM A being disciplined for sleeping on the unit. The DON said she is still unable to get clarification as to who cleaned the glass up in the resident room and left it there or when it was removed. During an interview on 11/3/2022 at 3:40 P.M., HM C said he/she had been assigned a resident to monitor 1:1 on the Women's Unit. HM C said he/she had stayed with his/her resident after Resident #4 broke the first window, and after things had settled checked out in the hall and saw HM A asleep in a chair in the common area. A little while went by and HM C heard Resident #1 break the window in his/her room. HM C said he/she saw staff run down to the room and remove both Resident #1 and #2 out of the room. HM C said he/she had not reported HM A sleeping. HM C said no staff is to be sleeping while on duty. HM C said when assigned a resident to monitor 1:1, he/she is with that resident the entire time while on duty, only switching off for breaks. During the night he/she is with the resident usually with the door shut to encourage a good night. During an interview on 11/3/2022 at 4:00 P.M., the Administrator and the DON said they would have expected the staff to clean up the glass from the resident room and immediately dispose of it, or at least put in a secured area. The Administrator and DON agreed no staff member should be sleeping while on duty. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NOTE: At the time of the 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 visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A 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 be taken to address Class I violation(s). Complaint #MO209391

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751 Based on observation, record review and interview the facility failed to ensure sufficient and competent staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being for one resident (Resident #1) of four sampled residents. Facility staff failed to recognize the potential hazard and secure broken glass on a secured unit of 22 mentally ill residents. Facility staff also failed to have sufficient, competent staff when the only available staff member on the unit slept and did not stop another resident's attack on Resident #1. The facility census was 132. 1. Policy review: Record review of the facility Abuse and Neglect policy revised [DATE], showed: - Class I neglect- failure of an employee to provide reasonable and necessary services to maintain the physical and mental health of any resident when that failure presents either imminent danger to the health, safety, or welfare of a resident, or substantial probability that death or physical injury would result; - Employees are trained through orientation and ongoing training on issues related to abuse prohibition practices, such as: dealing with aggressive residents, reporting allegations without fear of reprisal, recognizing signs of burnout, frustration or stress that may lead to abuse and the definition that constitutes abuse, neglect and misappropriation of resident property. Review of the facility Intensive Monitoring/Visual Checks policy, updated [DATE], showed: - Residents who are showing poor impulse control including verbal/physical aggression, elopement ideations, suicidal/homicidal ideations, decompensation mentally or medically may also be placed on one to one or two to one (within eyesight of staff at all times) monitoring at the discretion of the Administrative staff. - A one to one (1:1) or two to one (level of monitoring) will be determined at the severity of the behavior or medical condition and at the discretion of the Chief Operating Officer, Regional Director, Administrator, DON, Management Team and Physician. - Residents who require intensive monitoring of one to one will always have a dedicated staff member within eyesight. - One delegated staff member can monitor two residents in the same room if both residents require intensive monitoring related to medical or fall risks. This must be approved by the Administrator. This cannot be implemented for two residents that are behavioral. Review of the facility Hall Monitor Duties policy showed the following items may be assigned to any Hall Monitor working on an assigned unit: (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Walking Rounds - Face Checks - Smoking Breaks for Residents - Cleaning of facility/resident Equipment - Assist with Transportation of residents throughout unit, facility, or outings that do not require direct hands on care - Attend and assist with Code Greens - 1 :1 Monitoring - Cardiac Pulmonary Resuscitation (CPR) - Assist with activities (board games, puzzles, nail painting of residents) The following are duties the Hall Monitor may not be assigned: - Direct Patient Care - Vital Signs - Bathing - Dressing - Grooming - Turn and Repositioning - Feeding - Passing Snacks - Hands on Assistance of Residents found on floor or witnessed falls - AOL Cares - PeriCare - Catheters - Passing of Fluids - Intake and Output Measuring/Documenting (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on [DATE] showed: - The facility is a secured unit, with smaller secure units; - Residents #1 and #2 resided on the Women's Unit, a locked behavioral unit of 22 current residents all with mental health disorders with behaviors that would require a secured setting; - The Men's Unit had XX current residents all with mental health disorders with behaviors that would require a secured setting; -The nurse's station is located outside of both unit's locked doors. Record review of the facility's investigation summary showed on [DATE] around 3:30 A.M., Resident #2 acquired a glass shard from a previously broken window and stabbed Resident #1 on the hands and face. Hall Monitor (HM) A, was present and presumed asleep as he/she did not intervene until after Resident #1 cried out for help. Record review on [DATE] of the staffing listed as on duty during the time the incident occurred (early morning [DATE]) and provided by the Director of Nursing (DON), showed: - The Women's Unit had four assigned staff, two Certified Nurse Aids (CNA) and two Hall Monitors (HM); - Both CNAs were assigned to 1:1 monitoring of residents; - HM C had also been assigned to 1:1 monitoring of a resident; - HM A assigned to the unit in general; - After Resident #1 broke his/her glass window, HM A assigned to monitor 1:1 in the common area. 3. Record review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated [DATE] showed: - Diagnoses of schizophrenia (mental disorder of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation); Record review of the progress notes showed: - On [DATE] Resident #1 became agitated with Resident #4 because of all the commotion Resident #4 was causing on the secure unit. Resident #1 grabs a chair in his/her room and begins to break his/her bedroom window. At 3:36 A.M., Resident #1 receives a PRN (as needed) injection of Thorazine (a medication that may sometimes be used to control agitation with a potential side effect of drowsiness) to calm down. At 4:56 A.M. nurse called to secure unit related to Resident #1 had been stabbed multiple times in the face and hands by Resident #2. Sent to local emergency room (ER) per physician orders. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the ER report, dated [DATE], showed: - Wound on left hand measures 8 centimeters (cm) with 7 sutures in place; - Wound on right side of forehead measures 7 cm with 7 sutures in place; - Wound on right dorsal (back of hand) part of hand measure 3 cm with 4 sutures in place; - Wound below left eye measures 3 cm with Dermabond (a tissue adhesive that forms a strong bond across wound edges) applied; - Wound located left index and middle finger measures 2 cm with Dermabond applied. 4. Record review of Resident #2's quarterly MDS, dated [DATE] showed a diagnosis of schizophrenia. Review of Resident #2's PASRR (Pre Admission screening and resident review) (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated [DATE], showed: - A long history of mental illness and frequent psychiatric hospital admissions related to schizophrenia and borderline personality disorder (a mental health disorder that impacts the way you think and feel about yourself and others, causing problems functioning in everyday life); - A tendency of verbal and physical aggression towards other when told no, history of suicidal and homicidal ideations. Monitor for elopement. Currently displays aggressive behavior such as kicking doors and yells out. Currently displays physical aggression towards others, which increases with regards to smoking and told no it's not smoke break time; - Requires a structured environment and secured unit. During an interview on [DATE] at 11:00 A.M., the Director of Nursing (DON) said staff notified her by phone Resident #4 had broken a window in the common area at around 2:30 A.M. on [DATE]. After the staff attended to Resident #4, Resident #1 broke a window in his/her room that is shared with Resident #2. At that time, both Resident #1 and Resident #2 were removed from that room with Resident #2 going to a different room for the rest of the night and Resident #1 going to the common area to sleep on the couch while being placed on 1:1 oversight with HM A. The DON said meanwhile, an unknown staff member cleaned Resident #1 and Resident #2's room of the glass placing it in the trash can in the room, leaving it unattended. At approximately 3:50 A.M., the DON received another call from staff stating Resident #2 had stabbed Resident #1 with a piece of glass. The DON said none of the staff present during the incident could recall what happened to the glass from the window, or who cleaned it up. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:15 A.M., Resident #2 said Resident #1 came into their room and broke the window. Resident #2 said he/she got mad, starting pacing the hall and decided to stab Resident #1 in the eye for bothering him/her. Resident #2 then went back to his/her room, and found the trash can with all the broken glass. There were no staff on the hall. Resident #2 said the only staff on the hall was HM A and he/she was about to fall asleep like he/she does every night. Resident #2 said he/she waited until HM A was asleep, walked down the hall to the common area, past the sleeping HM A, and stabbed Resident #1 in the eyes and face. During an interview on [DATE] at 12:30 P.M. HM B said he/she was assigned to the Men's Hall to watch a resident 1:1. There were three staff on the Men's Unit, with two assigned to separate residents to watch 1:1. A Code [NAME] was called to the Women's Unit due to Resident #4 breaking a window in the common area. HM B said he/she responded, leaving the Men's Unit and the resident he/she had been assigned to be watched with the other HM. Before the incident with Resident #4 was completely through, Resident #1 broke the window in his/her room. HM B returned to the Men's Unit after the incident had settled, approximately 30 to 45 minutes. As this first incident was finishing up HM B said he/she saw HM A sleeping in a chair in the common area. HM B did not wake HM A up or report him/her sleeping to anyone. Approximately 30 minutes after the first incident a nurse from the Women's Unit opened the Men's Unit door, appeared upset and said he/she needed assistance. HM B said he/she responded again, leaving his/her resident to be monitored by the other HM. HM B said two nurses where attempting to stop the bleeding on Resident #1. The nurse instructed him/her to call 911 and the DON. HM B said he/she had previously noted on a couple of occasions HM A would sleep during his/her shift but never reported it to anyone. HM B said none of the Hall Monitors were to sleep while on duty. HM B said when staff is given a 1:1 resident assignment; they are to keep that resident in line of sight at all times. When he/she leaves the assigned resident during a Code Green, at least one other HM or CNA is supposed to stay back and watch those residents. HM B said there were two 1:1 resident assignments on the Men's Unit on [DATE]. HM B said he/she was not aware of who put the glass in the trashcan, or who was last out of the room. HM B said no glass should ever be left out on any of the units due to the residents' histories. During an interview on [DATE] at 3:25 P.M., HM A said after the incident with Resident #1 busting out the window in his/her room, Resident #1 was moved to the common area to sleep on the couch and Resident #2 was moved to another room. HM A said he/she did not know who cleaned up all of the glass from Resident #4 and Resident #1's incidents. The residents settled down and he/she dimmed the lights on the hall and sat in a chair, facing the hall, about four feet away from the couch where Resident #1 was sleeping in the common area. The next thing he/she knew Resident #1 started screaming and Resident #2 was stabbing Resident #1 in the face with a broken piece of glass. HM A denied seeing Resident #2 come up the hall or having a piece of glass until the incident. HM A denied sleeping as he/she had been in trouble once before for sleeping and was written up for it, but could not account how Resident #2 entered the room without his/her knowing. HM A said he/she was aware the residents on the hall he/she was assigned had severe mental illness with behaviors. During an interview on [DATE] at 4:00 P.M., the Administrator and the DON said staff should be aware of their duties to their assigned residents if they are to monitor 1:1, and not leave those residents inappropriately monitored. The Administrator and DON said they would start assigning code teams so not everyone will have to go. The DON said she was unaware HM A had ever slept while on duty, it is the facility's expectation no one sleeps while on duty. Complaint #MO209391