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	11/22/2022

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 16207 Based on interview and record review, the facility failed to protect the resident's (Resident #1) right to be free from verbal abuse by staff when Certified Nurse Aide (CNA) A told Resident #1 he/she was going to beat him/her up. A sample of six residents was reviewed from a facility census of 130. Record review of the facility's Abuse and Neglect Policy dated 9/17/2021 showed: - Verbal Abuse is defined as using profanity or speaking in a demeaning, non therapeutic, undignified, threatening or derogatory manner in a resident's presence. Examples include harassing a resident, mocking, insulting, ridiculing, yelling at a resident with the intent to intimidate or threatening a resident to deprive them of care of or withholding resident from contact with family and friends or activities; - 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 burn out, frustrations or stress that may lead to abuse and the definitions that constitute abuse; - The facility desires to prevent abuse by establishing a resident sensitive and resident secure environment. 1. Record review of Resident #'1's medical record showed Resident #1: - The resident entered the facility on 4/22/2022; - Diagnoses included Schizoaffective Disorder - Bi-Polar Type (A mental illness that includes psychotic symptoms such as hallucinations or delusions as well as episodes of mania or depression). Record review of the resident's Care Plan dated 11/3/2022 showed: - A history of verbal abuse toward staff; - Resident requires staff to speak in a calm manner and de-escalate. (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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(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 - Actual harm Residents Affected - Few	During an interview on 11/22/2022 at 12:40 P.M., CNA A said Resident #1 was in the dining room. When he/she left the dining area the resident followed him/her and started threatening to beat his/her ass. CNA A said the resident was angry due to CNA A telling the Administrator (ADM) about the resident giving another resident a pill. CNA A told the resident not to speak disrespectfully. CNA A denied threatening Resident #1. CNA A said he/she may have said something when walking off and the staff may have heard it, but he/she never addressed the resident in a threatening manner. During an interview on 11/22/2022 at 11:45 A.M., Resident #1 said he/she and another resident were in the dining room talking when CNA A interrupted by telling the resident that he/she needed to be back on the women's unit. The resident said he/she called CNA A a bitch, but denied threatening harm to CNA A. The resident said CNA A had lied to the staff that the resident had given another resident a pill. The resident said he/she was angry with CNA A. The resident said he/she followed CNA A out of the dining room. Resident #1 said CNA A just snapped and was out of control and got up in the resident's face, telling him/her to not disrespect him/her (CNA A) or he/she would beat the resident's ass. Resident #1 said when the other staff stepped in, both CNA A and him/herself was breathing hard. Resident #1 said she was not scared of CNA A because he/she could hold her own in a fight, but was worried and anxious the rest of the day from the incident. During an interview on 11/23/2022 at 9:30 A.M., CNA B said he/she was in the dining area. Resident #1 and CNA A were arguing and yelling at each other. Resident #1 was cursing at CNA A and CNA A told Resident #1 that he/she would not disrespect him/her. Resident #1 then followed CNA A into the hallway. CNA B heard them continue arguing. Resident #1 threatened to beat the CNA's ass. CNA A told the resident I will protect myself. If you touch me I will beat your ass. CNA B said he/she separated the two and tried to get CNA A to calm down. CNA B said both the resident and CNA A were visibly agitated. The ADM was called and CNA A was escorted from the building. Complaint #MO210090