

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Mayers Memorial Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 43563 Hwy 299 E Fall River Mills, CA 96028	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 40425</p> <p>Based on interview and record review, the facility failed to ensure five of seven sampled residents (Resident 1, 2, 3, 4 and 5) were free from verbal abuse when Certified Nurse Assistant (CNA) 1 verbally abused Residents 1, 2, 3, 4, and 5.</p> <p>This failure had the potential to negatively impact Resident 1, 2, 3, 4, and 5's sense of security, increased loss of dignity, and humiliation and emotional, and psychological well-being.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s clinical record, Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (memory loss), anxiety (fear of the unknown), Spinal stenosis (a narrowing of the spinal canal in the lower part of your back), and high blood pressure. The most recent Minimum Data Set (MDS, a standardized resident assessment) dated 3/27/24, indicated, Resident 1 was cognitively intact (able to think and reason).</p> <p>During an interview on 5/24/24, at 9:30 a.m., with Resident 1, Resident 1 stated, I have a hard time sitting up due to pain. CNA 1 told me she would not give me my food if I didn ' t sit up. I let her know I was unable to sit up due to the pain in my back. CNA 1 turned and walked out of the room without giving me my food. CNA 1 was not kind and shouldn ' t be working in this profession.</p> <p>During an interview on 5/24/24, at 2:14 p.m., with CNA 2, CNA 2 stated, I was sitting at the nurses station charting, when I heard CNA 1 tell Resident 1, she was not going to give him his tray because he would not sit up. CNA 1 was very rude and disrespectful.</p> <p>During a review of the facility ' s Progress Notes (PG), type, Event Note, dated 5/13/24, at 3:50 p.m., the PG indicated, Activities Aide reported, I observed when I was charting on 5/11/24 approximately 5:30 p.m., a traveling CNA, CNA 1, was working the front she was in the room with Resident 1 and she was refusing to give him his meal because he would not sit up, her tone was very rude, and another CNA ended up giving Resident 1 his tray.</p> <p>During a review of the facility ' s PG, type, Nursing Note, dated 5/15/24, at 2:03 p.m., the PG indicated, CNA 1 put Resident 1 ' s dinner tray on his table, told him to sit up or she would take his tray away. Resident 1 said he eats in this position all the time. CNA 1took his tray away. Resident 1 stated he had a horrible night because of CNA 1.</p> <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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review of a facility document titled, Report od Suspected Dependent Adult/Elders Abuse (SOC 341), dated 5/31/24, the SOC 341 indicated CNA 2 stated, CNA 1 was in Resident 1 ' s room refusing to give him his tray because he would not sit up.</p> <p>During a review of Resident 2 ' s clinical record, Resident 2 was admitted to the facility on [DATE] with diagnoses that included stroke, obesity, hearing loss, and arthritis. The most recent MDS dated [DATE], indicated Resident 2 was cognitively intact.</p> <p>During interview on 5/24/24, at 2:45 p.m., with RN, RN stated, CNA 1 came out of Resident 2 ' s room and yelled down the hall, Resident 2 is too big for me.</p> <p>During a review of the facility ' s PG, type, Event Note, dated 5/13/24, at 3:50 p.m., the PG indicated Activities Aide reported I heard her telling Resident 2 she was to big and could not get her tray closer to her, then CNA 1 walked out in to the hallway and was yelling I need help Resident 2 is a Hoyer and to big for me it ' s a 2 man job.</p> <p>During a review of the facility ' s PG, type, Nursing Note, dated 5/15/24, at 2:10 p.m., the PG indicated, the CNA 1 told Resident 2 she was too big to have her dinner tray while in her recliner. The CNA 1 was heard yelling down the hall to another coworker, I cannot do Resident 2 by myself; she is too heavy.</p> <p>During a record review of a facility document titled SOC 341, dated 5/31/24, the SOC 341 indicated, CNA 2 heard CNA 1 telling Resident 2 she was too big and could not get her tray close to her, then CNA walked out into the hallway and was yelling, I need help Resident 2 is a Hoyer and to big for me.</p> <p>During a review of Resident 3 ' s clinical record, Resident 3 was admitted to the facility on [DATE] with diagnoses that included obesity, Fibromyalgia (Widespread musculoskeletal pain accompanied by fatigue and trouble sleeping), and diabetes.</p> <p>The most recent MDS dated [DATE], indicated Resident 3 was cognitively intact.</p> <p>During an interview on 5/24/24, at 12:00 p.m., with Resident 3, Resident 3 stated, CNA 1 is a bad CNA and very abrupt.</p> <p>During an interview on 5/20/24, at 2:50 p.m., with RN, RN stated, Resident 3 stated CNA 1 is a bad CNA.</p> <p>During a review of the facility ' s PG, type, Event Note, dated 5/13/24, at 5:50 p.m., the PG indicated Resident 3 reported to RN CNA 1 is a bad CNA</p> <p>During a review of the facility ' s PG, type, Nursing Note, dated 5/15/24, at 2:15 p.m., the PG indicated Resident 3 had an alleged abuse on 5/11/24 on night shift. Nursing Description: CNA 1 is a bad CNA. This is what Resident 3 had to say about CNA 1, but Resident 3 would not elaborate. When asked what happened Resident 3 just said, nothing would be done anyway.</p> <p>During a record review of a facility document titled, SOC 341, dated 5/31/24, the SOC 341 indicated, RN reported Resident 3 stated CNA 1 is a bad CNA.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 4 ' s clinical record, Resident 4 was admitted to the facility on [DATE] with diagnoses that included Parkinson ' s disease (uncontrollable shaking), Cancer, and history of falling. The most recent MDS dated [DATE], indicated Resident 4 was cognitively intact.</p> <p>During an interview on 5/20/24, at 10:00 a.m., with Resident 4, Resident 4 stated, CNA 1 is unprofessional, not respectful, and made me feel pretty small. CNA 1 snapped at me and Resident 1 and said this is not my first rodeo.</p> <p>During a review of the facility ' s PG, type, Event Note, dated 5/13/24, at 3:50 p.m., the PG indicated Resident 4 reported to RN that he never wants CNA 1 to take care of him. Stated, She doesn't listen to me and told Resident 4, This is not my first rodeo.</p> <p>During a review of the facility ' s PG, type, Nursing Note, dated 5/14/24, at 1:00 p.m., the PG indicated Resident 4 stated this am that he never wants CNA 1 to take care of him. CNA 1 doesn't listen and would state, This is not my first rodeo. Resident 4 stated he'd rather lay in urine than to be cared for by CNA 1.</p> <p>During a record review of a facility document titled, SOC 341, dated 5/31/24, the SOC 341 indicated, Resident 4 reported to RN that he never wants CNA 1 to take care of him again. CNA 1 doesn ' t listen and would state, this is not my first rodeo. Resident 4 stated he would rather lay in his own urine than be cared for by CNA 1.</p> <p>During a review of Resident 5 ' s clinical record, Resident 5 was admitted to the facility on [DATE] with diagnoses that included Alzheimer ' s (memory loss), hip replacement, anxiety, and arthritis. The most recent MDS dated [DATE], indicated Resident 5 was cognitively intact.</p> <p>During an interview on 5/24/24, at 11:30 a.m., with Resident 5, Resident 5 stated, CNA 1 doesn ' t treat people well. CNA 1 is bossy, and she was the worst. CNA 1 continued to rush her and made her feel terrible. Resident 5 doesn ' t want CNA 1 to ever take care of her again and she should not be allowed to take care of people.</p> <p>During a review of the facility ' s PG, type, Event Note, dated 5/13/24, at 3:50 p.m., the PG indicated Resident 5 reported to RN that a CNA 1 rushes me and refused to help me to the toilet.</p> <p>During a review of the facility ' s PG, type, Nursing Note, dated 5/13/24, at 3:50 p.m., the PG indicated Resident 5 had an alleged abuse on5/11/24 on night shift: Nursing Description: CNA 1 rushes me and refused to help me to the toilet. I would rather have anyone but CNA 1 care for me, stated, Resident 5.</p> <p>During a record review of a facility document titled SOC 341, dated 5/31/24, the SOC 341 indicated, RN reported that Resident 5 stated, CNA 1 rushes me and refuses to help me to the toilet. I would rather have anyone but her care for me.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s policy and procedure (P&P) titled, [Facility Name] Policy and Procedure Abuse, Resident, dated 3/2/2023, the P&P indicated, verbal abuse is defined as, the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or with in hearing distance, regardless of age, ability to comprehend, or disability. Policy, It is [Facility Name] intent to ensure that each patient has the right to be free from abuse (verbal, sexual, physical, and mental) including corporal punishment and involuntary seclusion. Residents must not be subjected to any of the above by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers and other agencies that service the resident, family, staff members, legal guardians, friends or other individuals</p>