

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Friendship Village Sunset Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 12651 Village Circle Drive Saint Louis, MO 63127	

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>30687</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents was free from physical abuse by an agency Certified Nurse Aide (CNA). Review of a video, showed on the morning of 3/17/24, agency CNA A stood at Resident #1's bedside. He/She had one hand behind the resident's neck and with the other, pulled on the resident's leg towards a sitting position. The resident hit the CNA. With his/her right hand, CNA A punched the resident in the neck. He/She then loudly said, Stop. Why did you do that? The census was 136.</p> <p>On 04/12/24 9:49 A.M., the Administrator was notified of the past noncompliance immediate jeopardy (IJ) which occurred on 03/17/24. On 03/17/24, the administrator was notified of the incident and an investigation was started. CNA A was sent home and placed on the do not return list. Facility staff received education on Freedom from Abuse and Neglect. The IJ was corrected on 3/18/24.</p> <p>Review of the facility's Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property Policy, dated 10/2022, showed the following:</p> <p>-Preface: It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms;</p> <p>-Training Components:</p> <p>-Abuse Policy Requirements: It is the policy of this facility that all new and existing employees are educated on all forms of abuse, neglect, exploitation of residents, misappropriation of resident property, corporal punishment, injuries of unknown source, and involuntary seclusion, including freedom from physical or chemical restraints not required to treat a resident's medical symptoms. Training shall include prohibiting and prevention, identification, recognition, reporting and understanding behavioral symptoms that may increase risk of abuse and neglect in order to properly respond.</p> <p>Review of Resident #1's care plan, dated 2/27/24, showed the following:</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Problem: The resident has a history of resisting care and services. The resident has dementia and does not always understand what is being requested. The resident has become increasingly combative with staff and resistive with care. The resident is very difficult to redirect;</p> <p>-Goal: The resident will accept redirection during episodes of inappropriate behavior;</p> <p>-Approach: Introduce yourself upon contact, make eye contact, approach from front, explain all procedures prior to beginning. During periods of inappropriate behavior, use a consistent, calm, firm approach. Use the resident's name to help divert inappropriate behavior.</p> <p>Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/13/24, showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-No moods or behaviors;</p> <p>-No impairment to the upper and lower extremities;</p> <p>-Dependent with activities of daily living (ADLs);</p> <p>-Diagnoses of dementia and Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination).</p> <p>Review of the facility's investigation, dated 3/17/24, showed at approximately 9:00 P.M. on Sunday, 3/17/24, the Administrator was notified by the resident's family they had viewed a video from the camera they have in the resident's room and saw the day shift CNA punching or pushing the resident back on the bed as the CNA was assisting him/her up the morning of 3/17/24 at 9:24 A.M. The family requested this CNA no longer take care of the resident. The Administrator went to the facility to check on the situation. The nursing staff assessed the resident and found him/her to have no bruises or abrasions at that time. The resident is confused at baseline. The nursing agency was contacted to inform them of the issue with CNA A. The resident's family was informed early Monday (3/18/24) morning that CNA A would not be coming back to the facility. The resident was assessed and he/she appeared to be at his/her baseline.</p> <p>During an interview on 4/12/24 at 11:10 A.M., Family Member F said on 3/17/24 at approximately 9:30 P.M., he/she looked at video footage from his/her phone and saw CNA A hit the resident on the morning of 03/17/24 at 9:24 A.M. He/She called Family Member G immediately and told him/her what happened. Family Member F said he/she was very upset after watching the video footage.</p> <p>During an interview on 4/11/24 at 2:00 P.M., Family Member G said Family Member F called him/her on 3/17/24 at approximately 9:30 P.M. and told him/her what happened. He/She emailed the Director of Nursing immediately about the incident. He/She did not want CNA A giving care to the resident going forward.</p> <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>Review of a video, showed on the morning of 3/17/24 at 9:24 A.M., agency CNA A stood at the resident's bedside. He/She had one hand behind the resident's neck and with the other, pulled on the resident's leg towards a sitting position. The resident hit him/her. With his/her right hand, CNA A punched the resident in the neck. He/She then loudly said, Stop. Why did you do that? CNA A walked into the other room, coughing.</p> <p>During an interview on 3/26/24 at 12:54 P.M., CNA A said he/she was getting the resident dressed on 3/17/24 at 9:24 A.M. The resident has a history of being combative during care. CNA A said the resident hit him/her in the throat and he/she hit the resident back. CNA A said he/she did not mean to hit the resident. CNA A did not report the incident to the Charge Nurse because he/she did not think of it at the time. He/She was not familiar with the facility's abuse and neglect policy.</p> <p>During an interview on 4/1/24 at 9:20 A.M. Licensed Practical Nurse (LPN) B said he/she had not previously worked with CNA A. LPN B said as the day went on, CNA A seemed to be nonchalant and uncaring with his/her assignment and other staff members. Due to this behavior, he/she decided to send the CNA home. He/She did not remember the time and did not find out about the incident until later that night on 3/17/24.</p> <p>Review of CNA A's timesheet, showed he/she clocked out on 3/17/24 at 10:55:58 A.M. Central Standard Time.</p> <p>During an interview on 4/11/24 at 11:47 A.M., the Staff Coordinator (SC) said he/she looked at CNA A's performance review and he/she had 4.40 out of five score on the reviews. The agency staff have to physically read the facility's abuse and neglect policy before accepting a shift. This will show the agency staff have read and acknowledge the facility's policy.</p> <p>Review of CNA A's employee file, showed he/she read and accepted the facility's abuse and neglect policy on 3/14/24.</p> <p>During an interview on 4/12/24 at 11:50 A.M., LPN D said he/she was inserviced a couple of weeks ago on abuse and neglect, but did not remember the date, and again today on the facility's abuse and neglect policy. He/She said one should immediately report the hitting of a resident to the Director of Nursing or the Unit Manger.</p> <p>During an interview on 4/12/24 at 1:59 P.M., the Medical Director said he/she expected the facility CNAs and staff and agency CNAs to follow the facility's abuse and neglect policy.</p> <p>During an interview on 3/19/24 at 8:25 A.M., the Administrator said she expected facility staff and agency staff to follow the facility's abuse and neglect policy.</p> <p>MO00233320</p>		