

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Milan Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 52435 Infirmary Road Milan, MO 63556	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36185</p> <p>Based on interview and record review, the facility failed to report an allegation of sexual abuse involving two residents (Resident #1 and #2), in the review of six sampled residents to the state agency. The facility census was 94.</p> <p>Review of the facility Abuse and Neglect policy, last revised 06/12/2024, showed the following:</p> <ul style="list-style-type: none"> - It is the policy of the facility to report all allegations of abuse are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within the prescribed time frames; -Sexual abuse is non-consensual contact of any type with a resident. Sexual abuse includes, but is not limited to, the following: <ul style="list-style-type: none"> -Unwanted intimate touching of any kind especially of breasts or perineal area (the area of the body between the anus (rectal opening) and the external genitalia-the male or female reproductive organs); -All types of sexual assault or battery, such as rape, sodomy, and coerced nudity; -This also includes failure to intervene or attempt to stop or prevent non-consensual sexual activity or performance between residents; -The facility will investigate all allegations and types of incidents as listed in accordance to facility accordance to facility procedure for reporting and response; -The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required; -Best practice refer to the State Operations [NAME] (SOM) for reporting and utilize the abuse-neglect reporting decisions tree to assess the incident. Should the incident be a reportable event, notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after the discovery of the incident; -Follow-up with appropriate agencies, during business hours, to confirm the report was received; <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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Within five working days of the incident report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified.</p> <p>1. Review of Resident #1's Face Sheet, undated, showed the following:</p> <p>-The resident was admitted to the facility on [DATE];</p> <p>-He/She had a legal guardian;</p> <p>-Diagnoses included unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).</p> <p>Review of the resident's Care Plan dated 6/11/24, showed the following:</p> <p>-The resident has a communication problem related to dementia, hearing deficit, inattention and disorganized thinking</p> <p>-The resident had a psychosocial wellbeing problem due to distractibility and inability to concentrate. Encourage participation from the resident who depends on others to make own decisions, when conflict arises move the resident to a safe, calm environment, allow the resident to vent feelings.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 8/31/24, showed the resident was cognitively intact. He/She exhibited no behavioral symptoms.</p> <p>2. Review of Resident #2's Face Sheet, undated, showed the following:</p> <p>-The resident was admitted to the facility on [DATE];</p> <p>-He/She had a legal guardian</p> <p>-Diagnoses include early onset of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and dementia.</p> <p>Review of the resident's baseline Care Plan, dated 10/3/2, showed the following:</p> <p>-The resident was cognitively impaired and had a diagnosis of Alzheimer's disease. The resident communicated easily with staff and understood staff;</p> <p>-The resident did not require staff setup or physical assistance to walk in room, corridor, or locomotion on the unit.</p> <p>3. During an interview on 10/15/24 at 8:55 A.M. Nurse Aide (NA) B said on 10/6/24 at approximately 10:00 P. M., he/she entered Resident #1's room. Certified Nurse Aide (CNA) C was already in the room. Resident #2 stood beside Resident #1's bed. Resident #2 zipped up his/her pants when NA B walked in the room. Resident #2 tried to hit NA B and was agitated when staff assisted him/her out of Resident #1's room. Resident #2 was new to the facility and staff did not know a lot about him/her.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/15/24 at 9:30 A.M. CNA D said the following:</p> <ul style="list-style-type: none"> -He/She worked the day shift on 10/7/24. Staff from the previous shift reported the two residents (Resident #1 and #2) were having sex the night before; -Resident #2 tried to go down Resident #1's hall several times throughout the day shift. CNA D thought Resident #1 was looking for Resident #2 and it worried him/her; -The charge nurse said to keep an eye on Resident #1 and to make sure he/she wasn't on Resident #2's hall. <p>During an interview on 10/15/24 at 1:25 P.M., CNA C said the following:</p> <ul style="list-style-type: none"> -On 10/6/24 at approximately 10:00 P.M., he/she answered Resident #1's roommate's call light. Resident #1's privacy curtain was pulled when he/she entered the room. CNA C left the room to get ice for the roommate; -Upon returning to the room, CNA C heard a noise on Resident #1's side of the room. CNA C pulled the privacy curtain back and observed Resident #2 standing beside Resident #1's bed (Resident #1 faced Resident #2). Resident #1 abruptly zipped up his/her pants; -Resident #2 was new to the facility. Resident #2 tensed up and pulled away from staff, when he/she was redirected out of the room. CNA A reported to Licensed Practical Nurse (LPN) A that he/she felt something sexual had occurred between the two residents. CNA C was concerned for Resident #1's safety and was also concerned it wasn't reported to the state agency. <p>During an interview on 10/14/24 at 11:35 A.M. LPN A said the following:</p> <ul style="list-style-type: none"> -On 10/6/24 at approximately 10:00 P.M., CNA C and NA B reported Residents #1 and #2 were having oral sex. LPN A told CNA C and CNA B he/she did not feel anything had happened. He/She thought Resident #2 just helped Resident #2 back to his/her room and the staff were being dramatic about the situation; -LPN A called the Assistant Director of Nursing (ADON) and reported what the aides said occurred. LPN A kept a close eye on Resident #2 in case what NA B reported had actually occurred. He/She didn't interview Resident #1. The ADON said he/she would look into the incident the next day. <p>During an interview on 10/15/24 at 1:00 P.M. the ADON said the following:</p> <ul style="list-style-type: none"> -LPN A called him/her on 10/6/24 at approximately 10:00 P.M. and said CNA C found Resident #2 in Resident #1's room. CNA C said he/she thought something sexual occurred or was going to occur; -The ADON thought CNA C was being dramatic and the ADON told LPN A he/she would look into it in the morning and to keep the two residents separated; -He/She did not instruct LPN A to report the incident to the state agency as he/she didn't feel it was necessary. The ADON thought what CNA C said was a gossip and the staff exaggerated; <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff redirected Resident #2 back to his/her hall;</p> <p>-The following morning the ADON asked Resident #1 if he/she felt safe and he/she said yes, or if he/she had anything to report and Resident #1 said no. The ADON assumed nothing happened.</p> <p>During an interview on 10/17/24 at 10:20 A.M. the Director of Nursing said she would expect an allegation of sexual abuse be reported to the state agency.</p> <p>During an interview on 10/17/24 at 10:18 A.M. the Administrator said she would expect staff to report an allegation of sexual abuse to the state agency.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36185</p> <p>Based on interview and record review, the facility failed to complete a thorough investigation of an allegation of sexual abuse between two residents (Resident #1 and #2), of six residents sampled residents. The facility did not complete resident interviews with other residents following the incident to assess if they felt safe or had been subjected to or witnessed abuse and did not interview all staff present at the time of the alleged incident of abuse. The facility census was 94.</p> <p>Review of the facility Abuse and Neglect policy, last revised 06/12/2024, showed the following:</p> <ul style="list-style-type: none"> -Sexual abuse is non-consensual contact of any type with a resident. Sexual abuse includes, but is not limited to, the following: -Unwanted intimate touching of any kind especially of breasts or perineal area (the area of the body between the anus (rectal opening) and the external genitalia-the male or female reproductive organs); -All types of sexual assault or battery, such as rape, sodomy, and coerced nudity; -This also includes failure to intervene or attempt to stop or prevent non-consensual sexual activity or performance between residents; -The facility will investigate all allegations and types of incidents as listed in accordance with facility procedure for reporting and response; -When suspicion of abuse or reports of abuse occur, the licensed nurse will respond to the needs of the resident and protect him/her from further incident; -The Administrative/Designee will complete an administrative investigation to include personal statements from staff and residents involved in a situation that has any type of accusations of abuse either staff or resident abuse, or when administrative staff feel uncomfortable in any situation involving resident care or treatment; -The administrative investigation will also include a review of the resident's record to ensure that the documentation reveals that the legal guardian and/or responsible party was notified (if applicable), the physician was made aware, the resident was fully assessed, interventions and physician's orders were followed, the resident was re-evaluated, and the plan of care was updated to reflect the change in medical or behavioral status; -The facility Director of Nursing/Designee will ensure all clinical details and supportive plan of care interventions are completed for the administrative investigation. <p>1. Review of Resident #1's Face Sheet, undated, showed the following:</p> <ul style="list-style-type: none"> -The resident was admitted to the facility on [DATE]; <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had a legal guardian;</p> <p>-Diagnoses included unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).</p> <p>Review of the resident's Care Plan dated, 6/11/24, showed the following:</p> <p>-The resident has a communication problem related to dementia, hearing deficit, inattention and disorganized thinking</p> <p>-The resident had a psychosocial well-being problem due to distractibility and inability to concentrate. Encourage participation from the resident who depends on others to make decisions. When conflict arises move the resident to a safe, calm environment and allow the resident to vent feelings.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 8/31/24, showed the resident was cognitively intact. He/She exhibited no behavioral symptoms.</p> <p>2. Review of Resident #2's Face Sheet, undated, showed the following:</p> <p>-The resident was admitted to the facility on [DATE];</p> <p>-He/She had a legal guardian</p> <p>-Diagnoses include early onset of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and dementia.</p> <p>Review of the resident's baseline Care Plan, dated 10/3/24, showed the following:</p> <p>-The resident was cognitively impaired and had a diagnosis of Alzheimer's disease, the resident communicated easily with staff and understood staff;</p> <p>-The resident did not require staff setup or physical assistance to walk in room, corridor, or locomotion on the unit.</p> <p>3. During an interview on 10/15/24 at 8:55 A.M., Nurse Aide (NA) B said on 10/6/24 at approximately 10:00 P. M., he/she entered Resident #1's room. Certified Nurse Aide (CNA) C was already in the room. Resident #2 stood beside Resident #1's bed. Resident #2 zipped up his/her pants when NA B walked in the room. Resident #2 tried to hit him/her (NA B) and was agitated when staff assisted him/her out of Resident #1's room. Resident #2 was new to the facility and staff did not know a lot about him/her.</p> <p>During an interview on 10/15/24 at 9:30 A.M. CNA D said the following:</p> <p>-He/She worked the day shift on 10/7/24. Staff from the previous shift reported the two residents (Resident #1 and #2) had sex the night before;</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #2 tried to go down Resident #1's hall several times throughout the day shift. CNA D thought Resident #1 was looking for Resident #2 and it worried CNA D;</p> <p>-The charge nurse said to keep an eye on Resident #1 and to make sure he/she wasn't on Resident #2's hall.</p> <p>During an interview on 10/15/24 at 1:25 P.M., CNA C said the following:</p> <p>-On 10/6/24 at approximately 10:00 P.M., he/she answered Resident #1's roommate's call light. Resident #1's privacy curtain was pulled when he/she entered the room. CNA C left the room to get ice for the roommate;</p> <p>-Upon returning to the room, CNA C heard a noise on Resident #1's side of the room, CNA C pulled the privacy curtain back and observed Resident #2 standing beside Resident #1's bed (Resident #1 faced Resident #2). Resident #1 abruptly zipped up his/her pants;</p> <p>-Resident #2 was new to the facility. Resident #2 tensed up and pulled away from staff when he/she was redirected out of the room. CNA C reported to Licensed Practical Nurse (LPN) A that he/she felt something sexual had occurred between the two residents. CNA C was concerned for Resident #1's safety.</p> <p>During an interview on 10/14/24 at 11:35 A.M. LPN A said the following:</p> <p>-On 10/6/24 at approximately 10:00 P.M., CNA C and NA B reported Residents #1 and #2 were having oral sex. LPN A told CNA C and NA B he/she did not feel anything had happened. LPN A thought Resident #2 just helped Resident #2 back to his/her room and the staff were being dramatic about the situation;</p> <p>-LPN A called the Assistant Director of Nursing (ADON) and reported what the aides said occurred. LPN A kept a close eye on Resident #2 in case what NA B and CNA C reported had actually occurred. LPN A didn't interview Resident #1 or anyone else. He/She didn't obtain statements from residents or the staff involved. The ADON told LPN A he/she would look into the incident the next day.</p> <p>During an interview on 10/15/24 at 1:00 P.M. the ADON said the following:</p> <p>-LPN A called him/her on 10/6/24 approximately 10:00 P.M. and said CNA C found Resident #2 in Resident #1's room. CNA C said he/she thought something sexual occurred or was going to occur;</p> <p>-The ADON thought CNA C was being dramatic and told LPN A he/she would look into it in the morning and to keep the two residents separated. He/She thought what CNA C said was a gossip and staff exaggerated;</p> <p>-Staff redirected Resident #2 back to his/her hall;</p> <p>-The following morning, the ADON asked Resident #1 if he/she felt safe and he/she said yes, or if he/she had anything to report and Resident #1 said no. The ADON assumed nothing happened. He/She didn't complete an investigation into the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24 at 10:20 A.M. the Director of Nursing said she thought the comments the CNAs made were poor humor. She did not feel there were any concerns at the time of the incident. She would expect an allegation of sexual abuse be investigated.</p> <p>During an interview on 10/17/24 at 10:18 A.M. the Administrator said she was not aware a staff member had reported an allegation of sexual abuse on 10/6/24. She would expect staff to investigate any allegation of sexual abuse brought to them by a staff member.</p>		