

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2024
NAME OF PROVIDER OR SUPPLIER  Colonial Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  750 West Cooper Buffalo, MO 65622	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45190</b></p> <p>Based on interview and record review, the facility failed implement an abuse/neglect policy that ensured all reported allegations of possible abuse were reported to the State Survey Agency (Department of Health and Senior Services - DHSS) within two hours when staff failed to reported a documented allegation of touching of genitalia between two residents (Resident #1 and #2). The facility census was 105.</p> <p>Review of the facility policy titled, Patient Abuse/Neglect, Elder Abuse, and Persons with Disability Abuse, ADM03-03, last revised August 2021, showed the following:</p> <p>-Staff, employees, and physicians will follow regulations and standards in identification of and procedures for handling alleged victims of abuse;</p> <p>-In the event a person with responsibility for care of a person sixty years of age or older or adults with disabilities ages 18-59 has reasonable cause to suspect that an individual has been subjected to abuse or neglect, receives an allegation of abuse or neglect, or observes this individual being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that individual shall immediately make a report to the DHSS or the appropriate facility designee;</p> <p>-The designee will report or assist the person with direct knowledge of the concern to report immediately, within two hours of the allegation is for mental, physical, verbal, or sexual abuse or there has been bodily injury related to abuse. If not abuse and there is no injury, the designee should report within 24 hours of the observation or allegation, to DHSS at the hotline or in cases involving LTC (Long Term Care), the report shall be made first to the regional DHSS office during business hours or the hotline after hours. A fax notice or email to the regional DHSS during hours the hotline is closed is acceptable for the two-hour notice, but a follow up call is required;</p> <p>-In LTC, the designee is the facility Administrator, Administrator On-Call, Director of Nursing (DON) or registered nurse (RN) that shall be responsible for reporting suspected abuse or neglect;</p> <p>-Any concern, complaint, or allegation of patient/resident abuse/neglect (sexual, physical, or verbal) by another resident, employee, vendor or visitor shall be verbally reported immediately to the facility Administrator.</p> <p>1. Review of Resident #1's face sheet (a brief resident profile) 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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-admitted [DATE];</p> <p>-Resident had a guardian;</p> <p>-Diagnoses included bi-polar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and dementia.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by staff), dated 07/02/24, showed the following:</p> <p>-Cognitively intact;</p> <p>-Resident had a guardian;</p> <p>-No behaviors exhibited.</p> <p>Review of the resident's care plan, last revised 09/25/24, showed the following:</p> <p>-Resident had a history of bi-polar disorder, unspecified mood disorder, conversation disorder with motor symptoms and deficits, insomnia, altered mental status, and Parkinson's disease;</p> <p>-Mood interventions included to encourage expression of feelings, acknowledge/validate feelings, assist with coping skills, maintain a non-defensive stance, implement diversional activity, and assess for trigger situation such as pain, personal loss, relocation, conflict or prior history;</p> <p>Review of the resident's nursing note dated 08/08/24, at 9:51 P.M., showed the following:</p> <p>-The resident was found outside in courtyard with another resident. Resident #1 was touching the Resident #2's genitalia with his/her hand;</p> <p>-Residents were separated and put on 15-minute checks;</p> <p>-Resident was educated that his/her actions were inappropriate;</p> <p>-Staff notified the resident's guardian. The guardian advised he/she did not know what to do about the situation, but would be at the facility the following day to talk to the resident and the Administrator;</p> <p>-Staff notified the DON and who gave direction to place residents on 15-minute checks.</p> <p>During an interview on 09/26/24, at 10:52 A.M., the resident said the following:</p> <p>-He/she had been in a relationship with Resident #2 for over a year;</p> <p>-He/she touched Resident #2's genitalia and rubbing it in the courtyard.</p> <p>During an interview on 09/26/24, at 1:15 P.M., the resident's guardian said the following:</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>-A nurse notified him/her the resident was playing with Resident #2's genitalia on the back patio;</p> <p>-He/she advised the nurse to separate the residents and he/she would be at the facility the following day to speak to the Administrator;</p> <p>-The Administrator told the resident during the meeting the next day it is not appropriate for him/her to touch residents' in the private parts.</p> <p>Review of the resident's record showed staff did not document reporting the allegation abuse to DHSS.</p> <p>2. Review of Resident #2's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Resident had a Durable Power of Attorney (DPOA);</p> <p>-Diagnoses included major depressive disorder (persistently depressed mood or loss of interest in activities) and a history of stroke.</p> <p>Review of the resident's care plan, last reviewed on 02/27/24, showed the following:</p> <p>-Resident had a history of combat experience and has received professional treatment in the past, but does not wish to receive counseling or professional services;</p> <p>-Resident will not be exposed to triggers that may cause re-traumatization;</p> <p>-Observe for signs of adjustment difficulties such as inability to pursue interests or activities, sad or anxious mood, behavioral symptoms, impaired communication, sleep problems, and spiritual distress.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Moderate cognitive impairment;</p> <p>-No behaviors exhibited.</p> <p>Review of the resident's nursing note dated 08/08/24, at 11:23 P.M., showed the nurse was informed by aide that resident was outside in the courtyard receiving stimulation to his/her private area by another resident's hand. Residents were brought back into the building and remained in the dining room. Around 7:50 P.M., nurse called the resident's DPOA to notify of the incident. This nurse explained that the resident was found outside in the courtyard with another resident engaging in adult activity. The residents were separated and placed on 15-minute checks. Staff notified the DON of the situation.</p> <p>During an interview on 09/26/24, at 11:59 A.M., the resident said the following:</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>-He/she does not remember traumatic events at times and would consider someone touching his/her genitalia to be a traumatic event because he/she would not want another resident to be doing that to him/her at the facility.</p> <p>Review of the resident's record showed staff did not document reporting the allegation abuse to DHSS.</p> <p>3. Review of facility records showed staff did not provide documentation of reporting the allegation of possible abuse to DHSS.</p> <p>Review of DHSS records show DHSS did not have record of the facility reporting the allegation of sexual contact between Resident #1 and Resident #2.</p> <p>4. During interviews on 09/26/24, at 12:15 P.M. and 2:03 P.M., Certified Nurse Assistant (CNA) A said the following:</p> <p>-Staff should separate residents engaging in sexual touching and report to the Administrator immediately because staff may not know what the guardian's expectations are if the resident has a guardian;</p> <p>-The facility has 24 hours to report any abuse allegations to the state;</p> <p>-He/she would consider the incident of touching between Resident #1 and Resident #2 to be potential abuse and would have reported to the charge nurse.</p> <p>5. During interviews on 09/26/24, at 12:19 P.M. and 2:10 P.M., License Practical Nurse (LPN) B said the following:</p> <p>-Staff should separate residents with guardians engaging in sexual activity and contact the guardian and DON for further guidance;</p> <p>-Staff would not necessarily report residents with guardians engaging in sexual activity to the state agency if no harm or force was involved.</p> <p>6. During an interview on 09/26/24, at 12:31 P.M., CNA C said the following:</p> <p>-The guardian of a resident makes decisions regarding sexual activity with another resident, and staff should follow the guardian's decisions;</p> <p>-Resident #1's guardian did not want him/her engaging in sexual activity;</p> <p>-He/she did not know if Resident #2 consented;</p> <p>-Staff should have reported to the state agency because it could have been considered abuse.</p> <p>7. During interviews on 09/26/24, at 12:48 P.M., and 1:48 P.M., Licensed Practical Nurse (LPN) D said the following:</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>-The guardian of a resident makes decision regarding sexual activity with another resident, and staff should follow the guardian's decision;</p> <p>-If a guard of a resident does give permission to engage in sexual activity, the facility should provide a safe and private setting;</p> <p>-Staff should consider residents engaging in sexual activity without the permission of the guardian to be abuse and should report immediately to the guardian, DON, Administrator, and the state agency within 24 hours;</p> <p>-An aide reported observing Resident #1's hand on Resident #2's genitalia to another charge nurse who then reported to her/him;</p> <p>-He/she ensured the residents were separated;</p> <p>-He/she reported the incident to the guardian and the DON;</p> <p>-The guardian wanted the residents completely separated;</p> <p>-The DON advised to separate the residents and start 15-minute checks;</p> <p>-He/she did not report the incident to the state agency.</p> <p>8. During an interview on 09/26/24, at 2:17 P.M., the DON said the following:</p> <p>-Staff should immediately separate residents engaged in abusive behavior and report the incident to the charge nurse. The charge nurse reports to management;</p> <p>-Staff should immediately notify the responsible party and physician of any abuse allegation and the state agency within two hours;</p> <p>-Guardians and DPOA's make decisions regarding residents engaging in sexual relations with other residents;</p> <p>-The facility should take steps to honor decisions to now allow residents to engage in sexual relations by providing monitoring;</p> <p>-An aide reported observing Resident #1 touching Resident #2's genitalia while outside in the courtyard;</p> <p>-He did not feel this incident needed to be reported to the state agency as there was no allegation of abuse or neglect;</p> <p>-The facility did not have prior permission from Resident #1's guardian or Resident #2 DPOA to engage in sexual relations;</p> <p>-Residents should not be engaging in sexual relations outside at the facility;</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>-Staff should have treated the incident as an abuse situation if Resident #2 had said he/she did not consent, but to his knowledge, no staff had this conversation with either resident.</p> <p>9. During an interview on 09/26/24, at 3:22 P.M., the Administrator said the following:</p> <p>-Staff should separate residents following a resident-to-resident abuse allegation;</p> <p>-Staff should immediately report any abuse allegation to the charge nurse, DON, Administrator, and state agency within two hours;</p> <p>-The guardian of a resident makes decision regarding sexual activity with another resident, and staff should follow the guardian's decision;</p> <p>-If staff are unsure of a guardian's wishes regarding a resident engaging in sexual relations, staff should separate until a determination is made;</p> <p>-Staff found the residents outside and Resident #1 was touching Resident #2's genitalia;</p> <p>-Residents should not be touching one another's private parts outside at the facility;</p> <p>-The guardian of Resident #1 and DPOA of Resident #2 were contacted almost immediately;</p> <p>-The guardian of Resident #1 did not want him/her engaging in sexual behavior and the DPOA of Resident #2 did not have a preference;</p> <p>-He did not ask Resident #2 if he/she wanted to be touch and is unsure if any other staff asked;</p> <p>-Staff did not report to the state agency because they believed this was a mutual issue.</p> <p>MO00242275</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45190</p> <p>Based on interview and record review, the facility failed implement an abuse/neglect policy that ensured staff completed and documented a timely investigation of all reported allegations of possible abuse when staff failed to complete a documented investigation of a documented allegation of touching of genitalia between two residents (Resident #1 and #2). The facility census was 105.</p> <p>Review of the facility policy titled, Patient Abuse/Neglect, Elder Abuse, and Persons with Disability Abuse, ADM03-03, last revised August 2021, showed the following:</p> <ul style="list-style-type: none"> <li>-All complaints will be reviewed by the department director or facility administrator to determine the need for investigation;</li> <li>-The investigation party will determine the protocol for presenting the results of individual investigations to the Department of Health and Senior Services (DHSS) and may recommend changes to preclude recurrence of non-complaint activity;</li> <li>-The organization's designee will be responsible for immediately initiation and conducting an investigation of the alleged abuse/neglect;</li> <li>-During the investigation, residents will be protected from harm by interrupting the source of activity relating to the suspected abuse or neglect, providing education on appropriate behavior, and redirecting the resident as appropriate;</li> <li>-Residents will be removed from the area or distanced from the individual suspected of abuse/neglect;</li> <li>-In long-term care (LTC), the investigation will be completed by the administrator or designee and a summary submitted to the DHSS within five working days.</li> </ul> <p>1. Review of Resident #1's face sheet (a brief resident profile) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Resident had a guardian;</li> <li>-Diagnoses included bi-polar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and dementia.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by staff), dated 07/02/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Resident had a guardian;</li> </ul> <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>-No behaviors exhibited.</p> <p>Review of the resident's care plan, last revised 09/25/24, showed the following:</p> <p>-Resident had a history of bi-polar disorder, unspecified mood disorder, conversation disorder with motor symptoms and deficits, insomnia, altered mental status, and Parkinson's disease;</p> <p>-Mood interventions included to encourage expression of feelings, acknowledge/validate feelings, assist with coping skills, maintain a non-defensive stance, implement diversional activity, and assess for trigger situation such as pain, personal loss, relocation, conflict or prior history.</p> <p>Review of the resident's nursing note dated 08/08/24, at 9:51 P.M., showed the following:</p> <p>-The resident was found outside in courtyard with another resident. Resident #1 was touching the Resident #2 genitalia with his/her hand;</p> <p>-Residents were separated and put on 15-minute checks;</p> <p>-Resident was educated his/her actions were inappropriate;</p> <p>-Staff notified resident's guardian and the guardian advised he/she did not know what to do about the situation, but would be at the facility the following day to talk to the resident and the Administrator;</p> <p>-Staff notified the Director of Nursing (DON) who gave direction to place residents on 15-minute checks.</p> <p>During an interview on 09/26/24, at 10:52 A.M., the resident said the following:</p> <p>-He/she had been in a with Resident #2 for over a year;</p> <p>-He/she touched Resident #2's genitalia and was rubbing it in the courtyard.</p> <p>and Resident #2 are only allowed to hold hands now and can only go outside together during the day;</p> <p>During an interview on 09/26/24, at 1:15 P.M., the resident's guardian said the following:</p> <p>-A nurse notified him/her the resident was playing with Resident #2's genitalia on the back patio;</p> <p>-He/she advised the nurse to separate the residents and he/she would be at the facility the following day to speak to the Administrator;</p> <p>-The Administrator told the resident during the meeting the next day it is not appropriate for him/her to touch residents in the private parts.</p> <p>2. Review of Resident #2's face sheet showed the following:</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>-Management completes investigations regarding abuse allegation, which includes resident and staff interviews and resident assessments;</p> <p>-Guardians and DPOA's make decisions regarding residents engaging in sexual relations with other residents;</p> <p>-The facility should take steps to honor decisions to now allow residents to engage in sexual relations by providing monitoring;</p> <p>-An aide reported observing Resident #1 touching Resident #2's genitalia while outside in the courtyard;</p> <p>-He did not know if staff asked Resident #2 if he/she consented to being touched;</p> <p>-The facility did not complete an investigation regarding the incident because there was no allegation of abuse or neglect;</p> <p>-The facility did not have prior permission from Resident #1's guardian or Resident #2 DPOA to engage in sexual relations.</p> <p>-Staff should have treated the incident as an abuse situation if Resident #2 had said he/she did not consent, but to his knowledge, no staff had this conversation with either resident.</p> <p>9. During an interview on 09/26/24, at 3:22 P.M., the Administrator said the following:</p> <p>-Staff should separate residents following a resident-to-resident abuse allegation;</p> <p>-The facility should complete an investigation with any abuse allegation, including interviewing residents and staff and completing resident assessments;</p> <p>-The guardian of a resident makes decision regarding sexual activity with another resident, and staff should follow the guardian's decision;</p> <p>-If staff are unsure of a guardian's wishes regarding a resident engaging in sexual relations, staff should separate until a determination is made;</p> <p>-Staff found the residents outside and Resident #1 was touching Resident #2's genitalia;</p> <p>-Residents should not be touching one another's private parts outside at the facility;</p> <p>-The guardian of Resident #1 did not want him/her engaging in sexual behavior and the DPOA of Resident #2 did not have a preference;</p> <p>-He did not ask Resident #2 if he/she wanted to be touch and is unsure if any other staff asked;</p> <p>-An investigation was not completed.</p> <p>MO00242275</p>		