STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265419	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing Facility, Inc	2106 West Main Bowling Green, MO 63334

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42594 Based on observation, interview and record review, the facility failed to ensure three residents, (Resident #1, #2, and #5), in a sample of 14 residents, were treated with dignity and respect when Nursing Assistant (NA) H told Resident #1 don't cry, I didn't hurt you that much and when Certified Nurse Assistant (CNA) K turned off Resident #1's call light because he/she could not understand Resident #1. CNA I and CNA J made statements to Resident #2 about his/her smoking and medical diagnosis that upset and made Resident #2 mad. Additionally, Resident #5 said NA H was,very rude to him/her in the resident's room. The facility census was 42. Review of the facility's policy, Quality of Life -Dignity, dated 2/2020, showed the following: -Each resident shall be cared for in a manner the promotes and enhances each resident's sense of well-being, level of satisfaction with life, feeling of self-esteem and self-worth; -Residents are treated with dignity and respect at all times; -Staff speak respectfully to residents at all times, including addressing the resident by his/her name of choice and not labeling or referring to the resident by his/her room number, diagnosis or care needs; -Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents. For example; by promptly responding to a resident's request for toileting assistance. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 3/3/24, showed the following: -The resident was cognitively intact; -The resident had clear speech, was usually understood by others and could usually understand others; -The resident did not have any behaviors; -The resident did not reject cares; (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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident required substantial to maximum assistance to roll left to right; -The resident was dependent on staff for transfers from the chair to the bed; -The resident was dependent on staff for toileting and was always incontinent of bowel and bladder; -The resident had diagnoses that included dysphagia (difficulty swallowing) unsteadiness on feet, and muscle weakness. Review of the resident's care plan, dated 1/29/24, showed the following: -The resident had a communication problem related to garbled speech; -Encourage the resident to continue to state thoughts even if resident had difficulty; -Monitor/document frustration level. Wait 30 seconds before providing the resident with a word; -The resident had an activities of daily living (ADL) self-care performance deficit related to multiple disease processes; -The resident required extensive assistance of staff for repositioning and turning in bed and personal hygiene care; -The resident required total assistance with a Hoyer lift (mechanical lift machine used to transfer residents from one spot to another) for transfers. -Monitor/document/report to physician as needed any changes in his/her ability to communicate, potential contributing factors for communication problems and potential for improvement. -The resident had impaired cognitive function and impaired thought processes related to forgetfulness and confusion; -Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Review of the resident's care plan, dated 5/1/24, showed the resident used a notebook and pen to communicate his/her thoughts to others. Review of the facility's Grievance Report Form, dated 5/1/24, showed the following: -Resident #1 reported an incident that occurred in the resident's room to staff; -A staff member filled out a grievance form for the resident; -Resident #1 said Nursing Assistant (NA) H was rough and hurt his/her shoulder when NA H rolled the resident over. Review of the facility's Re-education Memo, dated 5/1/24, showed the following: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Employee name: NA H; -Areas of concern: see Attached; -Attached note, dated 5/1/24, showed NA H was interviewed and a statement obtained. NA H was coached in person by the administrator and was immediately suspended pending the investigation and per policy. NA H was later called and was told he/she could return to work on 5/4/24. NA H was coached over the phone on practicing professionalism in the workplace, practicing good communication skills, being mindful of volume, tact, clear communication, using open ended questions and listening for resident responses and feedback. NA H was in-serviced on abuse/neglect/reporting policy and resident rights. The note was signed by the administrator and the business office manager. NA H did not sign the form, indicating that he/she was in-serviced or coached on the above topics. During an interview on 5/9/24 at 11:50 A.M., Resident #1 said the following: -NA H was rough when he/she provided care on 5/1/24. NA H hurt one of his/her shoulders a little bit; -The resident yelled out when NA H rolled the resident over to change his/her brief; -NA H said, don't be crying, I didn't hurt you that much; -On 5/7/24, CNA K (agency staff) came in the resident's room to answer the call light. CNA K asked the resident what the resident wanted and the resident tried to use hand gestures. CNA K did not understand the resident. CNA K wanted the resident to write out his/her needs. The resident was unable to write while lying down. The CNA got upset because he/she could not understand the resident. CNA K turned off the call light and left the resident without helping him/her; -CNA K turned off the resident's call light at least four times without helping the resident on different occasions. During an interview on 5/9/24 at 4:01 P.M., Resident #1's family member said the following: -The resident became non-verbal shortly after he/she arrived at the facility in August 2023; -The resident told the family member he/she was upset and stressed out about the incident with NA H; -The resident would call sometimes and just mumble on the phone and that meant the resident needed assistance and was not getting it. The family member would call the facility to get staff to assist the resident. During an interview on 5/16/24 at 11:55 A.M., Licensed Practical Nurse (LPN) L said the following: -Resident #1 required two staff for most cares; -Resident #1 communicated to LPN L that he/she did not want NA H to take care of him/her or in his/her room because NA H was too rough and rude. (continued on next page)

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