| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265425 | A. Building<br>B. Wing | 04/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edgewood Manor Health Care Center | 11900 Jessica Lane<br>Raytown, MO 64138 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013<br><br>Based on interview and record review, the facility failed to preserve one sampled resident's (Resident #3) dignity when agency Certified Nurses Aide (CNA) B slapped the resident's hand and made inappropriate comments to the resident while he/she provided incontinence care out of seven sampled residents. The facility census was 77 residents.<br><br>On 4/18/24, the Administrator were notified of the past noncompliance (PNC) for an incident that occurred on 4/4/24. The facility administration had all staff including agency staff in-serviced on abuse and neglect, customer services, resident rights and dignity. The deficiency was corrected on 4/5/24.<br><br>Review of the facility's policy for Resident's Rights dated 6/29/23 showed:<br><br>-Every resident had the right to be treated with dignity and respect.<br><br>-All staff should speak to all residents with dignity and respect.<br><br>1. Review of Resident #3's Facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses:<br><br>-Schizoaffective disorder, bipolar type-(a mental condition that causes loss of contact with reality and mood problems along with periods of very high moods followed by very low moods).<br><br>-Paranoid schizophrenia-(a form of schizophrenia [a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others] characterized by persistent preoccupation with illogical, absurd, and changeable delusions, usually of a persecutory, grandiose, or jealous nature, accompanied by related hallucinations).<br><br>-Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety).<br><br>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated 2/8/24 showed he/she:<br><br>-Was not cognitively intact.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265425 | A. Building<br>B. Wing | 04/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edgewood Manor Health Care Center | 11900 Jessica Lane<br>Raytown, MO 64138 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Had little pleasure in doing things along with feeling bad about himself/herself nearly every day.<br><br>-Had trouble falling asleep or sleeping too much, feeling tired/having little energy, and thoughts of self-harm several days during a two-week period.<br><br>-Showed behavioral symptoms not directed at others such as screaming, rummaging, and disruptive sounds.<br><br>-Was wheelchair bound.<br><br>-Was dependent on facility staff for toileting/hygiene, showers/baths, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.<br><br>-Was dependent on facility staff for rolling left to right, sit to lying, chair/bed to chair transfers, and tub/shower transfers.<br><br>-Was dependent on facility staff to wheel his/her wheelchair 50 feet with two turns.<br><br>-Was dependent on facility staff to wheel his/her wheelchair 150 feet in a corridor or similar space.<br><br>-Was always incontinent of urine and stool.<br><br>Review of the resident's Nursing Care Plan dated 11/27/23 showed:<br><br>-He/she had a self-care deficit being totally dependent on facility staff for daily needs.<br><br>-He/she required assistance of one to two staff members to assist with incontinence care.<br><br>-The facility staff was to encourage the resident to participate in his/her cares to the fullest extent possible with each interaction.<br><br>-The facility staff was to encourage the resident to use his/her call light for assistance.<br><br>-He/she had behavior problems including obsessively yelling for help from the facility staff even when the care had just been provided.<br><br>-The facility staff was to anticipate and meet the resident's needs.<br><br>-The facility staff was to provide opportunity for positive interactions, attention, etc., with the resident including stopping and talking with him/her frequently throughout the day and during cares.<br><br>-The facility staff was to educate the resident on successful coping and interaction strategies while encouraging the resident and supporting him/her and the family.<br><br>-The facility staff was to explain all procedures/cares to the resident before starting them and allow the resident to adjust to changes in care.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265425 | A. Building<br>B. Wing | 04/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edgewood Manor Health Care Center | 11900 Jessica Lane<br>Raytown, MO 64138 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The facility staff was to intervene as necessary to protect the rights and safety of the resident and others.<br><br>-The facility staff was to approach and speak to the resident in a calm manner, diverting attention and removing the resident from any vulnerable situations.<br><br>-The facility staff was to administer the resident's medications which helped to curb negative behaviors, as ordered by the physician.<br><br>-The facility staff was to review the resident's behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy.<br><br>-The facility staff was to monitor the occurrences of the negative behaviors and document them per facility direction.<br><br>Review of the resident's Nurse's Notes dated 4/4/24 at 5:11 P.M., showed:<br><br>-Agency CNA A came to the Facility Administrator and stated that Agency CNA B slapped Resident #3's hand and stated don't touch me to the resident.<br><br>-The Facility Administrator asked the resident what happened and he/she stated, he/she slapped his/her hand and he/she told him/her don't hit me bitch.'<br><br>-A head to toe assessment was attempted however the resident said, No. It was my hand.<br><br>-The Facility Administrator further interviewed the resident who stated that he/she was not hurt and he/she was not scared to be in the facility.<br><br>-The resident's family was present during part of the investigation and was notified at that time.<br><br>-The resident's physician was notified as well.<br><br>Review of Agency CNA A's written statement dated 4/4/24 showed:<br><br>-Between 11:45 A.M., and 12:00 P.M., he/she went to Agency CNA B to ask him/her to assist with changing Resident #3.<br><br>-He/she informed Agency CNA B the room was a mess because the resident had a bowel movement to which Agency CNA B appeared to be upset about the mess.<br><br>-Agency CNA A and Agency CNA B transferred the resident into his/her bed to get him/her cleaned up.<br><br>-Agency CNA A turned around to get the wipes and heard a slapping sound.<br><br>-When Agency CNA A turned around, he/she saw Agency CNA B slap the resident's hand and tell the resident not to touch him/her.<br><br>-The resident then said, Don't hit me, bitch.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265425 | A. Building<br>B. Wing | 04/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edgewood Manor Health Care Center | 11900 Jessica Lane<br>Raytown, MO 64138 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Agency CNA A then went and told the nurse and Abuse Coordinator who was the Facility Administrator.<br><br>Review of the Facility Administrator's undated Investigation Summary showed:<br><br>-Agency CNA A came to him/her and stated that Agency CNA B slapped Resident #3 on his/her hand and stated, Don't touch me.<br><br>-When the resident was asked what happened, he/she stated the CNA slapped him/her and he/she told him/her, 'Don't hit me bitch.<br><br>-The Facility Administrator asked Agency CNA B if he/she had hit the resident and Agency CNA B said that he/she wouldn't do that.<br><br>-The Facility Administrator then walked Agency CNA B out of the building.<br><br>-A head to toe assessment was attempted on the resident, however the resident refused as it only involved his/her hand.<br><br>-The resident then stated that he/she was not harmed and the slap did not hurt, nor was he/she scared.<br><br>Review of the resident's Psychosocial Post-Incident Impact Questionnaire dated 4/4/24 at 12:43 P.M., showed:<br><br>-The resident was the victim in the incident.<br><br>-He/she did feel safe.<br><br>-He/she did not feel that he/she needed to speak with someone else.<br><br>-He/she did have at least one staff member that he/she felt safe to share his/her thought/feelings with if needed.<br><br>-He/she had no after-effects from the incident.<br><br>-He/she did not have any other needs or items that he/she wanted to address after the incident.<br><br>During an interview on 4/15/24 at 1:19 P.M., Agency CNA A said:<br><br>-He/she heard the resident yelling and went to check on him/her.<br><br>-The resident was seated in his/her wheelchair and had feces all over him/her and on the floor.<br><br>-The resident stated that he/she tried to get to the bathroom but did not make it there in time.<br><br>-Agency CNA A asked Agency CNA B for help in cleaning up the resident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265425 | A. Building<br>B. Wing | 04/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edgewood Manor Health Care Center | 11900 Jessica Lane<br>Raytown, MO 64138 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Agency CNA A told Agency CNA B that it was a mess in the room as there was feces even on the floor.<br><br>-Agency CNA B immediately seemed to get a bad attitude about the situation, however he/she agreed to come help.<br><br>-After they got the resident into the bed to get him/her cleaned up, Agency CNA A turned to get the wipes an immediately heard a slapping sound.<br><br>-He/she turned around and saw Agency CNA B slap the resident on his/her hand and said. Don't touch me! I don't' like you!<br><br>-Immediately after cleaning the resident up, he/she went to tell the Facility Administrator what had happened.<br><br>-The Facility Administrator then made Agency CNA B leave the facility.<br><br>During an interview on 4/15/24 at 2:45 P.M., the resident said:<br><br>-He/she did get slapped, but was not hurt.<br><br>-He/she felt safe in the facility.<br><br>-He/she was not afraid.<br><br>-When asked how he/she felt about Agency CNA B, he/she stated, I was not impressed by him/her. That is all I have to say.<br><br>During an interview on 4/18/24 at 1:40 P.M., Agency CNA B said:<br><br>-He/she never slapped the resident's hand.<br><br>-The resident at one point, went to grab ahold of his/her hand and there was feces on the resident's hand.<br><br>-When the resident made a motion to grab his/her hand so he/she blocked his/her hand and there could have been a slapping sound because of that.<br><br>-He/she believed that when he/she blocked the resident's arm, he/she might have said, I don't like this!, referring to the messy situation.<br><br>-He/she never told the resident he/she did not like him/her.<br><br>During an interview on 4/23/24 at 2:00 P.M., the Facility Administrator said:<br><br>-He/she would have expected the agency staff member to maintain the residents' dignity at all times.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265425 | A. Building<br>B. Wing | 04/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edgewood Manor Health Care Center | 11900 Jessica Lane<br>Raytown, MO 64138 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/she would have expected the agency staff member to make no derogatory comments to any residents.<br><br>-He/she would have expected the agency staff to have been well educated in maintaining the resident's dignity and rights.<br><br>MO00234201 |