STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265473	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Gardens Nursing & Rehab	3535 East Cherokee Springfield, MO 65809

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43193 Based on interview and record review, the facility failed to report all allegations of abuse immediately to management and to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required time two hour frame when an allegation of one staff member staff member (Certified Nursing Assistant (CNA) B) being physically abusive to one resident (Resident #1), out of five sampled residents, was made and not reported in a timely manner. The facility census was 96. Review of the facility's policy titled New Abuse/Neglect Report Regulations - Effective 11/28/16, revised 01/2017, showed the following: -With recent changes to Federal & State Regulations, one important change requiring immediate action involves Abuse Prohibition Protocol; -Immediately educate all staff to report to the Administrator and/or Designees any alleged (all allegations) violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property; -Per regulation 483.12 (c), the Administrator or designee must report to the State Survey agency no later than two hours after the allegation is made if the event that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the event that caused the allegation did not involve abuse and did not result in serious bodily injury. Review of the facility's policy titled, Guidelines for Facility Self-Reporting Effective November 28, 2016, revised 01/2017, showed the following: -The facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures. Review of the facility's policy titled Response and Reporting Guidelines, dated 05/2016, showed the following: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It is the purpose of the facility to report all substantiated incidents of abuse or neglect to the appropriate state agencies and the designated individuals at the facility's consultant office; -If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than two hours after forming the suspicion. 1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance) showed the following: -admitted [DATE]; -The resident had a responsible party; -Diagnoses included dementia, depression, hemiplegia (paralysis affecting one side of the body) following a cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems) affecting the right side, and reduced mobility. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 11/01/23, showed the following: -Mild cognitive impairment; -No behaviors; -Functional limitation in range of motion of the upper extremity on one side; -Used a wheelchair and walker for locomotion; -Required moderate assistance of one staff member to roll left and right, move from sit to lying, and move from lying to sitting on the side of the bed; -Required substantial assistance of one staff member to transfer from sitting to standing, from chair or bed to chair, toilet transfers, tub and shower transfers and to walk ten feet. Review of the resident's care plan, revised 11/22/23, showed the following: -Staff to develop a trusting relationship through frequent contact being honest and non-judgmental while projecting an accepting attitude toward the resident; -Staff to explain all cares, procedures, and medications before beginning; -Include the resident in the planning process, giving them choices whenever possible to enhance a sense of trust and respect for the resident; -Resident was at risk for falls; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident required a walker for short distances with supervision to set-up assist for safe ambulation; -Resident used a wheelchair for long distance mobility; -Staff to assist resident as needed or requested; -Staff to observe, document, and report any functional decline and provide assistance as needed; -Provide increased activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) assistance as needed and appropriate due to weakness or unsteady gait; -The resident did transfer self, but provide assistance as needed and requested. Always use a gait belt for all assisted transfers for safety; -Resident required assist of one for all his/her ADL's related to weakness and decreased mobility; -Resident was stand-by assistance to one person assistance with transfers and positioning. Review the facility's investigation, dated 02/06/24, showed the following: -On 02/05/24, at 6:19 A.M., the Administrator received a call from the Director of Nursing (DON) concerning an allegation of possible abuse on involving the resident; -The DON said Registered Nurse (RN) A text her at 4:30 A.M. and the RN called her back at 4:40 A.M.; -The DON said that RN A reported that CNA K responded to the resident's call light around 1:50 A.M. The CNA reported that the resident was hurting because CNA B made the resident go back to bed; -The RN went to the resident's room and asked him/her questions regarding the event. The resident told the RN that CNA B took him/her by the wrist and slammed him/her down hard onto the bed (he/she clarified into a sitting position). The resident said it wasn't necessary and it was uncalled for. CNA B was out of control, almost; -The RN noticed a small bruise to the palm-side of the left thumb proximal (close) to the base on the [NAME] surface (fatty part of the thumb). It measured 0.7 centimeters (cm); -The RN asked when CNA B slammed him/her down onto the bed. The resident stated nine o' clock. The resident said that he/she went to bed and woke up in pain and told CNA K; -The Administrator completed an online, after hours abuse and neglect report with DHSS at 7:00 A.M. (five hours after the allegation of abuse was received by staff); -The Administrator reported incident to DHSS, ombudsman, and the resident's doctor. Review of the resident's nurse's progress note dated 02/05/24, at 7:09 A.M. showed the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A CNA reported to the RN at approximately 1:50 A.M., the resident was complaining of wrist pain and reported the events leading to this pain. The RN spent the next half to one hour talking with the resident and staff regarding the events and assessing for facts. At approximately 4:28 A.M., RN was able to get a text to the DON regarding the events. RN then spoke on the phone with the DON. RN provided CNAs with required paperwork for event follow up. During an interview on 02/09/24, at 2:05 P.M., CNA K said the following: -If a resident reported abuse to him/her, he/she reported to the charge nurse immediately; -The charge nurse reported to DHSS within two hours; -On 02/05/24, at approximately 1:30 A.M. to 1:40 A.M., he/she answered the resident's call light and the resident reported that CNA B told the resident he/she had to go to bed, grabbed his/her arm, threw him/her in bed, and told him/her to stay in bed. The resident said his/her arm hurt and when the CNA looked at it, the CNA did not see any marks; -He/she left the room approximately five minutes after answering the resident's call light and reported this the RN A. During an interview on 02/08/24, at 11:54 A.M., RN A said the following: -If a resident reported abuse to a CNA or CMT, they reported to the charge nurse immediately. The charge nurse then reported to the DON immediately; -The Administrator reported to DHSS within two hours; -On 02/05/24, at approximately 1:50 A.M., CNA K reported to him/her that the resident complained of wrist pain and stated that CNA B grabbed the resident by the wrists and slammed him/her down; -The RN spoke with the resident after CNA K reported to the RN and the resident said that he/she hurt his/her wrist. CNA B told him/her to go to bed, grabbed him/her by the wrists, and slammed him/her down on the bed onto his/her bottom; -At 4:28 A.M., the RN reported the allegation to the DON; -He/she should have reported to the DON sooner. During an interview on 02/08/24, at 9:06 A.M., the resident said approximately one week ago, CNA B put him/her in bed strongly. It hurt and the CNA handled her in an inappropriate way. During an interview on 02/08/24, at 9:18 A.M., Housekeeper E said if a resident reported abuse to him/her, he/she reported to his/her supervisor immediately. The DON reported to DHSS within four hours. During an interview on 02/08/24, at 9:25 A.M., Certified Medication Technician (CMT) F said if a resident reported abuse to him/her, he/she reported to the charge nurse immediately. The DON or Administrator reported to DHSS within two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/08/24, at 9:29 A.M., CNA G said if a resident reported abuse to him/her, he/she reported to the charge nurse immediately. The DON or Administrator reported to DHSS within 24 to 48 hours. During an interview on 02/08/24, at 9:31 A.M., RN H said if a resident reported abuse to a CNA or CMT, they reported to him/her immediately after they ensured the resident was safe. He/she assessed the resident then reported to the Assistant Director of Nursing (ADON) or DON. The ADON or DON reported to DHSS immediately but within two hours. During an interview on 02/08/24, at 9:37 A.M., CNA D said if a resident reported abuse to him/her, he/she reported to the charge nurse immediately. The DON reported to DHSS. During an interview on 02/08/24, at 9:39 A.M., Licensed Practical Nurse (LPN) I said if a resident reported abuse to a CNA or CMT, they reported this to the charge nurse immediately. The charge nurse reported to the DON immediately. Reports of abuse in the middle of the night still required to be reported to the DON immediately. The DON reported to DHSS within two hours. During an interview on 02/08/24, at 9:46 A.M., CNA J if a resident reported abuse to him/her, he/she reported to the charge nurse immediately. The charge nurse reported to the DON and the DON reported to DHSS immediately. During an interview on 02/08/24, at 12:35 P.M., the DON said the following: -If a resident reported abuse to a CNA or CMT, they should report to the charge nurse immediately; -The charge nurse interviewed and assessed the resident and then contacted the DON or Administrator immediately; -He/she or the Administrator reported to DHSS within two hours; -On 02/05/24, between 1:45 A.M. and 2:00 A.M., CNA K reported to RN A that the resident stated CNA B slammed him/her down on the bed and told the resident to get to bed; -He/she considered that an allegation of abuse; -RN A texted him/her around 4:30 A.M. and he/she called the RN around 4:40 A.M. and the RN reported the allegation of abuse at that time to him/her; -He/she reported the allegation to the Administrator after 6:00 A.M. but he/she should have reported to the Administrator immediately. During an interview on 02/08/24, at 1:10 P.M., the Administrator said the following: -He/she reported allegations of abuse to DHSS within two hours; -CNA K reported to RN A on 02/05/24, at 1:50 A.M.; -RN A reported to the DON on 02/05/24, at approximately 4:30 A.M.; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The DON reported to him/her at 6:19 A.M. and he/she reported to DHSS at approximately 7:00 A.M.; -The allegation should have been reported to DHSS by 3:50 A.M. MO00231374

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43193 Based on interview and record review, the facility failed following their abuse policy and take steps to protect all residents during an investigation of alleged abuse after staff reported that one resident (Resident #1) alleged a staff member (Certified Nursing Assistant (CNA) B) physically abused him/her and the CNA continued to work independently with residents. Five residents were sampled in a facility with a census of 96. Review of the facility's policy titled Abuse Prohibition, dated 11/2016, showed the following: -It is the purpose of this facility to prohibit mistreatment, neglect, abuse, misappropriation of resident's property and exploitation of any resident; -To assure that everything possible is being done to prevent abuse, the facility has implemented the following seven component processes: Screening of potential employees, training, initial and ongoing of employees, prevention of abuse, neglect or mistreatment or any of the types of abuse, identification of suspicious events, protection of residents during an investigation, investigation of all alleged violations, and response and reporting of an abusive situation to necessary agencies. Review of the facility's policy titled Guidelines for Facility Self-Reporting, Effective November 28, 2016, revised 01/2017, showed the following: - The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse, neglect or exploitation or mistreatment while the investigation is in progress. Review of the facility's policy titled Protection Guidelines, dated 03/2012, showed the following: -It is the purpose of the facility to protect the resident from harm during an abuse investigation; -To protect the resident from an employee during an abuse investigation, the employee will be suspended without pay during the investigation process. Review of the facility's policy titled Response and Reporting Guidelines, dated 05/2016, showed the following: -All alleged persons (employees) suspicious of a crime (any resident injury-serious or not) will be immediately suspended during the investigation. 1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance) showed the following: -admitted [DATE]; -The resident had a responsible party; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included dementia, depression, hemiplegia (paralysis affecting one side of the body) following a cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems) affecting the right side, and reduced mobility. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 11/01/23, showed the following: -Mild cognitive impairment; -No behaviors; -Functional limitation in range of motion of the upper extremity on one side; -Used a wheelchair and walker for locomotion; -Required moderate assistance of one staff member to roll left and right, move from sit to lying, and move from lying to sitting on the side of the bed; -Required substantial assistance of one staff member to transfer from sitting to standing, from chair or bed to chair, toilet transfers, tub and shower transfers and to walk ten feet. Review of the resident's care plan, revised 11/22/23, showed the following: -Staff to develop a trusting relationship through frequent contact being honest and non-judgmental while projecting an accepting attitude toward the resident; -Staff to explain all cares, procedures, and medications before beginning; -Include the resident in the planning process, giving them choices whenever possible to enhance a sense of trust and respect for the resident; -Resident was at risk for falls; -Resident required a walker for short distances with supervision to set-up assist for safe ambulation; -Resident used a wheelchair for long distance mobility; -Staff to assist resident as needed or requested; -Staff to observe, document, and report any functional decline and provide assistance as needed; -Provide increased activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) assistance as needed and appropriate due to weakness or unsteady gait; -The resident did transfer self, but provide assistance as needed and requested. Always use a gait belt for all assisted transfers for safety; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident required assist of one for all his/her ADL's related to weakness and decreased mobility; -Resident was stand-by assistance to one person assistance with transfers and positioning. Review the facility's investigation, dated 02/06/24, showed the following: -On 01/05/24, at 6:19 A.M., the Administrator received a call from the Director of Nursing (DON) concerning an allegations of possible abuse from the resident; -The DON said Registered Nurse (RN) A texted her at 4:30 A.M. and the RN called her back at 4:40 A.M.; -The DON said RN A reported that Certified Nursing Assistant (CNA) K responded to the resident's call light around 1:50 A.M. The CNA reported that the resident was hurting because CNA B made the resident go back to bed; -The RN went to the resident's room and asked him/her questions regarding the event. The resident told the RN that CNA B took him/her by the wrist and slammed him/her down hard onto the bed (he/she clarified into a sitting position). The resident said it wasn't necessary and it was uncalled for. CNA B was out of control, almost; -The RN noticed a small bruise to the palm-side of the left thumb proximal (near) to the base on the [NAME] surface (fatty part of the thumb). It measured 0.7 centimeters (cm); -The RN asked when CNA B slammed him/her down onto the bed. The resident stated nine o' clock. The resident said that he/she went to bed and woke up in pain and told the CNA K; -The Administrator completed an online, after hours abuse and neglect report with DHSS at 7:00 A.M.; -CNA B was not in the building when this writer was called due to the CNA's shift ending at 6:00 A.M.; -RN A stated in his/her report that CNA B was not going back into the resident's room and he/she would have CNA K answer the resident's call light until shift change. During interviews on 02/08/24, at 10:36 A.M. and 11:35 A.M., CNA B said the following: -On 02/05/24, when he/she returned from lunch, the charge nurse told him/her not to go back into the resident's room due to the resident reported he/she slammed the resident on the bed; -He/she worked the rest of his/her shift and left the facility around 6:00 A.M.; -He/she did not have to have another staff member with him/her when he/she entered other residents' rooms that night. During an interview of 02/09/24, at 2:05 P.M., CNA K said the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-After he/she reported the allegations of abuse made by the resident to RN A, CNA B worked the rest of his/her shift and was not required to have another staff member with him/her; -He/she worked C hall so he/she did not know if CNA B entered the resident's room again during their shift; -The RN did tell him/her to answer the resident's call light for the rest of the shift. During an interview on 02/08/24, at 11:54 A.M., RN A said the following: -On 02/05/24, when CNA B returned from lunch, he/she spoke with the CNA within fifteen minutes of the CNAs return to work about the resident's allegation; -He/she told CNA B to not go in the resident's room the rest of his/her shift; -CNA B worked the rest of his/her shift and the RN did not make the resident work alongside another aide when entering other residents' rooms; -If he/she would have deemed the CNA a threat, he/she would have treated the situation differently, but felt keeping him/her away from the resident was sufficient; -When he/she notified the DON of the allegations, he/she did not receive any further guidance of what to do with the CNA; -He/she believed that a staff member would be sent home pending investigation, depended on the accusation. During an interview on 02/08/24, at 11:17 A.M., RN H said the following: -If a staff member was accused of abuse, he/she had the staff member stay where he/she could monitor them until he/she received further direction from the Administrator; -That staff member should not work until the investigation was completed. During an interview on 02/08/24, at 11:25 A.M., Licensed Practical Nurse (LPN) I said the following: -If a staff member was accused of abuse, he/she made that staff member stay with him/her until he/she received further direction from the DON; -He/she did not believe a staff member accused of abuse should be allowed to come back to work until the investigation was completed. During an interview on 02/08/24, at 12:35 P.M., the DON said the following: -If a staff member was accused of abuse, they would be removed from that resident and normally he/she had them leave the building until the investigation was completed; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When RN A reported the allegation of abuse to him/her, the RN said CNA B was not caring for the resident for the rest of the CNA's shift; -The CNA did care for other residents that night after the allegation was made and was not required to have another staff member with him/her; -He/she felt the other residents were protected from the CNA because there was a charge nurse and other aides in the building; -The Administrator suspended the CNA after his/her shift ended until the investigation was completed. During an interview on 02/08/24, at 1:10 P.M., the Administrator said the following: -If a resident made an allegation of abuse against a staff member, the staff member should be suspended until the investigation was completed; -On 02/05/24, the resident was protected from CNA B, but the other residents were not; -If RN A would have reported immediately, CNA B would have been suspended immediately. MO00231374