STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265475	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maranatha Village, Inc	233 East Norton Road Springfield, MO 65803

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on record review and interview, the facility failed to ensure staff treated all residents in a dignified fashion when one staff member (Licensed Practical Nurse (LPN) B) made rude and degrading comments during a procedure to replace an indwelling (Foley) catheter (sterile tube inserted to drain the bladder) for one resident (Resident #1). A sample of eight residents with catheters was reviewed. The facility census was 94. Review of the facility policy entitled Resident Rights, revised February 2021, showed the following: -Employees shall treat all residents with kindness, respect, and dignity; -All residents of the facility have the right to a dignified existence; -Orientation and in-service training programs are conducted quarterly to assist employees in understanding the residents' rights. Review of the facility policy entitled Dignity, revised February 2021, showed the following: -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem; -Residents are treated with dignity and respect at all times; -Staff speak respectfully to residents at all times; -Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. 1. Review of Resident #1's face sheet (gives basic resident profile information) showed the following: -admitted [DATE]; (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included mini-stroke and stroke with dominant sided weakness, chronic pain, major depressive disorder, hydronephrosis with renal and ureteral calculous obstruction (back up of urine from bladder to the kidney due to abnormal vessel structure), flaccid neuropathic bladder (dysfunction of the bladder muscles), retention of urine, history of urinary tract infection (UTI), kidney inflammation, pain in right knee, contracture of muscle, osteoarthritis, and adjustment disorder with mixed anxiety and depressed mood. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/31/24, showed the following: -Hearing adequate with no difficulty in normal conversation; -Cognition intact; -Indwelling catheter; -Functional impairment of upper and lower extremity, one side. Review of the resident's Physician Order Sheet (POS), current as of 08/29/24, showed the following: -An order, dated 12/15/22, for catheter care daily on every shift; -An order, dated 02/10/24, for may change Foley catheter as needed for accidental removal, displacement or obstruction with 18 French (size) catheter instilled with 10 cubic centiliters (cc) balloon. Staff to document in progress note the reason for as needed change, how procedure was tolerated, and any output; -An order, dated 04/27/24, for Foley catheter change every month and as needed on the 28th day of every month related to flaccid neuropathic bladder. Staff to put in progress note when Foley catheter is changed. Review of the resident's care plan, last updated 07/29/24, showed indwelling catheter related to diagnosis of flaccid neuropathic bladder. Staff to assess and monitor for signs/symptoms of potential UTI. Review the resident's nurse's note dated 07/30/24, at 7:31 A.M., showed staff documented they discontinued (removed) Foley after deflating the balloon. Staff cleaned area and instilled new #18 Foley with sterile technique and placed 10 cc sterile water in balloon, attached (leg) stabilizer, and received return of yellow urine. During an interview on 08/29/24, at 8:48 A.M., the Director of Nursing (DON) said on 07/30/24, at around 8:00 A.M., an aide reported that Licensed Practical Nurse (LPN) B had spoken inappropriately to the resident during catheter insertion a short time before, making comments about the resident having to spread his/her legs for sex with his/her spouse. The DON said the witnessed interaction during the catheter procedure was very rude and undignified for the resident. Review of a written statement by Certified Nursing Assistant (CNA) A, signed and dated 07/30/24, showed the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 7:15 A.M., CNA A was asked by the overnight nurse to assist with a catheter change; -As the nurse was trying to insert the catheter, the resident kept tensing up. The nurse made remarks to resident that included Haven't you had sex before? You had to relax for your spouse to get in there; -Then after the resident still didn't relax, the nurse threw resident's leg over his/her (the nurse's) head and then told the resident if he/she broke his/her neck, he/she was going to jail. During an interview on 08/29/24, at 2:35 P.M., CNA A verified his/her written statement. CNA A added that LPN B didn't use lubricant, at least at first, for the catheter insertion, because he/she forgot to bring any in with him/her. During the procedure, the resident emitted a high pitched whining, which he/she does when tense or anxious. He/she reported the rude and inappropriate comments and behavior to management. Review of a written statement by CNA D, signed and dated 07/30/24, showed the following: -CNA D entered the resident's room to help his/her hall partner and the overnight nurse with the catheter; -CNA D witnessed the overnight nurse saying it would not bother him/her if the resident stayed wet. The nurse was upset because he/she could not find the right placement for the catheter; -The nurse lifted the resident's leg over the nurse's head and told the resident that if his/her leg broke the nurse's neck the resident would go to jail; -The overnight nurse also stated that the catheter was in as far as he/she could put it in, and it either worked or not, and left the room. During an interview on 08/30/24, at 10:22 A.M., CNA D verified his/her written statement. CNA D said LPN B didn't use any lubricant for the catheter insertion at first, because he/she forgot to bring it into the room. The LPN said, I'm just going in dry. LPN B was out of sorts and was rude to the resident regarding the resident's paralysis and stiff legs. The LPN put the resident's leg over his/her own head and said, If you break my neck, you'll go to jail. CNA D said the resident tried to pull away during the procedure. After they exited the room, CNA A told CNA D about the LPN's sexual comments to the resident. CNA D had heard LPN B say to other staff that residents should be able to bend and open their legs if they've ever had sex before. CNA D said the whole procedure was very rude and undignified for the resident. During an interview on 08/30/24, at 10:00 A.M., LPN C said staff should speak politely to residents, using softer tones and respectful language. The LPN said it would not be appropriate to refer to sexual positions while completing catheter care. During an interview on 08/30/24, beginning at 11:23 A.M., the DON and the Administrator's Executive Assistant both said staff should not use inappropriate comments when speaking to or in front of a resident. They said the witnessed comments made by LPN B were very rude and disrespectful to the resident. (continued on next page)

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