

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2023
NAME OF PROVIDER OR SUPPLIER Pin Oaks Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 West Monroe Mexico, MO 65265	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42594</p> <p>Based on interview and record review, the facility failed to ensure staff treated three residents (Residents #7, #8 and #9), in a review of ten sampled residents, with dignity and respect when they refused to provide assistance and verbalized rude and disrespectful comments to the residents. The facility census was 71.</p> <p>Review of the facility undated policy Resident's Rights showed the following:</p> <ul style="list-style-type: none"> -Long-term care residents have a right to care which maintains or enhances the quality of life; -Residents should be treated with consideration and respect, with full recognition of their dignity and individuality. <p>Review of the undated facility admission packet showed the following:</p> <ul style="list-style-type: none"> -As a nursing home resident, you have the right to privacy and respect; -You shall be treated with consideration, respect and full recognition of your dignity and individuality; <p>-It is the intent of the facility to promote and ensure that highest standards of conduct and reliability by its employees and consultants to in turn produce environments in the facility that promote the highest standards of care and security for our residents and the families we serve.</p> <p>1. Review of Resident #7's care plan, dated 4/3/23, showed the following:</p> <ul style="list-style-type: none"> -The resident required assistance with his/her activities of daily living (ADLs); -The resident was incontinent of bowel and bladder and used briefs for dignity. <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 8/9/23, showed the following:</p> <ul style="list-style-type: none"> -The resident was cognitively intact; <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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident was frequently incontinent of bladder and bowel.</p> <p>During an interview on 11/7/23 at 2:03 P.M., Resident #7 said the following:</p> <p>-He/She had a fall to the floor when he/she attempted to transfer to his/her bed;</p> <p>-(Certified Nurse Aide) CNA B called him/her a fatty and told the resident they would have to use a Hoyer lift (a mechanical lift to transfer residents from one surface to another) to get the resident into bed;</p> <p>-CNA B also told the resident if he/she fell again, the CNA would leave the resident on the floor and no one would help him/her;</p> <p>-On one occasion, CNA B was changing the resident's brief and told the resident, your pee stinks and you need to drink more water;</p> <p>-One morning the resident was still asleep when CNA B came into his/her room and pulled the covers off of the resident to wake him/her. CNA B did not speak to the resident at all while getting the resident up for breakfast;</p> <p>-The resident had used his/her call light and at times CNA B came to the resident's room and turned off the call light and told the resident he/she would be back to help but didn't come back. The resident had to push his/her call light again and a different CNA would always answer the call light. CNA B would never come back when he/she said he/she would;</p> <p>-CNA B was rowdy, loud, and cusses when he/she was in the resident's room. If something wasn't going just right CNA B would use the F word and other cuss words;</p> <p>-The resident didn't like cussing and did not like it when CNA B used cuss words;</p> <p>-CNA B made Resident #7 feel disrespected when they spoke to the resident about his/her urine, leaving the resident on the floor if he/she fell again, and not responding to his/her call light;</p> <p>-The resident felt CNA B did not like him/her.</p> <p>2. Review of Resident #8's care plan, dated 9/30/22, showed the following:</p> <p>-The resident required assistance with his/her ADLs;</p> <p>-The resident transferred with a Hoyer lift and assist of two staff;</p> <p>-The resident used a wheelchair for mobility;</p> <p>-The resident had multiple sclerosis (MS, a disease that affects the central nervous system (brain, spinal cord and optic nerves), chronic obstructive pulmonary disease (COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems), congestive heart failure (CHF, when the heart muscle doesn't pump blood as well as it should);</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident was at risk for falls due to his/her diagnoses of multiple sclerosis, diabetes, MS, COPD and CHF and the need for assistance with ADLs.</p> <p>Review of the resident's significant change MDS, dated [DATE], showed the following:</p> <p>-The resident was cognitively intact;</p> <p>-The resident required substantial/maximum assistance (helper did more than one half the effort) to roll left to right in bed, sitting to lying and lying to sitting positions;</p> <p>-The resident was unable to stand;</p> <p>-The resident was dependent on staff for chair to bed transfers, bathing and toileting (the resident had an indwelling catheter (a tube inserted into the bladder allowing urine to drain freely) and a colostomy (a hole (stoma) in the abdominal wall allowing waste to leave the body. A colostomy bag attaches to the stoma to collect the waste).</p> <p>During an interview on 11/7/23 at 11:46 A.M. and 11/15/23 at 10:00 A.M., Resident #8 said the following:</p> <p>-CNA B was very rude and talked down to him/her;</p> <p>-CNA B talked to the resident as if he/she were a child;</p> <p>-CNA B told the resident that it stunk in his/her room and it was going to make him/her sick. This made the resident upset and mad and the resident just asked all the staff to leave his/her room;</p> <p>-The resident said he/she had a colostomy and he/she knew it smelled but the resident could not help it;</p> <p>-CNA B told the resident his/her room was a mess and the resident needed to clean it up because it made the CNAs obsessive compulsive disorder (OCD, a long-lasting disorder in which a person experiences uncontrollable and recurring) act up;</p> <p>-The resident said he/she was bed bound and was not able to get up and clean his/her room and it really frustrated him/her when CNA B said that;</p> <p>-The resident said he/she did cry about how CNA B talked to him/her;</p> <p>-CNA B made the resident feel frustrated and angry.</p> <p>3. Review of Resident #9's undated Continuity of Care Document showed the following:</p> <p>-The resident had diagnoses that included muscle weakness, difficulty in walking, chronic kidney disease, and malignant neoplasm of the colon and a history of a cerebral infarction (stroke, a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it).</p> <p>Review of the resident's care plan, dated 10/20/23, showed the following:</p> <p>(continued on next page)</p>

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident was admitted to the facility on [DATE];</p> <p>-The resident had an advanced directive: do not resuscitate.</p> <p>During an interview on 11/7/23 at 11:49 A.M., the resident said the following:</p> <p>-On 11/4/23 or 11/5/23, the resident put his/her call light on because he/she needed to be changed, the resident had soiled his/her incontinence brief;</p> <p>-CNA B came into the resident's room and told the resident it was time to get up;</p> <p>-The resident told CNA B he/she needed to be changed because he/she had a bowel movement;</p> <p>-CNA B put both hands up to the side of his/her head and said, I have other people to take care of. CNA B also said he/she couldn't change the resident right then. CNA B turned off the call light and left the room;</p> <p>-CNA B did not come back to change the resident and the resident had to turn on his/her call light again to get help;</p> <p>-The resident was angry he/she did not get changed and had a dirty brief;</p> <p>-The resident said he/she did not have control over his/her bladder or bowels and could not help it.</p> <p>During an interview on 11/8/23 at 1:37 P.M. CNA D said the following:</p> <p>-CNA B and CNA E had never said they wouldn't work with or assist Resident #7 or Resident #9, but if their calls lights went off and CNA B and CNA E were at the nurse's station, CNA B and CNA E would not answer their lights. CNA B and CNA E would continue to talk at the nurse's station until someone else answered their call lights;</p> <p>-CNA B did call Resident #7 a fatty and said the resident needed to lose some weight when the resident was on the floor after a fall;</p> <p>-CNA E entered Resident #7's room when CNA D called out for help. When CNA E saw the resident on the floor he/she said I'm not going to lift the resident. You are going to have to call the ambulance to get the resident up;</p> <p>-CNA D had heard CNA B and CNA E cuss in the presence of residents;</p> <p>-On one occasion, CNA D and a couple of other CNAs were in Resident #8's room to assist with care. CNA B came in the room and Resident #8 said to get him/her out of the resident's room;</p> <p>-CNA B did go into Resident #8's room once with his/her shirt pulled up over his/her nose. CNA B said I can't take it. That smells so bad. It makes me want to throw up. CNA D said Resident #8 had a wound that did have a foul odor but staff should not say things like that.</p> <p>(continued on next page)</p>

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/7/23 at 1:51 P.M., Licensed Practical Nurse (LPN) C said the following:</p> <ul style="list-style-type: none"> -LPN C knew CNA B told Resident #8 his/her room was a mess and they needed to clean it up; -LPN C talked to CNA B and told him/her not to talk to the resident like that. It was the staff's responsibility to clean the resident's room because the resident was not able to get out of bed on his/her own; -LPN C also told CNA B he/she should not have talked about how the resident's room made the CNA feel. <p>During an interview on 11/7/23 at 2:30 P.M., the Interim Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> -She was not aware that CNA B turned off call lights and did not assist residents and then left the room, pulled blankets off of a resident to wake them up, cussed in the presence of residents, or called a resident a name (fatty); -She would expect CNA B and all staff to treat the residents with respect; -She wouldn't want staff to talk down to the residents or cuss in the presence of the residents. <p>During an interview on 11/7/23 at 3:45 P.M. the Administrator said the following:</p> <ul style="list-style-type: none"> -She would expect all staff to treat the residents with dignity and respect; -She was not aware of the things CNA B had said to Residents #7, #8 and #9. <p>MO226983</p>