STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265491	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Nursing	914 Chickesaw Street Seneca, MO 64865

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** 43193 Based on interview and record review, the facility failed to ensure all residents were treated with dignity and respect when one staff member (Certified Nursing Assistant (CNA) B) placed his/her hand close to one resident's (Resident #1) mouth while providing cares to the resident to muffle the sound of the resident yelling. Four residents were sampled out of a facility census of 50. Review of the facility's policy titled Resident Rights, undated, showed the following: -Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside facility; -A facility must treat each resident with respect and dignity and care for each resident in a manner and environment that promotes maintenance or enhancement of her quality of life, recognizing each resident's individuality. Facility must protect and promote rights of resident; -Residents have a right to be treated with respect and dignity. 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]; -Diagnoses included anxiety, dementia, and depression. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 09/06/24, showed the following: -The resident had severe cognitive impairment; -The resident had no behaviors; -The resident required maximum assistance from staff for toilet hygiene and was dependent on staff for personal hygiene, upper and lower body dressing, and bathing; (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	-The resident used a wheelchair for locomotion and required moderate assistance from staff for locomotion; -The resident required maximum assistance from staff for bed mobility and was dependent on staff for all transfers. Review of the resident's care plan, revised 10/29/24, showed the following: -The resident resisted care including taking showers related to diagnoses of anxiety and psychosis. -The resident would yell out inappropriately at times and become combative with staff. -Staff to ask the resident if he/she was in pain or uncomfortable and let the nurse know if he/she was. -Staff to encourage as much participation/interaction by the resident as possible during care activities. -Staff to give the resident a clear explanation of care activities before and as they occur during each staff/resident contact. -If the resident was unable to be redirected, give him/her a few minutes to calm down and return. Review of the facility's investigation, dated 10/31/24, showed the following: -On 10/26/24, at approximately 12:05 P.M., Nursing Assistant (NA) A reported to the Business Office Manager (BOM) that CNA B put his/her hand over the resident's face; -On 10/26/24, the Administrator spoke with NA A about the NA's written statement. The NA stated he/she and the CNA were in the resident's room and were changing the resident. The resident was screaming. The CNA placed his/her hand over the resident's mouth and the NA told the CNA no. The CNA then leaned down and yelled in the resident's ear to shut up. The NA was unsure of which hand the CNA used. The NA said he/she stood on the left side of the resident's bed and the CNA stood on the right side. The CNA held the resident on his/her side while the NA cleaned the resident. When they rolled the resident to his/her back, the CNA leaned forward and told the resident to shut up. The NA did not believe the resident heard the CNA as the resident yelled louder than normal this date. The NA said the CNA then used his/her right hand and placed it above the resident's mouth for a split second and the NA told the CNA no. The CNA said he/she did not mean to actually touch the resident. The NA and CNA got the resident up with the Hoyer lift (mechanical lift); (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 10/26/24, the Administrator contacted the CNA and asked the CNA to come to the facility to discuss the incident. The CNA arrived at the facility at approximately 5:10 P.M. The Administrator and Social Worker went over the CNA's statement. The CNA said he/she went with the NA to assist the resident. The CNA said the resident said in a semi-loud voice that's enough over and over again. The CNA rolled the resident towards him/her while the NA cleaned the resident and when the resident was clean, rolled the resident back to the resident's back. The CNA noticed the NA's tattoo and started a conversation about the tattoo. The CNA said he told the NA to shut up jokingly about the NA's tattoo. The resident continued to yell louder and the CNA leaned to the resident's right ear and asked the resident to please be quiet as he/she could not hear the NA. This had no effect, so the CNA attempted to block the resident's mouth from his/her line of vision with his/her left hand. The CNA said he/she was not attempting to cover the resident's mouth, but because he/she was not looking, he/she accidentally touched the resident's chin with the loose part of his/her glove. The CNA said he/she touched the resident and he/she was sorry and the NA told the CNA that he/she could not do that. The CNA told the NA he/she did not mean to and that it would not happen again. -On 10/30/24, the Administrator, Director of Nursing (DON) and regional team determined resident abuse did not occur, however the resident was not treated with good customer service and the CNA failed to treat the resident with dignity and respect. During an interview on 10/29/24, at 10:42 A.M., NA A said the following: -He/she and CNA B were providing care for the resident; -The resident was yelling because they were changing him/her and this was normal for the resident; -CNA B told the resident to shut up and the resident continued to yell; -CNA B put his hand on the resident's mouth for a split second; -The NA told the CNA not to do this and the CNA said he/she did not mean to touch the resident; -The CNA did not strike the resident, he/she was just trying to get the resident to stop yelling; -He/she and the CNA finished caring for the resident; -He/she found the Business Office Manager (BOM) and reported the incident to the BOM; -He/she did not believe the CNA treated the resident with dignity and respect. During interviews on 10/29/24, at 11:33 A.M., and on 10/31/24, at 1:24 P.M., CNA B said the following: -He/she and NA A were changing the resident; -The resident yelled and the CNA could not hear the NA; -He/she was trying to block the sound of the resident so he/she could hear the NA; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/24, at 1:31 P.M., the Director of Nursing (DON) said the following: -When he/she spoke with CNA B, the CNA said he/she assisted NA A with changing the resident; -The CNA said he/she was making small talk with the NA and the resident was screaming and he/she asked the resident to be quiet; -The CNA reported he/she placed his/her hand up to block the noise from the resident and accidentally touched the resident's chin; -The CNA reported he/she did not place his/her hand over the resident's mouth; -The DON said the CNA did not treat the resident with dignity and respect; -The CNA should have backed away from the resident, left the resident's room, and attempted to reapproach the resident later; -If, when the CNA approached the resident later, and the resident continued to scream, the CNA should get another staff to perform the cares; -Staff should treat residents like family and with dignity and respect. MO00244168