STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265514	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claru Deville Nursing Center	105 Spruce Street Fredericktown, MO 63645

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 - 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** 46460 Based on observation, interview, and record review, the facility failed to ensure and promote an environment that promoted maintenance or enhancement of each resident's quality of life, recognizing each resident's rights, failed to protect and promote the rights of the resident, failed to allow the resident to exercise his or her rights as a resident of the facility without coercion, interference, discrimination, or reprisal from the facility, and failed to ensure the residents were able to exercise their rights as a resident of the facility and were free of restraints when 3 of 22 residents (Residents #11, #61 and #68) were placed in a secured unit without evaluation for appropriate placement and their resident rights were removed per the guardians' directions, based on a list of actions and consequences. The facility's census was 74. Review of the document Resident Rights, signed by all staff upon hire and annually, undated, showed: - A resident has the right to participate in their care. Residents are entitled to take part in planning their care and in being informed of all aspects of their care. Residents may refuse any treatment they do not want; - A resident has the right to keep their possessions. Residents may retain personal possessions as space permits, unless to do so would infringe on the rights of others; - A resident has the right to exercise their rights. Encouragement and assistance will be provided for the exercise of the resident's right as a resident and as a citizen. Residents may voice grievances and recommend changes to facility staff or to outside representatives free from restraint, interference, coercion, discrimination, or reprisal; - A resident has the right to be free from abuse. Residents shall not be subjected to physical, sexual, or emotional injury or harm; - A resident may associate with and communicate privately with persons of their choice and send and receive mail unopened; - A resident may or may not engage in social, religious, and community activities of their choice, unless a physician determines that such activity would be harmful. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Actual harm Residents Affected - Few	1. Observation on 01/14/25 at 12:13 P.M. showed a printed paper posted on Resident #11's bathroom door which read: - Actions and Consequences, you all are aware of the rules, they are now set in place. So, if you have one of these actions there will be consequences and we will be following through with each one of them. - The document was then divided into two columns, one labeled Action the other Consequences. The Consequences column had two options for each action depending on a resident's smoking status; - Action: Arguing with another resident. Consequence: Sent to room to work on coping skills; - Action: Arguing with staff, not listening. Consequence: Resident loses one smoke break; - Action: Arguing with staff, not listening. Consequence: Resident loses one day of snack cart; - Action: Cursing out staff. Consequence: Resident loses two smoke breaks; - Action: Cursing out staff. Consequence: Resident loses a week of snack cart; - Action: Hitting a staff member or a resident. Consequence: Resident loses smoke break for 48 hours; - Action: Hitting a staff member or a resident. Consequence: Resident loses snack cart for two weeks; - Action: Stealing from another resident. Consequence: Resident loses two smoke breaks; - Action: Stealing from another resident. Consequence: Resident loses snack cart for a week; - Action: Attention seeking Self-Harming behavior. Consequence: Resident loses belongings and smoke break for the day and is to wear a gown with pants; - Action: Attention seeking Self-Harming behavior. Consequence: Resident loses belongings and snack cart for the week and is to wear a gown with pants; - Action: Refusing medication. Consequence: Resident loses everything until medication is taken; - Action: Taking off a resident tray or sharing food. Consequence: Resident loses smoke break for 24 hours; - Action: Taking off a resident tray or sharing food. Consequence: Resident loses snack cart for the week; - Action: Resident refusing shower for two days. Consequence: Resident loses smoke break until shower is taken; (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	- Action: If a resident stands where staff is charting after staff has redirected. Consequence: Resident loses one smoke break, and snack cart for the day; - Action: Resident not listening to being sent to room, due to behavior on the hall and not shutting the door when asked. Consequence: Resident will lose all privileges for the rest of the day; - Action: Resident sharing anything without staff approval. Consequence: Resident loses one smoke break; - Action: Resident sharing anything without staff approval. Consequence: Resident loses one snack cart day; - Action: Resident going past the double doors with the phone after being reminded. Consequence: Resident loses one smoke break; - Action: Resident going past the double doors with the phone after being reminded. Consequence: Resident loses one snack cart day; - Action: Resident not following directions or listening to the staff when asked of something. Consequence: Resident loses one smoke break; - Action: Resident not following directions or listening to the staff when asked of something. Consequence: Resident loses one snack cart; - Action: Resident keeping things in their room, that are not allowed. Consequence: Resident loses one smoke break per item found in room; - Action: Resident keeping things in their room, that are not allowed. Consequence: Resident loses snack cart days per item found in room. Review of Resident #11's medical record showed: - admitted on [DATE]; - Diagnoses of bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and nicotine dependence (a chronic brain disorder that causes a person to compulsively need nicotine, a substance found in tobacco products and includes withdrawal symptoms like restlessness, agitation, increased hunger, insomnia, constipation, or diarrhea). Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by the facility staff), dated 11/05/24, showed: - No cognitive impairment; - Independent with activities of daily living (ADLs). Review of the resident's care plan, revised 11/11/24, showed: (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	- Resident at increased risk for behavioral/mood problems due to history of behaviors. - Unit Coordinator got approval per guardian directive that if resident has a behavior, staff can take away any open hall activities and a smoke break and do room searches for safety reasons; - Unit Coordinator spoke with resident's guardian in regard to the unit policies and procedures and went over each one with the guardian. The guardian agreed with the unit policies and procedures, and states she gives verbal consent and to add these to resident's guardian directives. - Resident smokes cigarettes; - Nicotine lozenge four milligrams (mg). May have one lozenge every two hours as needed for nicotine withdrawal between 11:00 P.M. and 7:00 A.M. May not consume during smoking hours; - Divert resident's behavior by encouraging use of coping skills. The resident often uses journaling, drawing, helping others, or painting as coping skills; - Do not confront, argue against, or deny resident's hallucinations. Explore resident's underlying feelings rather than the content of the hallucinations (e.g. anxiety, fear, etc.); - Maintain a calm, slow, understandable approach with resident; - Respect resident's needs for privacy and space. Avoid unnecessary touching. - On 12/16/23, Per guardian phone calls must be supervised; - On 02/22/24, Resident upset the Unit Coordinator would not allow him/her to email his/her family. Resident had lost his/her privileges to use the Internet due to previous behaviors; - On 05/16/24, Per guardian, resident lost smoking privilege at 6:30 P.M. smoke break; - On 08/10/24, Resident has been argumentative with staff and yelling down the hall at other residents when they are about to go outside for smoke break during facility scheduled time. Resident is upset over not being able to smoke per guardian; - On 08/11/24, Resident states that he/she did nothing wrong and feels like he/she is in jail. Educated resident on reasons that privileges were taken per guardian and resident began to curse at the nurse. Review of the facility's Behavior Binder showed: - On 01/14/25, Resident #11 asked Unit Coordinator for his/her smoke break back. Unit Coordinator stated per guardian, resident lost smoke breaks for assaulting a staff member. Resident started screaming and cussing at Unit Coordinator. Resident called guardian screaming and yelling. Review of Resident #11's medical record showed a lack of physician evaluation to establish how the resident's mental health could benefit from restricted smoke breaks as a behavioral health intervention, restricted Internet use, lack of privacy, and secured on a locked unit. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/14/25 at 12:13 P.M., the resident said they have an actions and consequences list on the bathroom door. Resident #11 said he/she had punched CNA A in the face after a verbal altercation. The resident felt humiliated and now he/she can't smoke for three days. 2. Review of Resident #61's medical record showed: - admitted [DATE]; - Diagnoses of schizophrenia, restlessness and agitation, and oppositional defiant disorder (a condition characterized by a persistent pattern of defiant, angry, and irritable behavior towards authority figures, such as parents, teachers, or caregivers); - Per the PASARR Level II screening: Resident with history of overdose on opiates, poor insight/judgment, looseness of association, flight of ideas, thought broadcasting, poor sleep, grandiose delusions, decreased appetite, depressed mood, elevated anxiety level, irritability, decreased energy, feelings of helplessness/hopelessness/guilt, self-isolation, excessive worry, panic attacks, heart racing, and sweating. Review of the resident's quarterly MDS, dated [DATE], showed: - No cognitive impairment; - Physical (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal (e.g., threatening others, screaming at others, cursing at others) behavioral symptoms directed toward others, other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) and wandering all occurred one to three days in the seven-day look back period; - Independent with ADLs; - The resident received antipsychotic, antianxiety, and antidepressant medication in the seven-day look back period. Review of the resident's care plan, revised 11/29/24, showed: - The resident resides on the secured behavioral unit due to history of behaviors. At risk to harm self or others. At risk for elopement; - On 06/13/24, Unit Coordinator spoke with guardian and resident is only allowed to have one incoming and one outgoing call per day; (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	- On 06/17/24, Per resident's court appointed guardian resident's family may call the resident on Sundays at 2:00 P.M. They can talk for up to 15 minutes and the calls are to be monitored. He/She is not allowed phone calls with anyone else at this time. If the family member treats staff rudely again, all calls will be stopped for 30 days. The Unit Coordinator told the resident's guardian, If the resident calls his/her family once a day there might be an increase in behaviors. Resident #61's calls to his/her family will start with them talking one time per week and can increase if no behaviors follow; - On 07/19/24, Resident came out of room, upset, over not talking to family on phone; - On 09/10/24, Resident upset and pacing back and forth. Resident said he/she was mad because he/she was told he/she could not talk to his/her family for a long time; - On 12/02/24, Resident is allowed to talk to his/her mother on the phone on speaker in front of staff supervised once per day for fifteen minutes as long as he/she has good behavior the day of and day prior to his/her phone call. Review of the resident's progress notes showed: - On 01/12/25 at 5:30 P.M., Resident #11 was agitated an went into office and grabbed scissors. Resident tried to cut right thumb. There is a small mark on resident's finger. Unit Coordinator instructed staff to remove resident's belongings from room to prevent resident from harming himself/herself in any other way. When staff tried to pack resident's belongings up, resident got mad and tried attacking staff. Staff initiated defense team with staff support and handled appropriately. No injuries present. Staff put resident's belongings in office and locked office; - On 01/15/25 at 11:15 A.M., Resident was having a behavioral outburst, and showing signs and symptoms of attention seeking behaviors. Nurse went to speak with resident with other staff present. When asked why he/she was upset, resident stated I want all my shit back. Review of Resident #61's medical record showed a lack of physician evaluation to establish how the resident could benefit from restricted contact with his/her family, removal of all his/her possessions including clothing, lack of privacy and secured on a locked unit. Observations of Resident #61 showed: - On 01/14/25 at 1:33 P.M., the resident walked in the hall wearing a hospital gown and pants; - On 01/15/25 at 1:32 P.M., the resident lay in bed with covers over his/her head; - On 01/15/25 at 2:53 P.M., the resident sat on the floor in the hall wearing a hospital gown and pants. During an interview on 01/14/25 at 1:33 P.M., Resident #61 said he/she is wearing a hospital gown because he/she was self-harming by trying to cut his/her arm. He/She would like to wear his/her own clothes. He/She has some clothes in the office, but they won't let him/her wear them until he/she quits self-harming. That's the Unit Coordinator's rule. On 01/15/25 at 2:53 P.M., Resident #61 said wearing a hospital gown made him/her feel bad. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	3. Review of Resident #68's medical record showed: - admitted [DATE]; - Diagnoses of borderline intellectual functioning (on the border between normal intellectual functioning and intellectual disability), suicide attempt, borderline personality disorder (a mental illness that severely impacts a person's ability to regulate their emotions), and poisoning by multiple unspecified drugs; - Per the PASARR Level II screening: Resident has history of sexual abuse. Resident has verbalized feeling guilt and overwhelming sadness and experiences auditory and visual hallucinations. The voices are angry with him/her and tell him/her he/she deserved what happened. He/She also verbalized having difficulty dealing with coping with his/her aunt's terminal illness. He/She has overdosed on all of his/her medications multiple times in the past and prior to this admission. He/She has a history of self-abuse by cutting, with the last reported incident several months ago. Staff use distraction and visualization when the resident is experiencing suicidal ideations. Review of the resident's quarterly MDS assessment, dated 10/10/24, showed: - No cognitive impairment; - Independent with ADLs; - The resident received antipsychotic and antidepressant medications in the seven-day look back period. Review of the resident's care plan, revised 10/25/24, showed: - Resident resides on the secured behavioral unit due to history of behaviors. At risk to harm self or others. At risk to elope from facility; - History of suicidal ideations and multiple suicide attempts by overdosing on medications; - History of self abuse/mutilating by cutting; - Chronic self-injurious behaviors; - Homicidal statements that he/she felt like hurting someone; - Experienced nightmares, isolation, and anxiety; - On 01/07/24, Guardian has emailed Unit Coordinator and stated that resident is to have no contact whatsoever with his/her parents at this time. Guardian will let Unit Coordinator know when contact will be allowed again; - On 02/09/24, CNA reported resident exhibiting suicidal thoughts. Facility got orders to send out for eval. POA and case manager notified. Case manager giving permission for resident to be sent out and stated that facility may take away his/her items due to behavior; (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	- On 02/28/24, Resident stated he/she was depressed and missed talking to his/her family. Deputy from resident's legal guardian's office explained to resident that his/her guardian did not want resident to have phone conversations with his/her family for 30 days after admission to the facility, so that he/she could have an adjustment period and history of getting upset after phone calls from his/her family; - On 03/11/24, Unit Coordinator talked to resident's guardian about his/her behaviors over the weekend. Resident is not allowed to see his/her family until his/her guardian approves; - On 03/15/24, Resident refused medication and did some yelling this morning. Unit Coordinator told the resident he/she will not be able to participate in today's festivities per his/her guardian. Review of the resident's progress notes showed: - On 01/07/25 at 3:26 P.M., Guardian has emailed Unit Coordinator and stated that he/she wants resident to have no contact whatsoever with his/her parents at this time. Guardian will let Unit Coordinators know when he/she will allow contact again. During an interview on 01/14/25 at 1:36 P.M., Resident #68 said he/she is wearing a hospital gown because he/she was self-harming (scratching really hard on the inside of his/her wrist). Once he/she quits, he/she will get his/her clothes back. He/She would really like to wear his/her clothes. On 01/15/25 at 1:16 P.M., Resident #68 said he/she has had to wear the hospital gown for two weeks. He/She said it makes him/her feel embarrassed when he/she has to wear a hospital gown. Observations of Resident #68 showed: - On 01/14/25 at 12:06 P.M., the resident lay on a mattress in the floor with the cover pulled over his/her head. - On 01/15/25 at 1:16 P.M., the resident sat on the mattress on the floor wearing a hospital gown; - On 01/15/25 at 4:26 P.M., the resident's mattress was on the floor; - On 01/16/25 at 8:44 A.M., the resident's mattress was on the floor. Review of Resident #68's medical record showed a lack of physician evaluation to establish how the resident could benefit from restricted communication to his/her family, wearing a hospital gown instead of normal clothes for an extended period of time and keeping his/her mattress on the floor for an extended period of time. During an interview on 01/15/25 at 3:00 P.M., Resident #68 said his/her bed was taken away as a consequence of self-harming. He/She is the only one on the unit who sleeps on the floor like that. He/She feels like a hobo and his/her back is starting to hurt from it. 4. During a telephone interview on 01/22/25 at 2:25 P.M., Licensed Practical Nurse (LPN) B was aware of the Actions/Consequences program and that staff would take belongings or smoke breaks away following the program. LPN B could see how some residents could possibly view the program as a punishment. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/15/25 at 11:40 A.M., CNA I said the actions and consequences program was in place when he/she began working at the facility over a month ago. CNA I said he/she had been instructed to enforce the consequences. There is a Behavior Book where staff is to keep track of which residents have had what taken away and for how long. CNA I said he/she feels the consequences can escalate behaviors for some residents. During an interview on 01/15/25 at 11:55 A.M., CNA J/Unit Coordinator said the actions and consequences program started in December 2023. Resident's guardians and responsible parties have all signed off on it as well. Staff are expected to enforce the program. CNA J explained the process as when a staff member sees a resident exhibiting one of the actions, they are to come to CNA J and report what they saw and then discuss and agree on what consequence to take. A summary of each consequence is sent to the resident's guardians/responsible party. They approve by signing the form and sending it back, and it is kept on file. CNA J said staff track behaviors and consequences in the Behavior Book. CNA J said some resident's behaviors are escalated by the consequences. During an interview on 01/15/25 at 12:10 P.M., the DON said she started working at the facility two years ago and the Foundation Program (name of the action/consequence list) was in place when she got here. The residents all have copies of the actions and consequences list, and all resident's guardians are aware, and we have either verbal or written consent. The CNAs will report actions to the Unit Coordinator and the Unit Coordinator keeps track of which residents receive what consequence in a binder. The DON believes the program has been very beneficial. When the prior Unit Coordinator was here, the unit was in utter chaos. The DON said some residents can be triggered by the consequences. During an interview on 01/17/25 at 4:35 P.M., the Administrator, DON, and ADON said they would expect residents to retain their personal items that they are allowed to have and for the behavioral program to not infringe on resident rights. During a telephone interview on 01/27/25 at 8:37 A.M., CNA J/Unit Coordinator said there was no tracking tool for behaviors. Staff would just go through the behavior binder to see how it was. He/She is there six days a week. Staff would give report for the next shift and that's how they would know who had consequences. Staff would ask the nurse when residents should get their items back because the nurse was always notified. Resident #11 lost his/her smoke breaks for punching and biting CNA A on 01/11/25 and the next day Resident #11 was acting like she wanted to fight other staff, so he/she got 48 hours of smoke breaks taken away on 01/12/25. Resident #61 threatens things every day, like he/she would start scratching himself/herself when a pen, then staff would take that away. Then Resident #61 would say he/she was going to find something else to kill himself/herself with. He/She had a pair of pants and was trying to choke himself/herself and that was when we gave him/her the gown. Staff notified the guardian and the guardian was going to try to get the resident into a Department of Mental Health place, but the guardian said she couldn't find a place. CNA J cannot remember when Resident #61's action began and when the consequence should have ended. When Resident #61 and #68 know that they are getting their items back, they will try the same things again. Staff were trying to keep them safe because staff can't do 1:1 with everyone on the hall. CNA J cannot remember when Resident #68's action began and when the consequence should have ended. The longest the residents get items taken away is 72 hours. Residents will try to choke themselves with their pants and break hangers and eat them. Resident #68's mattress was on the floor because the resident would attempt to cut himself/herself with the springs on the bed. CNA J cannot remember when this happened, but Resident #68 had only been without a frame for about five days. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	During an interview on 02/05/25 at 11:34 A.M., the DON said all employees sign the Resident Rights form upon hire and annually. She also has the agency staff sign it as well on their first shift. She just started having agency sign these in June of last year. During an interview on 02/06/25 at 8:09 A.M., the DON said the only criteria the facility has for working on the behavior unit is staff must be at least [AGE] years old. The facility staffs two CNAs and the Unit Coordinator most days and that is preferred, but when call outs happen that is not always an option so sometimes it's one CNA and the unit coordinator, who is also a CNA. During an interview on 02/06/25 at 10:48 AM, the DON said there are no written policies regarding the behavior unit at this time, however that is something we are working on and hope to have in place in the near future. The DON said the facility uses a contracted training for staff which encompasses behavioral health, but it is not required to be obtained before working on the unit. The DON said the beds on the locked behavior unit are nursing home beds and the residents residing on that unit are qualified to be in a nursing home. They are placed on the unit to ensure ease of care for their particular needs.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46460 Based on observation, interview, and record review, the facility failed to protect residents on the secured behavioral unit from abuse through deprivation of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This deficiency affected three sampled residents (Resident #11, #61, and #68) on the secured behavioral unit, resulting in humiliation and embarrassment for those residents and back pain for Resident #68 from sleeping on a mattress on the floor and had the potential to affect all residents on the secured behavioral unit. The facility also failed to protect one resident's (Resident #11) right to be free from physical abuse when Certified Nurse Assistant (CNA) A physically forced Resident #11 to the ground and physically restrained Resident #11 while on the ground, making Resident #11 feel humiliated. The facility's census was 74. The administration was notified on [DATE] at 3:15 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Review of the facility's policy, Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property, undated, showed: - It is the policy of this facility that each resident will be free from abuse; - Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment, or involuntary seclusion; - The resident will also be free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms; - Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility; - No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection; - The facility will strive to educate staff and other applicable individuals in techniques to protect all parties; - All employees of this facility are mandated reporters; - All employees who have been alleged to commit abuse will be suspended immediately pending investigation; - If the allegation is substantiated, there is a potential that the employee will be terminated, added to the Employee Disqualification List and not allowed to work in a nursing home, disciplined by their licensing agency and charged with a crime. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claru Deville Nursing Center	105 Spruce Street Fredericktown, MO 63645

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the document Resident Rights, signed by all staff upon hire and annually, undated, showed: - A resident has the right to participate in their care. Residents are entitled to take part in planning their care and in being informed of all aspects of their care. Residents may refuse any treatment they do not want; - A resident has the right to keep their possessions. Residents may retain personal possessions as space permits, unless to do so would infringe on the rights of others; - A resident has the right to be free from abuse. Residents shall not be subjected to physical, sexual, or emotional injury or harm. 1. Observation on [DATE] at 12:13 P.M. showed a printed paper posted on Resident #11's bathroom door which read: - Actions and Consequences, you all are aware of the rules, they are now set in place. So, if you have one of these actions there will be consequences and we will be following through with each one of them. - The document was then divided into two columns, one labeled Action the other Consequences. The Consequences column had two options for each action depending on a resident's smoking status; - Action: Arguing with another resident. Consequence: Sent to room to work on coping skills; - Action: Arguing with staff, not listening. Consequence: Resident loses one smoke break; - Action: Arguing with staff, not listening. Consequence: Resident loses one day of snack cart; - Action: Cursing out staff. Consequence: Resident loses two smoke breaks; - Action: Cursing out staff. Consequence: Resident loses a week of snack cart; - Action: Hitting a staff member or a resident. Consequence: Resident loses smoke break for 48 hours; - Action: Hitting a staff member or a resident. Consequence: Resident loses snack cart for two weeks; - Action: Stealing from another resident. Consequence: Resident loses two smoke breaks; - Action: Stealing from another resident. Consequence: Resident loses snack cart for a week; - Action: Attention seeking Self-Harming behavior. Consequence: Resident loses belongings and smoke break for the day and is to wear a gown with pants; - Action: Attention seeking Self-Harming behavior. Consequence: Resident loses belongings and snack cart for the week and is to wear a gown with pants; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Action: Refusing medication. Consequence: Resident loses everything until medication is taken; - Action: Taking off a resident tray or sharing food. Consequence: Resident loses smoke break for 24 hours; - Action: Taking off a resident tray or sharing food. Consequence: Resident loses snack cart for the week; - Action: Resident refusing shower for two days. Consequence: Resident loses smoke break until shower is taken; - Action: If a resident stands where staff is charting after staff has redirected. Consequence: Resident loses one smoke break, and snack cart for the day; - Action: Resident not listening to being sent to room, due to behavior on the hall and not shutting the door when asked. Consequence: Resident will lose all privileges for the rest of the day; - Action: Resident sharing anything without staff approval. Consequence: Resident loses one smoke break; - Action: Resident sharing anything without staff approval. Consequence: Resident loses one snack cart day; - Action: Resident going past the double doors with the phone after being reminded. Consequence: Resident loses one smoke break; - Action: Resident going past the double doors with the phone after being reminded. Consequence: Resident loses one snack cart day; - Action: Resident not following directions or listening to the staff when asked of something. Consequence: Resident loses one smoke break; - Action: Resident not following directions or listening to the staff when asked of something. Consequence: Resident loses one snack cart; - Action: Resident keeping things in their room, that are not allowed. Consequence: Resident loses one smoke break per item found in room; - Action: Resident keeping things in their room, that are not allowed. Consequence: Resident loses snack cart days per item found in room. Review of Resident #11's medical record showed: - admitted on [DATE]; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Diagnoses of bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and nicotine dependence (a chronic brain disorder that causes a person to compulsively need nicotine, a substance found in tobacco products and includes withdrawal symptoms like restlessness, agitation, increased hunger, insomnia, constipation, or diarrhea); - Per the Preadmision Screening and Resident Assessment (PASARR) Level II screening (a comprehensive assessment of current and historical treatment): Resident has history of depression, anxiety, paranoia, agitation, aggression, mood swings, non-compliance with medication and treatment, impulsive behaviors, poor decision making, racing thoughts, irritation, anger outbursts, poor sleep at times, poor appetite at times, at a previous facility was found walking on the road, non-compliance with rules, suicidal ideation - thought of hanging self, history of suicidal attempt, punching walls, and marijuana use. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by the facility staff), dated [DATE], showed: - No cognitive impairment; - Exhibited hallucinations in the seven-day look back period; - Independent with activities of daily living (ADLs); - The resident routinely received antipsychotic medication in the seven-day look back period. Review of the resident's care plan, revised [DATE], showed: - Resident at increased risk for behavioral/mood problems due to history of behaviors. At risk to harm self or others. At risk to elope from facility; - History of physical violence. - Unit Coordinator got approval per guardian directive that if resident has a behavior, staff can take away any open hall activities and a smoke break and do room searches for safety reasons; - Unit Coordinator spoke with resident's guardian in regard to the unit policies and procedures and went over each one with the guardian. The guardian agreed with the unit policies and procedures, and states she gives verbal consent and to add these to resident's guardian directives; - Care plan did not address actions/consequences list. Review of the resident's Physician's Order Sheet (POS), dated [DATE], showed: - An order for nicotine gum, two mg, give one piece four times a day as needed for nicotine withdrawal, dated [DATE]; - An order for nicotine lozenge; four mg, may have one lozenge buccal (in the cheek) every two hours as needed between 11:00 P.M. and 7:00 A.M. for nicotine withdrawal, dated [DATE]; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- An order for Latuda (antipsychotic medication), 120 mg, give one tablet with 20 mg tablet to equal 160 mg daily, for bipolar disorder, dated [DATE]; - An order for Latuda, 40 mg, give one tablet with 120 mg tablet to equal 160 mg daily, for schizophrenia, dated [DATE]; - An order for Trileptal (anticonvulsant medication), 150 mg, give one tablet by mouth twice daily, for schizophrenia, dated [DATE]; - An order for carbamazepine (anticonsulvant used to treat bipolar disorder), 100 mg, give one chewable tablet by mouth twice daily, for mood disorder, dated [DATE]; - An order for chlorpromazine (antipsychotic medication), 50 mg, give 50 mg by mouth daily, for schizophrenia, dated [DATE]; - An order for Abilify Maintena suspension (antipsychotic medication), 400 mg, give 400 mg intramuscularly every 28 days, for mood disorder, dated [DATE]; - An order for Geodon solution (antipsychotic medication), 20 mg/ml, give one ml intramuscularly every 12 hours as needed for behaviors, dated [DATE]; - An order for trazodone (antidepressant medication), 50 mg, give one tablet at bedtime as needed, for insomnia, dated [DATE]. Review of the resident's Medication Administration Record (MAR), dated [DATE] through [DATE], showed no administration of either nicotine gum or nicotine lozenges for nicotine withdrawal. Review of the resident's progress notes showed: - On [DATE] at 11:11 A.M., Resident this morning screaming and yelling at all staff and guardian on the phone. Resident was redirected several times and ignored redirection. Resident stating that staff and Director of Nursing (DON) is the reason why he/she cannot advance to another facility. Resident yelling and screaming at staff still nurse came down and tried to redirect. Redirection ignored once again. Resident currently calmed down at this time; - On [DATE] at 5:35 P.M., Resident had behavioral outburst this morning of yelling, cussing, and being verbally aggressive towards staff. Staff was able to redirect resident with 1:1 conversation, after conversation, resident calmed down and has had no behaviors since; - On [DATE] at 11:07 P.M., Resident had outbursts most of the day. The resident voiced that he/she was upset about losing his/her smoke break. Resident later became extremely loud and began cussing and yelling. Staff alerted this nurse upon arrival in room, resident was resistant to a Geodon (antipsychotic medication) injection, but eventually stated he/she would take one. Injection given in right deltoid (shoulder muscle) without difficulty; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On [DATE] at 2:32 P.M., Resident standing at the end of the hallway looking outside the window and screaming how he/she wants to die, wants to leave, hates his/her guardian. DON was speaking with this resident. Resident expressed wanting the PRN (as needed) Geodon to help him/her calm down. The DON spoke with this resident regarding possible placement at behavior hospital and resident expressed he/she wanted to do that. The DON stated she would look into it. Resident let this nurse give him/her PRN Geodon in right deltoid, tolerated well. Resident went back to his/her room to calm down. - On [DATE] at 5:37 P.M., Resident this evening around 4:00 P.M. started to have increase in behavioral outburst and show signs and symptoms of manic behavior and had started to punch the walls and attempted to attack staff. Resident also making homicidal ideations towards staff and others and becoming more violent and showing signs and symptoms of becoming a danger to himself/herself and others. Staff attempted to re-direct resident, but resident was not responding to redirection. Nurse notified psychiatric physician of increase in resident's behaviors and that he/she was not responding to re-direction and that PRN Geodon had been administered a few hours prior. New order given for resident to be sent to the emergency room for psychiatric evaluation and treatment as indicated; - On [DATE] at 4:17 P.M., Resident called facility. Unit Coordinator answered. Resident stated to Unit Coordinator that I need you to pack my shit. I am being discharged from the facility. Unit Coordinator stated that he/she knew nothing of that and that if resident was being discharged that it would most likely be back to the facility. Resident stated No, if I go back to the facility, it's not going to be pretty for you! I will tear that entire place up and destroy you and the facility! I cannot live there anymore and I will not. Do you hear me? Unit Coordinator tried to speak, but resident just continued to get louder and then hung up the phone. Unit Coordinator called guardian and guardian stated, Oh well, all I can say is good luck. Review of the facility's Incident Investigation, dated [DATE], showed: - At 9:30 P.M. on [DATE], Resident #11 and CNA A were arguing back and forth on the 500 hall. Resident #11 punched CNA A in the left side of the face and CNA A took Resident #11 to the ground and held the resident until the nurse was able to give a PRN (as needed) injection and the resident calmed down; - No injuries to the resident or complaints of pain at this time; - Resident #11 was escorted to his/her room and CNA A was taken off the hall and made to leave the facility. Review of the facility's In-service Training Record, dated [DATE], showed CNA A was present for Abuse and Neglect Training, which included the Abuse Policy and a handout titled Freedom from Abuse, Neglect, Misappropriation, and Exploitation. Review of Resident #11's progress note, recorded as a late entry by Licensed Practical Nurse (LPN) B on [DATE] at 2:56 A.M. showed: - LPN B heard yelling from the 500 hall unit. Upon entering the unit, he/she observed this resident and CNA A arguing. LPN B was able to calm the situation down for a minute and was walking with the resident back to his/her room as he/she and CNA A were still yelling back and forth; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Resident #11 turned around and went back to CNA A, where he/she acted like he/she was going to urinate on CNA A's feet. Resident #11 then stood up and exchanged words with CNA A, then punched CNA A on left side of face; - Resident #11 was taken to the ground and this nurse obtained an order for Geodon (antipsychotic medication) injection that was given; - Resident #11 was held until he/she said he/she would not be aggressive towards staff anymore. LPN B walked the resident back to his/her room; - CNA A then showed LPN B that Resident #11 had busted CNA A's lip when Resident #11 hit CNA A and bit CNA A's left forearm and drew blood from bite mark; - LPN B had CNA A wash his/her arm with soap and water and then use alcohol pads to bite mark. The DON was notified and other appropriate persons. Will continue to monitor. Review of the resident's behavior notes from the behavior binder showed: - On [DATE], Resident was fine and laughing this morning with Unit Coordinator. Resident asked Unit Coordinator for his/her smoke break back. Unit Coordinator stated per guardian, resident lost smoke breaks for assaulting a staff member. Resident started screaming and cussing at Unit Coordinator. Resident called guardian screaming and yelling, demanding guardian to get him/her out of this facility or shit was about to be really bad for everyone here. Resident started screaming and cussing at guardian. Guardian hung up the phone. Resident yelling at Unit Coordinator demanding that Unit Coordinator give resident back his/her smoke breaks that per guardian, resident lost due to resident assaulting a staff member twice. Unit Coordinator stated that those are the consequences for his/her actions. Resident stated I would hit you in your fucking face if I wouldn't lose a smoke break because of it. Observation of the resident on [DATE] at 1:30 P.M. showed the resident, wearing his/her own clothes, appearing agitated, pacing on the hall, speaking about religion, tithing, and giving his/her money to television evangelists and how he/she hates his/her guardian, while other residents were outside smoking. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 12:13 P.M., Resident #11 said he/she had an altercation with Certified Nursing Assistant (CNA) A and he/she punched CNA A in the face. CNA A put him/her in a head lock and threw him/her to the ground and CNA A sat on him/her. He/She can still go out and get fresh air during smoke break times. They have an actions and consequences list on the bathroom door. Some residents ruin things for other residents. The resident's toilet was flooding, so he/she yelled that they needed a plunger and blankets. CNA A was complaining about it being clogged. Resident #11 and CNA A got into it because the toilet overflowed. This was a Friday morning and CNA A also worked Saturday. It was at 3:52 P.M. when he/she asked for another roll of toilet paper. CNA A said he/she just gave Resident #11 a roll yesterday. CNA A said he/she uses too much toilet paper. He/She uses about a roll a day. He/She bitched about it. CNA A talked about it on smoke break and told Resident #11 that CNA A's family of nine doesn't use that much. CNA A came into Resident #11's room and didn't knock. CNA A said, You're still mad about the toilet paper? He was telling CNA E about the incident and Resident #11 felt humiliated and now he/she can't smoke for three days. He/She got toe to toe with CNA A, and CNA A pointed at his/her room and told him/her to go to his/her room. He/She punched CNA A and CNA A got him/her in a head lock and threw him/her to the ground and CNA A sat on him/her. Resident #11 told LPN B to get an injection because he/she knew he/she needed it. CNA A was sitting on his/her butt and he/she was up on her elbows and CNA A was pushing his/her head back down. During an interview on [DATE] at 3:06 P.M., CNA J/Unit Coordinator said staff get training about how to take down a resident properly, but CNA A did not have that training and he/she will not be coming back. During an interview on [DATE] at 11:00 A.M., the Assistant Director of Nursing (ADON) said that when employees are hired, they get abuse/neglect training and it's documented in the payroll system. Agency staff do written training when they are hired. During a telephone interview on [DATE] at 3:48 P.M., CNA E said he/she was working the locked unit the night the incident occurred between Resident #11 and CNA A. Resident #11 came out in the hall from his/her room and had a verbal altercation with CNA A. CNA E believes Resident #11 was upset with CNA A about a previous toilet paper situation where CNA A did not want to give the resident toilet paper because CNA A believed the resident was using too much. CNA A and Resident #11 were a good distance apart on the hall yelling at each other; they weren't up in each other's face at this point. The resident was so loud that LPN B and another CNA outside the locked unit at the nurses station heard them and LPN B came back on the unit. LPN B had his/her hands on the resident's shoulders attempting to redirect the resident back to his/her room. The resident was still yelling at CNA A, who was still responding to the resident yelling. Resident #11 came back around and came at CNA A and punched him/her in the mouth. CNA A grabbed the resident around his/her shoulder and neck area and tackled the resident to the floor. The resident was lying flat on the floor on his/her stomach with his/her hands on the ground. CNA A wasn't really kneeling on the resident, but instead half-way straddling the resident's back. CNA A had his/her right hand on the resident's right shoulder holding him/her there. LPN B left the locked unit to obtain an injection for behaviors, came back and gave the resident the injection. LPN B asked if the resident was going to go back to his/her room if CNA A let the resident up, to which the resident replied he/she would. The resident returned to his/her room, they pulled CNA A off the hall and CNA E worked the rest of the night. CNA E picks up shifts at this facility quite often, but has only worked on the locked unit a couple of times. He/She believed the facility offers training for these types of situations, but the facility has not offered a class to him/her since he/she has worked there. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 2:25 P.M., LPN B said he/she heard the resident yelling, so he/she walked back to the unit. When he/she first arrived on the unit, CNA A and Resident #11 were arguing, which is not uncommon for the resident. He/She was able to redirect Resident #11 and were going back to the resident's room to sit and chat about what was going on, and LPN B got the resident about halfway down the hall and Resident #11 and CNA A were still arguing. Resident #11 ran up to CNA A and pulled his/her pants down and said that because CNA A didn't want to give Resident #11 any more toilet paper that he/she was going to piss on CNA A's shoes. Resident #11 didn't do that, but instead slugged Resident #11. CNA A got Resident #11 in a hold around his/her neck and took the resident down. On the way down, Resident #11 bit CNA A's arm. After that, LPN B was able to give Resident #11 an injection. The facility provides training on how to take a resident down. LPN B does not have the training, but quite a few of the agency CNAs have the training. LPN B works at the facility about two to three days a week. LPN B was aware of the Actions/Consequences program and that staff would take belongings or smoke breaks away. LPN B could see how some residents could possibly view the program as a punishment. LPN B did not feel that behaviors were escalated except for Resident #11, who really did not like consequences at all. Resident #11 had a lot of behaviors. During a telephone interview on [DATE] at 4:53 P.M., CNA A said Resident #11 was becoming aggravated and aggressive over an incident with some toilet paper. CNA A asked Resident #11 why he/she needed more toilet paper because CNA A had previously given Resident #11 some. CNA A had found out that Resident #11 had also gotten two other rolls from someone else and either Resident #11 or Resident #11's roommate had clogged the toilet with a roll the morning before. Resident #11 came out of his/her room when everyone else was asleep and was hollering and CNA A was trying to coerce Resident #11 back to his/her room to calm down so the resident could talk about it when he/she was calmer. Anything CNA A would do or say to calm the resident down didn't help. LPN B had Resident #11 walking back to his/her room, and then the resident came running back at CNA A and threatened to pee on CNA A's foot. Resident #11 got up in CNA A's face and punched him/her in the face and bloodied CNA A's lip. The resident's arms were down by his/her waist after this happened. CNA A then got behind Resident #11 and had his/her hands at the resident's elbows and gently tried to take the resident by his/her arms in order to sit the resident down as gently as possible to keep him/her from hurting himself/herself or anyone else. On the way down, Resident #11 bit CNA A on the forearm. After the resident bit CNA A, CNA A sat the resident down on his/her bottom and rolled the resident over onto his/her stomach. LPN B came back to give Resident #11 a shot and LPN B asked the resident if he/she was going to come after anyone and the resident said no, so CNA A let Resident #11 go and Resident #11 walked back to his/her room. CNA A was sent home after that. CNA A had not had any type of training either from the facility, a previous employer, or the staffing agency through which he/she is employed. CNA A believed the house staff receives training, but they never mentioned anything to him/her about receiving training. CNA A was working about four days a week at the facility, but feels he/she wasn't able to pick up as many shifts recently until the incident happened. CNA A said the facility had in services, but they occurred when he/she wasn't there. During an interview on [DATE] at 4:43 P.M the DON said CNA A started picking up shifts at the facility in July of 2023. The only training/inservice CNA A participated in was the one on abuse and neglect on [DATE], which was provided during survey. The facility typically does not include agency staff in trainings unless it is for Person-Centered Interventions (PCI - a training for two-person team and three person defensive hold). Agency staff have certain trainings they have to complete through the staffing agency to keep their accounts active, but she does not have access to those things other than to know if CNA A passed or failed them. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Review of Resident #61's medical record showed: - admitted [DATE]; - Diagnoses of schizophrenia, restlessness and agitation, and oppositional defiant disorder (a condition characterized by a persistent pattern of defiant, angry, and irritable behavior towards authority figures, such as parents, teachers, or caregivers); - Per the PASARR Level II screening: Resident with history of overdose on opiates to end life, held gun to his/her head, poor insight/judgment, looseness of association, flight of Ideas, thought broadcasting, poor sleep, grandiose delusions, decreased appetite, depressed mood, elevated anxiety level, irritability, decreased energy, feelings of helplessness/hopelessness/guilt, self-isolation, excessive worry, panic attacks, heart racing, and sweating. Review of the resident's quarterly MDS, dated [DATE], showed: - No cognitive impairment; - Physical (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal (e.g., threatening others, screaming at others, cursing at others) behavioral symptoms directed toward others, other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) and wandering all occurred one to three days in the seven-day look back period; - Independent with ADLs; - The resident received antipsychotic, antianxiety, and antidepressant medication in the seven-day look back period. Review of the resident's care plan, revised [DATE], showed: - The resident resides on the secured behavioral unit due to history of behaviors. At risk to harm self or others. At risk for elopement; - Care plan does not address actions/consequences list. - History of acting like a police officer/threatening to arrest staff/and making/pointing finger guns at staff; reported that he/she was a volunteer fireman and police explorer; - Whatever the resident listens to/watches on YouTube, that is what he/she becomes next (during recent power failure, the resident put on a jacket, acted as if he/she was a security guard, checked all perimeters, and reported to staff that all was secured; - History of overdose of opiates to end life; held gun to his/her head; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claru Deville Nursing Center	105 Spruce Street Fredericktown, MO 63645

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Poor insight/judgment; looseness of association; flight of ideas; thought broadcasting; poor sleep; grandiose delusions; decreased appetite; depressed mood; elevated anxiety level; irritability; decreased energy; feelings of helplessness/hopelessness/guilt; self-isolation; excessive worry; panic attacks; heart racing; sweating; crying spells; presents with grandiose bravado demeanor; behaving in an intimidating manner; delusions; likes to stand close to people and be in their space; sleeping excessively; and suicidal ideation; - History of threatening to elope if staff at previous facility did not send him/her to the hospital. Also hit and kicked staff at previous facility; - Resident's preferred coping skills are exercise, listening to music, talking to someone close to him/her, smiling at five people, and playing with modeling clay. Review of the resident's POS, dated [DATE], showed: - An order for trazodone, 100 mg, give one tablet by mouth at bedtime, for insomnia, dated [DATE]; - An order for risperidone (antipsychotic medication), one mg, give one tablet by mouth twice a day, for schizophrenia, dated [DATE]; - An order for divalproex extended release (anticonvulsant medication used as a mood stabilizer), 500 mg, give 1000 mg by mouth once daily, for schizophrenia, dated [DATE]; - An order for zoloft (antidepressant medication), 100 mg, give 200 mg by mouth once daily, for major depressive disorder, dated [DATE]; - An order for Invega Sustenna (antipsychotic medication), 234 mg/1.5 ml, give 234 mg intramuscularly every 21 days, for schizophrenia, dated [DATE]; - An order for Geodon solution, 20 mg/ml, give 20 mg intramuscularly one time, for restlessness and agitation, dated [DATE]; - An order for Ativan solution (antianxiety medication), two mg/ml, give two mg intramuscularly one time, for restlessness and agitation, dated [DATE]; - An order for Geodon solution, 20 mg/ml, give 20 mg intramuscularly one time, for restlessness and agitation, dated [DATE]. Review of the resident's progress notes showed: - On [DATE] at 5:30 P.M., resident threatening to hit staff and hovering over staff on hall. Staff told resident to stop hovering over them. Resident did not like that and got mad, yelling at staff. Resident went into office and grabbed scissors. Resident tried to cut right thumb. There is a small mark on resident's finger. Unit Coordinator instructed to remove resident's belongings from room to prevent resident from harming himself/herself in any other way. When staff tried to pack resident's belongings up, resident got mad and tried attacking staff. Staff initiated defense team with staff support and handled appropriately. No injuries present. Staff put resident's belongings in office and locked office. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On [DATE] at 3:52 P.M., Resident started having a behavioral outburst, was cussing at staff, being verbally aggressive to staff, and making threatening statements to staff. Staff attempted to verbally redirect resident. Resident was not easily redirectable at this time. Nurse notified psychiatric physician of resident's current behavior. New order given for Geodon injection. With CNAs present, nurse administered injection to left deltoid with no complications; - On [DATE] at 11:15 A.M., Resident was having a behavioral outburst, and showing signs and symptoms of attention seeking behaviors. Nurse went to speak with resident with other staff present. When asked why he/she was upset, resident stated I want all my shit back. Staff reminded resident that he/she was making suicidal ideation (SI) statements and for his/her safety, that not all items could be returned at this time. Resident then started to laugh and smile and then states Well, I am SI now. Nurse asked resident if he/she had a plan, and resident stated Well, No. This nurse tried to redirect resident with 1:1 conversation. Resident was not responding well to 1:1 conversation. Resident then stated If you even tr [TRUNCATED]

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39360 Based on interview and record review, the facility failed to complete a Level I Preadmission Screening and Resident Review (PASARR - a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder, to determine the level of care needed) for one resident (Resident #63) out of 18 sampled residents. The facility's census was 74. The facility did not provide a policy for PASARR. 1. Review of Resident #63's medical record showed: - An admitted [DATE]; - Diagnoses of dementia (a group of thinking and social symptoms that interfere with daily functioning), traumatic brain injury in the ear, and schizoaffective disorder-bipolar type (a condition that combines symptoms of schizophrenia, a disorder affecting one's ability to think, feel and behave clearly, and bipolar, which include manic episodes of extreme high energy and mood to depressive lows); - No documentation of the required level one pre-screening upon admission to the facility. During an interview on 1/16/25 at 4:20 P.M., the Assistant Director of Nursing (ADON) said the PASARR was never completed. During an interview on 01/17/25 at 4:35 P.M., the Administrator, Director of Nursing and ADON collectively said they would expect residents to have a PASARR (DA124) filled out prior to admission.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49754 Based on observation, interview, and record review, the facility failed to clean bilevel positive airway pressure (BiPAP, a machine that pushes pressurized air into the lungs at distinct levels on inhalation and exhalation) and continuous positive air pressure (CPAP, a treatment for breathing issues that involves a machine delivering constant pressurized air through a mask) machines per the manufacturer's guidelines for two residents (Resident #39 and #46) out of two sampled residents. The facility's census was 74. Review of the facility's policy titled, Oxygen Administration, dated March 2015, showed: - Purpose, to administer oxygen to the resident when insufficient oxygen in being carried by the blood to the tissues; - At regular intervals, check and clean oxygen equipment, masks, tubing and cannulas; - At regular intervals, check liter flow contents of oxygen cylinder, fluid level in humidifier and assess resident's respiration to determine further need for oxygen therapy; - The policy did not address the use of BiPAP and CPAP machines. Review of [NAME] Respironics DreamStation BiPAP and CPAP manufacturer's guidelines for cleaning dated 2004-2025, showed: - Unplug the power cord from the wall outlet before cleaning; - Clean the device's exterior surface weekly or more often if necessary; - Use one teaspoon liquid dishwashing detergent per gallon of water and clean exterior with lint free cloth, replace damaged parts; - Remove all filters; rinse the reusable filter monthly and let air dry, replace with a new one every six months; - Clean tubing weekly and replace with new tubing every six months; - Disconnect tubing from machine and immerse in a solution of one teaspoon liquid dishwashing soap to one gallon of water for three minutes; - Rinse tubing thoroughly for one minute and allow to air dry. 1. Review of Resident #39's medical record showed: - admitted [DATE]; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of cough, shortness of breath, and obstructive sleep apnea (a condition where breathing is interrupted by the airway blocking the flow of air) and insomnia (sleep disorder making it hard to fall asleep or stay asleep.) Review of the resident's care plan, revised 01/10/25, showed CPAP when sleeping, start date 08/28/24. The care plan did not address the maintenance of the CPAP machine. There was no tracking of the cleaning of the machine or changing of the tubing. Observation on 01/14/25 at 1:00 P.M. and 01/17/25 at 9:00 A.M. showed: - The resident lay in bed with CPAP machine on; - No date on machine of last cleaning or changing of tubing/filters. During an interview on 01/17/25 at 9:00 A.M., Resident #39 said the nurses clean his/her machine, but not very often. 2. Review of Resident #46's medical record showed: - admitted [DATE]; - Diagnosis of cough, shortness of breath, sleep apnea, mild intermittent asthma (a condition in which the airway narrows and swells and may produce extra mucus triggering cough and shortness of breath), and insomnia. Review of the resident's care plan, revised 11/29/24, showed episodes of insomnia, uses BiPAP while sleeping per sleep study results, start date 04/14/23. The care plan did not address the maintenance of the CPAP machine. There was no tracking of the cleaning of the machine or changing of the tubing. Observation on 01/14/25 at 1:15 P.M. and 01/17/25 at 9:15 A.M. showed: -The resident lay in bed with BiPAP machine on; -No date on machine of last cleaning or changing of tubing/filters. During an interview on 01/14/25 at 1:15 P.M., Resident #46 said he/she wears a BiPAP anytime he/she is sleeping and no one has ever cleaned it that he/she knows of. 3. During an interview on 01/16/25 at 3:05 P.M., Certified Nurse Aide (CNA) H said they fill the BiPAP and CPAP machines with distilled water every shift and they get cleaned every two to three days. He/She has no experience with cleaning them, because they don't get cleaned on his/her shift. They usually clean them on the night shift before bed. During an interview on 01/17/25 at 8:50 A.M., Registered Nurse G said BiPAPs and CPAPs are cleaned on the night shift by the nurses. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/17/25 at 4:35 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said they would expect BiPAPs and CPAPs to be cleaned according to the manufacturer's directions. During an interview on 01/27/25 at 11:42 A.M., the DON/ADON said that they did not have a system in place for the cleaning of the machine, mask, tubing or changing of the tubing at the time of survey. They created a TAR on 01/27/25 for the cleaning of the machine and mask, but are waiting to hear back from the manufacturer for the appropriate protocol on cleaning/changing tubing. They said the tubing is typically changed every 90 days and the respiratory company they get the machines from send the tubing out when it is due to be changed. The facility also replaces the tubing if they notice any problems with the tubing such as holes, cracks, etc. During an interview on 01/28/25 at 11:06 A.M, LPN M said the night nurses clean BiPAPs and CPAPs on Sunday nights. He/She said that he/she changed the filters on two machines last week. He/She said that the filters and tubing are changed out weekly. He/She said there is no specific cleaning, they just change the filters and tubing out.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46460 Based on observation, interview, and record review, the facility failed to provide staff with appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain the highest practicable physical, mental, and psychosocial well-being for three sampled residents (Residents #11, #61 and #68) who resided on the secured behavior unit. This deficient practice had the potential to affect all 22 residents on the secured behavioral unit. The facility's census was 74. The facility did not provide any policies or procedures regarding secured behavior unit staffing needs, specialized training needed to work on the locked behavior unit, or criteria for admission to the locked behavior unit. The facility did not provide any mental health behavior training program for staff working on the secured behavioral unit. Review of the Facility Assessment, last updated 7/20/24, showed: - An average of 20-22 residents are receiving care on a locked behavioral unit; - An average of 20 residents requires a special level of behavioral mental health from facility staff; - Services and care offered to residents based on their needs included: - Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior; - Identify and implement interventions to help support individuals with issues such as dealing with anxiety; - Care of someone with cognitive impairment; - Care of individuals with depression, trauma/PTSD and other psychiatric diagnoses, intellectual or developmental disabilities. 1. Observation on 01/14/25 at 12:13 P.M. showed a printed paper posted on Resident #11's bathroom door which read: - Actions and Consequences, you all are aware of the rules, they are now set in place. So, if you have one of these actions there will be consequences and we will be following through with each one of them. - The document was then divided into two columns, one labeled Action the other Consequences. The Consequences column had two options for each action depending on a resident's smoking status; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Action: Arguing with another resident. Consequence: Sent to room to work on coping skills; - Action: Arguing with staff, not listening. Consequence: Resident loses one smoke break; - Action: Arguing with staff, not listening. Consequence: Resident loses one day of snack cart; - Action: Cursing out staff. Consequence: Resident loses two smoke breaks; - Action: Cursing out staff. Consequence: Resident loses a week of snack cart; - Action: Hitting a staff member or a resident. Consequence: Resident loses smoke break for 48 hours; - Action: Hitting a staff member or a resident. Consequence: Resident loses snack cart for two weeks; - Action: Stealing from another resident. Consequence: Resident loses two smoke breaks; - Action: Stealing from another resident. Consequence: Resident loses snack cart for a week; - Action: Attention seeking Self-Harming behavior. Consequence: Resident loses belongings and smoke break for the day and is to wear a gown with pants; - Action: Attention seeking Self-Harming behavior. Consequence: Resident loses belongings and snack cart for the week and is to wear a gown with pants; - Action: Refusing medication. Consequence: Resident loses everything until medication is taken; - Action: Taking off a resident tray or sharing food. Consequence: Resident loses smoke break for 24 hours; - Action: Taking off a resident tray or sharing food. Consequence: Resident loses snack cart for the week; - Action: Resident refusing shower for two days. Consequence: Resident loses smoke break until shower is taken; - Action: If a resident stands where staff is charting after staff has redirected. Consequence: Resident loses one smoke break, and snack cart for the day; - Action: Resident not listening to being sent to room, due to behavior on the hall and not shutting the door when asked. Consequence: Resident will lose all privileges for the rest of the day; - Action: Resident sharing anything without staff approval. Consequence: Resident loses one smoke break; - Action: Resident sharing anything without staff approval. Consequence: Resident loses one snack cart day; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Action: Resident going past the double doors with the phone after being reminded. Consequence: Resident loses one smoke break; - Action: Resident going past the double doors with the phone after being reminded. Consequence: Resident loses one snack cart day; - Action: Resident not following directions or listening to the staff when asked of something. Consequence: Resident loses one smoke break; - Action: Resident not following directions or listening to the staff when asked of something. Consequence: Resident loses one snack cart; - Action: Resident keeping things in their room, that are not allowed. Consequence: Resident loses one smoke break per item found in room; - Action: Resident keeping things in their room, that are not allowed. Consequence: Resident loses snack cart days per item found in room. 1. Review of Resident #11's medical record showed: - admitted on [DATE]; - Diagnoses of bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and nicotine dependence (a chronic brain disorder that causes a person to compulsively need nicotine, a substance found in tobacco products and includes withdrawal symptoms like restlessness, agitation, increased hunger, insomnia, constipation, or diarrhea); - Per the Preadmision Screening and Resident Assessment (PASARR) Level II screening (a comprehensive assessment of current and historical treatment): Resident has history of depression, anxiety, paranoia, agitation, aggression, mood swings, non-compliance with medication and treatment, impulsive behaviors, poor decision making, racing thoughts, irritation, anger outbursts, poor sleep at times, poor appetite at times, at a previous facility was found walking on the road, non-compliance with rules, suicidal ideation - thought of hanging self, history of suicidal attempt, punching walls, and marijuana use. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by the facility staff), dated 11/05/24, showed: - No cognitive impairment; - Exhibited hallucinations in the seven-day look back period; - Independent with activities of daily living (ADLs); - The resident routinely received antipsychotic medication in the seven-day look back period. Review of the resident's care plan, revised 11/11/24, showed: (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident at increased risk for behavioral/mood problems due to history of behaviors. At risk to harm self or others. At risk to elope from facility; - History of physical violence; - Unit Coordinator got approved per guardian directive that if resident has a behavior, staff can take away any open hall activities and a smoke break and do room searches for safety reasons; - Unit Coordinator spoke with resident's guardian in regard to the unit policies and procedures and went over each one with the guardian. The guardian agreed with the unit policies and procedures, and states she gives verbal consent and to add these to resident's guardian directives. The care plan did not address resident specific interventions to monitor or protect the resident from abuse and did not address the actions/consequences list. During an interview on 01/14/25 at 12:13 P.M., Resident #11 said he/she had an altercation with Certified Nursing Assistant (CNA) A and he/she punched CNA A in the face. They have an actions and consequences list on the bathroom door. Resident #11 said because he/she hit the nurse, he/she can't smoke for three days. Resident #11 said it was humiliating. During an interview on 01/16/25 at 3:06 P.M., CNA J/Unit Coordinator said staff get training about how to take down a resident properly, but CNA A did not have that training and he/she will not be coming back. During an interview on 01/17/25 at 11:00 A.M., the Assistant Director of Nursing (ADON) said that when employees are hired, they get abuse/neglect training and it's documented in the payroll system. Agency staff do written training when they are hired. 2. Review of Resident #61's medical record showed: - admitted [DATE]; - Diagnoses of schizophrenia, restlessness and agitation, and oppositional defiant disorder (a condition characterized by a persistent pattern of defiant, angry, and irritable behavior towards authority figures, such as parents, teachers, or caregivers); - Per Level II screening: Resident with history of overdose on opiates to end life, held gun to his/her head, poor insight/judgment, looseness of association, flight of Ideas, thought broadcasting, poor sleep, grandiose delusions, decreased appetite, depressed mood, elevated anxiety level, irritability, decreased energy, feelings of helplessness/hopelessness/guilt, self-isolation, excessive worry, panic attacks, heart racing, and sweating. Review of the resident's quarterly MDS, dated [DATE], showed: - No cognitive impairment; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Physical (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal (e.g., threatening others, screaming at others, cursing at others) behavioral symptoms directed toward others, other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) and wandering all occurred one to three days in the seven-day look back period; - Independent with ADLs; - The resident received antipsychotic, antianxiety, and antidepressant medication in the seven-day look back period. Review of the resident's care plan, revised 11/29/24, showed the resident resides on the secured behavioral unit due to history of behaviors. At risk to harm self or others. At risk for elopement. The care plan did not address resident specific interventions to monitor or protect the resident from abuse and did not address the actions/consequences list. Review of the resident's progress notes showed: - On 01/12/25 at 5:30 P.M., resident threatening to hit staff and hovering over staff on hall. Staff told resident to stop hovering over them. Resident did not like that and got mad, yelling at staff. Resident went into office and grabbed scissors. Resident tried to cut right thumb. There is a small mark on resident's finger. Unit Coordinator instructed floor staff to remove resident's belongings from room to prevent resident from harming himself/herself in any other way. When staff tried to pack resident's belongings up, resident got mad and tried attacking staff. Staff initiated defense team with staff support and handled appropriately. No injuries present. Staff put resident's belongings in office and locked office. Observations of Resident #61 showed: - On 01/14/25 at 1:33 P.M., the resident walked in the hall wearing a hospital gown and pants; - On 01/15/25 at 1:32 P.M., the resident lay in bed with covers over his/her head; - On 01/15/25 at 2:53 P.M., the resident sat on the floor in the hall wearing a hospital gown and pants; During an interview on 01/14/25 at 1:33 P.M., Resident #61 said he/she had to wear a hospital gown because he/she was self-harming by trying to cut his/her arm and staff took everything out of his/her room. He/She would like to wear his/her own clothes. Resident #61 said his/her clothes are locked in the office, but they won't let him/her wear them until he/she quits self-harming. That's the Unit Coordinator's rule. During an interview on 01/15/25 at 2:53 P.M., Resident #61 said wearing a hospital gown made him/her feel bad. He/She was thinking of self-harming and had been working on coping skills. 3. Review of Resident #68's medical record showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claru Deville Nursing Center	105 Spruce Street Fredericktown, MO 63645

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- admitted [DATE]; - Diagnoses of borderline intellectual functioning (on the border between normal intellectual functioning and intellectual disability), suicide attempt, borderline personality disorder (a mental illness that severely impacts a person's ability to regulate their emotions), and poisoning by multiple unspecified drugs; - Per Level II screening: Resident has history of sexual abuse. Resident has verbalized feeling guilt and overwhelming sadness and experiences auditory and visual hallucinations. The voices are angry with him/her and tell him/her he/she deserved what happened. He/She also verbalized having difficulty dealing with coping with his/her aunt's terminal illness. He/She has overdosed on all of his/her medications multiple times in the past and prior to this admission. He/She has a history of self-abuse by cutting, with the last reported incident several months ago. Staff use distraction and visualization when the resident is experiencing suicidal ideations. Review of the resident's quarterly MDS assessment, dated 10/10/24, showed: - No cognitive impairment; - Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others), other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds), and rejection of care occurred one to three days during the seven-day look back period; - Independent with ADLs; - The resident received antipsychotic and antidepressant medications in the seven-day look back period. Review of the resident's care plan, revised 10/25/24, showed: - Resident resides on the secured behavioral unit due to history of behaviors. At risk to harm self or others. At risk to elope from facility; - History of suicidal ideations and multiple suicide attempts by overdosing on medications; - History of self abuse/mutilating by cutting; - Chronic self-injurious behaviors; - Homicidal statements that he/she felt like hurting someone; - Experienced nightmares, isolation, and anxiety; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 03/31/24: Resident having behavioral outburst, and showing signs and symptoms of attention seeking behavior as he/she has a history of behavior. Resident acting as if he/she will use zipper off his/her clothes to harm self, and making suicidal statements. Staff removed resident's clothing and resident given hospital gown related to resident attempting to use items off his/her clothes to harm self with. Resident not cooperative at first and was yelling and being tearful but no tears present noted. Resident became agitated and physically aggressive toward staff. The care plan did not address resident specific interventions to monitor or protect the resident from abuse and did not address the actions/consequences list. During an interview on 01/14/25 at 1:36 P.M., Resident #68 said he/she is wearing a hospital gown because he/she was self-harming (scratching really hard on the inside of his/her wrist). Once he/she quits, he/she will get his/her clothes back. He/She would really like to wear his/her clothes. During an interview on 01/15/25 at 1:16 P.M., Resident #68 said he/she has had to wear the hospital gown for two weeks. He/She said it makes him/her feel embarrassed when he/she has to wear a hospital gown. Observations of Resident #68 showed: - On 01/14/25 at 12:06 P.M., the resident lay on a mattress in the floor with the cover pulled over his/her head. - On 01/15/25 at 1:16 P.M., the resident sat on the mattress on the floor wearing a hospital gown; - On 01/15/25 at 4:26 P.M., the resident's mattress on the floor; - On 01/16/25 at 8:44 A.M., the resident's mattress on the floor. During an interview on 01/15/25 at 3:00 P.M., Resident #68 said his/her bed was taken away as a consequence of self-harming. He/She is the only one on the unit who sleeps on the floor like that. He/She feels like a hobo and his/her back is starting to hurt from it. During an interview on 01/15/25 at 11:40 A.M., CNA I said the actions and consequences program was in place when he/she began working at the facility over a month ago. CNA I said he/she had been instructed to enforce the consequences. There is a Behavior Book where staff is to keep track of which residents have had what taken away and for how long. CNA I said he/she feels the consequences can escalate behaviors for some residents. During an interview on 01/15/25 at 11:55 A.M., CNA J/Unit Coordinator said the actions and consequences program started in December 2023. Resident's guardians and responsible parties have all signed off on it as well. Staff are expected to enforce the program. CNA J explained the process as when a staff member sees a resident exhibiting one of the actions, they are to come to CNA J and report what they saw and then discuss and agree on what consequence to take. A summary of each consequence is sent to the resident's guardians/responsible party. They approve by signing the form and sending it back, and it is kept on file. CNA J said staff track behaviors and consequences in the Behavior Book. CNA J said some resident's behaviors are escalated by the consequences. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/27/25 at 8:37 A.M., CNA J/Unit Coordinator said Resident #61 threatens things every day, like he/she would start scratching himself/herself when a pen, then staff would take that away. Then Resident #61 would say he/she was going to find something else to kill himself/herself with. He/She had a pair of pants and was trying to choke himself/herself and that was when we gave him/her the gown. When Resident #61 and #68 know that they are getting their items back, they will try the same things again. Staff were trying to keep them safe because staff can't do 1:1 with everyone on the hall. Resident #68's mattress was on the floor because the resident would attempt to cut himself/herself with the springs on the bed. CNA J cannot remember when this happened, but Resident #68 had only been without a mattress for about five days. Interviews with the DON: - On 01/15/25 at 12:10 P.M., the DON said she started working at the facility two years ago and the Foundation Program was in place (name for the action/consequence list) when she got here. The residents all have copies of the actions and consequences list, and all resident's guardians are aware, and we have either verbal or written consent. The CNAs will report actions to the Unit Coordinator and the Unit Coordinator keeps track of which residents receive what consequence in a binder. The DON believes the program has been very beneficial. When the prior Unit Coordinator was here, the unit was in utter chaos. The DON said some residents can be triggered by the consequences; - On 01/21/25 at 4:43 P.M the DON said CNA A started picking up shifts at the facility in July of 2023. The only training/inservice CNA A participated in was the one on abuse and neglect on 04/04/24, which was provided during survey. The facility typically does not include agency staff in trainings unless it is for Person-Centered Interventions (PCI - a training for two-person team and three person defensive hold). Agency staff have certain trainings they have to complete through the staffing agency to keep their accounts active, but she does not have access to those things other than to know if CNA A passed or failed them; - On 02/06/25 at 8:09 A.M., the DON said the only criteria the facility has for working on the behavior unit is staff must be at least [AGE] years old. The facility staffs two CNAs and the Unit Coordinator most days and that is preferred, but when call outs happen that is not always an option so sometimes it's one CNA and the unit coordinator, who is also a CNA; - On 02/06/25 at 10:30 A.M., the DON said the facility has a psychiatrist and his Nurse Practitioner (NP) that assess the residents monthly. The psychiatrist does televisits and the NP comes in to the building. Several of the residents also receive counseling weekly with a counselor from Advanced Psychiatry services. Assessments with the psychiatrist and NP include medication review, mental status exam which includes general appearance and behavior, mood, affect, appetite, sleep, immediate memory, insight and judgement, attention span and concentration, psychomotor activity, orientation, and labs; - On 02/06/2025 at 10:48 AM, the DON said there are no written policies regarding the behavior unit at this time, however that is something we are working on and hope to have in place in the near future. The DON said the facility uses a contracted training for staff which encompasses behavioral health, but it is not required to be obtained before working on the unit; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 02/06/2025 at 10:48 AM, the DON said the beds on the unit are nursing home beds and the residents residing on that unit are qualified to be in a nursing home. They are placed on the unit to ensure ease of care for their particular needs; - On 02/07/25 at 10:07 A.M., CNA J moved into the position as unit coordinator on December 1st, 2024. He/She had PCI training and had worked the unit for a little over two years prior to assuming the role. Once in the role, he/she has been trained on documentation and assessments, and has ongoing training as he/she learns his/her role. He/She is a CNA, so he/she is under the supervision of a nurse at all times.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46460 Based on observation, record review and interview, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for three sampled residents (Residents #11, #61 and #68) out of 22 residents who reside on the secured behavior unit. The facility failed to care plan resident specific interventions and did not assess the affect of the use of an actions/consequences list requested by the guardian. The facility did not develop a behavior plan or crisis intervention plan for residents as indicated by the pre-admission behavioral health screening. The unit enforced a program of negative consequences should a resident exhibit behaviors. The facility census was 74. The facility did not provide any policies or procedures regarding locked behavior unit staffing needs, specialized training needed to work on the locked behavior unit or criteria for admission to the locked behavior unit. The facility did not provide any mental health behavior training program for staff working on the locked behavioral unit. Review of the Facility Assessment, last updated 7/20/24 showed: - An average of 20-22 residents are receiving care on a locked behavioral unit; - An average of 20 residents requires a special level of behavioral mental health from facility staff; - Services and care offered to residents based on their needs included: - Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior; - Identify and implement interventions to help support individuals with issues such as dealing with anxiety; - Care of someone with cognitive impairment; - Care of individuals with depression, trauma/PTSD and other psychiatric diagnoses, intellectual or developmental disabilities; 1. Observation on 01/14/25 at 12:13 P.M. showed a printed paper posted on Resident #11's bathroom door which read: (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	- Actions and Consequences, you all are aware of the rules, they are now set in place. So, if you have one of these actions there will be consequences and we will be following through with each one of them. - The document was then divided into two columns, one labeled Action the other Consequences. The Consequences column had two options for each action depending on a resident ' s smoking status; - Action: Arguing with another resident. Consequence: Sent to room to work on coping skills; - Action: Arguing with staff, not listening. Consequence: Resident loses one smoke break; - Action: Arguing with staff, not listening. Consequence: Resident loses one day of snack cart; - Action: Cursing out staff. Consequence: Resident loses two smoke breaks; - Action: Cursing out staff. Consequence: Resident loses a week of snack cart; - Action: Hitting a staff member or a resident. Consequence: Resident loses smoke break for 48 hours; - Action: Hitting a staff member or a resident. Consequence: Resident loses snack cart for two weeks; - Action: Stealing from another resident. Consequence: Resident loses two smoke breaks; - Action: Stealing from another resident. Consequence: Resident loses snack cart for a week; - Action: Attention seeking Self-Harming behavior. Consequence: Resident loses belongings and smoke break for the day and is to wear a gown with pants; - Action: Attention seeking Self-Harming behavior. Consequence: Resident loses belongings and snack cart for the week and is to wear a gown with pants; - Action: Refusing medication. Consequence: Resident loses everything until medication is taken; - Action: Taking off a resident tray or sharing food. Consequence: Resident loses smoke break for 24 hours; - Action: Taking off a resident tray or sharing food. Consequence: Resident loses snack cart for the week; - Action: Resident refusing shower for two days. Consequence: Resident loses smoke break until shower is taken; - Action: If a resident stands where staff is charting after staff has redirected. Consequence: Resident loses one smoke break, and snack cart for the day; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	- Action: Resident not listening to being sent to room, due to behavior on the hall and not shutting the door when asked. Consequence: Resident will lose all privileges for the rest of the day; - Action: Resident sharing anything without staff approval. Consequence: Resident loses one smoke break; - Action: Resident sharing anything without staff approval. Consequence: Resident loses one snack cart day; - Action: Resident going past the double doors with the phone after being reminded. Consequence: Resident loses one smoke break; - Action: Resident going past the double doors with the phone after being reminded. Consequence: Resident loses one snack cart day; - Action: Resident not following directions or listening to the staff when asked of something. Consequence: Resident loses one smoke break; - Action: Resident not following directions or listening to the staff when asked of something. Consequence: Resident loses one snack cart; - Action: Resident keeping things in their room, that are not allowed. Consequence: Resident loses one smoke break per item found in room; - Action: Resident keeping things in their room, that are not allowed. Consequence: Resident loses snack cart days per item found in room. Review of Resident #11's medical record showed: - admitted on [DATE]; - Diagnoses of bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and nicotine dependence (a chronic brain disorder that causes a person to compulsively need nicotine, a substance found in tobacco products and includes withdrawal symptoms like restlessness, agitation, increased hunger, insomnia, constipation, or diarrhea). Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by the facility staff), dated 11/05/24, showed: - No cognitive impairment; - Exhibited hallucinations in the seven-day look back period; - Independent with activities of daily living (ADLs); - The resident routinely received antipsychotic medication in the seven-day look back period. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Level II screening (a comprehensive assessment of current and historical treatment), dated 03/17/21, showed: - Resident has history of depression, anxiety, paranoia, agitation, aggression, mood swings, non-compliance with medication and treatment, impulsive behaviors, poor decision making, racing thoughts, irritation, anger outbursts, poor sleep at times, poor appetite at times, at a previous facility was found walking on the road, non-compliance with rules, suicidal ideation - thought of hanging self, history of suicidal attempt, punching walls, and marijuana use; - Resident needs a Behavioral Plan in place for ongoing assessment for mental status changes, including mood and thought process. The resident's previous behavior plan in place during hospital placement included 1. A safe day with no emergency procedures due to unsafe behaviors that are not redirectable. 2. No threats of harm or unsafe behaviors that are not redirectable within 3 attempts. 3. Ability to go to a quieter/safer area to calm down when agitated. If she meets all the above for the entire day, she will earn 1 soda the following day. See hospital records. Ensure safety of sharps due to history of ingesting. Review of the resident's care plan, revised 11/11/24, showed: - Resident at increased risk for behavioral/mood problems due to history of behaviors. At risk to harm self or others. At risk to elope from facility; - History of physical violence. - Unit Coordinator got approved per guardian directive that if resident has a behavior, staff can take away any open hall activities and a smoke break and do room searches for safety reasons; - Unit Coordinator spoke with resident's guardian in regard to the unit policies and procedures and went over each one with the guardian. The guardian agreed with the unit policies and procedures, and states she gives verbal consent and to add these to resident's guardian directives. The care plan did not address resident specific interventions and did not address the use of an actions/consequences list. The facility did not provide a behavior plan as indicated by the Level II screening. The facility did not provide a crisis intervention plan for behaviors. During an interview on 01/14/25 at 12:13 P.M., Resident #11 said he/she had an altercation with Certified Nursing Assistant (CNA) A and he/she punched CNA A in the face. They have an actions and consequences list on the bathroom door. Resident #11 said because he/she hit the nurse he/she can't smoke for three days. Resident #11 said it was humiliating. During a telephone interview on 01/27/25 at 8:37 A.M., CNA J/Unit Coordinator said Resident #11 lost his/her smoke breaks for punching and biting CNA A on 01/11/25 and the next day Resident #11 was acting like she wanted to fight other staff, so he/she got 48 hours of smoke breaks taken away on 01/12/25. 2. Review of Resident #61's medical record showed: - admitted [DATE]; (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	- Diagnoses of schizophrenia, restlessness and agitation, and oppositional defiant disorder (a condition characterized by a persistent pattern of defiant, angry, and irritable behavior towards authority figures, such as parents, teachers, or caregivers); Review of the resident's quarterly MDS, dated [DATE], showed: - No cognitive impairment; - Physical (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal (e.g., threatening others, screaming at others, cursing at others) behavioral symptoms directed toward others, other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) and wandering all occurred one to three days in the seven-day look back period; - Independent with ADLs; - The resident received antipsychotic, antianxiety, and antidepressant medication in the seven-day look back period. Review of Resident Level II screening, dated 12/16/22 showed: - Resident with history of overdose on opiates to end life, held gun to his/her head, poor insight/judgment, looseness of association, flight of Ideas, thought broadcasting, poor sleep, grandiose delusions, decreased appetite, depressed mood, elevated anxiety level, irritability, decreased energy, feelings of helplessness/hopelessness/guilt, self-isolation, excessive worry, panic attacks, heart racing, and sweating; - The need for the facility to establish a daily behavior plan for Resident #61 to facilitate his getting up and actively participating In the program, regardless of level of sleep need. It Is recommended the facility obtain a copy of his ISP from [NAME] Regional Office to Identify areas in which he requires education and urging/encouragement to work toward less restricted level of care. Review of the resident's care plan, revised 11/29/24, showed the resident resides on the secured behavioral unit due to history of behaviors. At risk to harm self or others. At risk for elopement. The care plan did not address resident specific interventions and did not address the use of an actions/consequences list. The facility did not provide a behavior plan as indicated by the Level II screening. The facility did not provide a crisis intervention plan for behaviors. Review of the resident's progress notes showed: (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	- On 01/12/25 at 5:30 P.M., resident threatening to hit staff and hovering over staff on hall. Staff told resident to stop hovering over them. Resident did not like that and got mad, yelling at staff. Resident went into office and grabbed scissors. Resident tried to cut right thumb. There is a small mark on resident's finger. Unit Coordinator instructed floor staff to remove resident's belongings from room to prevent resident from harming himself/herself in any other way. When staff tried to pack resident's belongings up, resident got mad and tried attacking staff. Staff initiated defense team with staff support and handled appropriately. No injuries present. Staff put resident's belongings in office and locked office; During an interview on 01/14/25 at 1:33 P.M., Resident #61 said he/she had to wear a hospital gown because he/she was self-harming by trying to cut his/her arm and staff took everything out of his/her room. He/She would like to wear his/her own clothes. Resident #61 said his/her clothes are locked in the office, but they won't let him/her wear them until he/she quits self-harming. That's the Unit Coordinator's rule. During an interview on 01/15/25 at 2:53 P.M., Resident #61 said wearing a hospital gown made him/her feel bad. He/She was thinking of self-harming and had been working on coping skills. During a telephone interview on 01/27/25 at 8:37 A.M., CNA J/Unit Coordinator said Resident #61 threatens things every day, like he/she would start scratching himself/herself with a pen, then staff would take that away. Then Resident #61 would say he/she was going to find something else to kill himself/herself with. He/She had a pair of pants and was trying to choke himself/herself and that was when we gave him/her the gown. Staff notified the guardian and the guardian was going to try to get the resident into a Department of Mental Health place, but the guardian said she couldn't find a place. 3. Review of Resident #68's medical record showed: - admitted [DATE]; - Diagnoses of borderline intellectual functioning (on the border between normal intellectual functioning and intellectual disability), suicide attempt, borderline personality disorder (a mental illness that severely impacts a person's ability to regulate their emotions), and poisoning by multiple unspecified drugs. Review of the resident's quarterly MDS assessment, dated 10/10/24, showed: - No cognitive impairment; - Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others), other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds), and rejection of care occurred one to three days during the seven-day look back period; - Independent with ADLs; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claru Deville Nursing Center	105 Spruce Street Fredericktown, MO 63645

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F 0742 Level of Harm - Actual harm Residents Affected - Few	- The resident received antipsychotic and antidepressant medications in the seven-day look back period. Review of Resident #68's Level II screening, dated 11/19/23, showed: - Resident has history of being sexually abused. Resident has verbalized feeling guilt and overwhelming sadness and experiences auditory and visual hallucinations. The voices are angry with him/her and tell him/her he/she deserved what happened. He/She also verbalized having difficulty dealing with coping with his/her aunt's terminal illness. He/She has overdosed on all of his/her medications multiple times in the past and prior to this admission. He/She has a history of self-abuse by cutting, with the last reported incident several months ago. Staff use distraction and visualization when the resident is experiencing suicidal ideations; - The resident's needs could be met in a nursing facility; - The resident needs the following support services: - Obtain Individual Support Plan (ISP), Individual Treatment Plan (ITP), Behavior Heath Plan (BHP) from the Department of Mental Health, or other such entity; - Monitoring of behavioral needs; - Trauma informed services; - Tools of Choice or other Positive Behavioral Support service. Review of the resident's care plan, revised 10/25/24, showed: - Resident resides on the secured behavioral unit due to history of behaviors. At risk to harm self or others. At risk to elope from facility; - History of suicidal ideations and multiple suicide attempts by overdosing on medications; - History of self abuse/mutilating by cutting; - Chronic self-injurious behaviors; - Homicidal statements that he/she felt like hurting someone; - Experienced nightmares, isolation, and anxiety; - 03/31/24: Resident having behavioral outburst, and showing signs and symptoms of attention seeking behavior as he/she has a history of behavior. Resident acting as if he/she will use zipper off his/her clothes to harm self, and making suicidal statements. Staff removed resident's clothing and resident given hospital gown related to resident attempting to use items off his/her clothes to harm self with. Resident not cooperative at first and was yelling and being tearful but no tears present noted. Resident became agitated and physically aggressive toward staff. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	The care plan did not address resident specific interventions and did not address the use of an actions/consequences list. The facility did not provide a behavior plan as indicated by the Level II screening. The facility did not provide an ISP, ITP or BHP. The facility did not provide a crisis intervention plan for behaviors. During an interview on 01/14/25 at 1:36 P.M., Resident #68 said he/she is wearing a hospital gown because he/she was self-harming (scratching really hard on the inside of his/her wrist). Once he/she quits, he/she will get his/her clothes back. He/She would really like to wear his/her clothes. During an interview on 01/15/25 at 1:16 P.M., Resident #68 said he/she has had to wear the hospital gown for two weeks. He/She said it makes him/her feel embarrassed when he/she has to wear a hospital gown. During an interview on 01/15/25 at 3:00 P.M., Resident #68 said his/her bed was taken away as a consequence of self-harming. He/She is the only one on the unit who sleeps on the floor like that. He/She feels like a hobo and his/her back is starting to hurt from it. During a telephone interview on 01/27/25 at 8:37 A.M., CNA J/Unit Coordinator said there was no tracking tool for behaviors. Staff were trying to keep them safe because staff can't do 1:1 with everyone on the hall. CNA J cannot remember when Resident #68's action began and when the consequence should have ended. The longest the residents get items taken away is 72 hours. Resident #68's mattress was on the floor because the resident would attempt to cut himself/herself with the springs on the bed. CNA J cannot remember when this happened, but Resident #68 had only been without a mattress for about five days. Observations of Resident #68 showed: - On 01/14/25 at 12:06 P.M., the resident lay on a mattress in the floor with the cover pulled over his/her head; - On 01/15/25 at 1:16 P.M., the resident sat on the mattress on the floor wearing a hospital gown; - On 01/15/25 at 4:26 P.M., the resident's mattress on the floor; - On 01/16/25 at 8:44 A.M., the resident's mattress on the floor. During an interview on 01/15/25 at 11:40 A.M., CNA I said the actions and consequences program was in place when he/she began working at the facility over a month ago. CNA I said he/she had been instructed to enforce the consequences. There is a Behavior Book where staff is to keep track of which residents have had what taken away and for how long. CNA I said he/she feels the consequences can escalate behaviors for some residents. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/15/25 at 11:55 A.M., CNA J/Unit Coordinator said the actions and consequences program started in December 2023. Resident's guardians and responsible parties have all signed off on it as well. Staff are expected to enforce the program. CNA J explained the process as when a staff member sees a resident exhibiting one of the actions, they are to come to CNA J and report what they saw and then discuss and agree on what consequence to take. A summary of each consequence is sent to the resident's guardians/responsible party. They approve by signing the form and sending it back, and it is kept on file. CNA J said staff track behaviors and consequences in the Behavior Book. CNA J said some resident's behaviors are escalated by the consequences. Interviews with the DON: - On 01/15/25 at 12:10 P.M., the DON said she started working at the facility two years ago and the Foundation Program was in place (name for the action/consequence list) when she got here. The residents all have copies of the actions and consequences list, and all resident's guardians are aware, and we have either verbal or written consent. The CNAs will report actions to the Unit Coordinator and the Unit Coordinator keeps track of which residents receive what consequence in a binder. The DON believes the program has been very beneficial. When the prior Unit Coordinator was here, the unit was in utter chaos. The DON said some residents can be triggered by the consequences; - On 02/06/2025 at 10:48 AM, the DON said there are no written policies regarding the behavior unit at this time, however that is something we are working on and hope to have in place in the near future. The DON said the facility uses a contracted training for staff which encompasses behavioral health, but it is not required to be obtained before working on the unit; - On 02/06/2025 at 10:48 AM, the DON said the beds on the unit are nursing home beds and the residents residing on that unit are qualified to be in a nursing home. They are placed on the unit to ensure ease of care for their particular needs.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49754 Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent when medications were administered. There were 25 opportunities with three medication errors made, for an error rate of 12%. Out of six residents observed, this affected two residents (Resident #41 and #57) out of 18 sampled residents and one resident (Resident #53) outside the sample. The facility's census was 74. Review of the facility's policy titled, Diabetes Mellitus (a chronic metabolic disease that occurs when the body can't produce or use insulin properly), Control of, dated March 2015, showed: - Purpose, to assist the resident to establish a balance between diet, exercise and insulin (a hormone that regulates blood sugar levels by moving blood sugar into cells where it can be used for energy); - Appropriate diagnostic testing to determine nutritional status; - Assess and identify risk factors; - Plan resident and care giver education plan; - Assess and identify complications; - The policy did not address the use of insulin pens. Review of Humalog KwikPen (insulin in a pen-type device) instructions, revised March 31, 2020, showed: - Pull the pen cap straight off; - Select a new needle and push the capped needle onto the pen and twist until tight and remove outer needle shield; - Prime your pen, turn the dose selector to select two units; - Press and hold the dose button until the counter shows zero and a drop of insulin appears; - Select your dose; - Clean skin with an alcohol swab and let dry; - Give injection; - After the dose counter reaches zero, slowly count to five; - Carefully replace the outer needle shield; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Remove the needle and place in a sharps container; - Replace the pen cap. Review of NovoLog FlexPen (insulin in a pen-type device) instructions, dated June 14, 2024, showed: - Remove cap; - Attach needle; - Prime pen by turning dose selector to select two units; - Press and hold button and make sure drop of insulin appears; - Select dose; - Give injection; - After dose counter reaches zero, count to six; - After injection, remove needle and place in sharps container. 1. Observation on 01/16/25 at 11:30 A.M. showed: - Registered Nurse (RN) F obtained the finger stick blood sugar (FSBS) for Resident #41; - RN F obtained the Humalog KwikPen from the medicine cart and adjusted the pen to the amount of insulin ordered; - RN F did not prime the pen with two units of insulin per the manufacturer's directions prior to administering insulin to the resident. 2. Observation on 01/16/25 at 11:40 A.M. showed: - RN F obtained the FSBS for Resident #53; - RN F obtained the Humalog KwikPen from the medicine cart and adjusted the pen to the amount of insulin ordered; - RN F did not prime the pen with two units of insulin per the manufacturer's directions prior to administering insulin to the resident. 3. Observation on 01/16/25 at 11:50 A.M. showed: - RN F obtained the FSBS for Resident #57; - RN F obtained the Novolog FlexPen from the medicine cart and adjusted the pen to the amount of insulin ordered; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN F did not prime the pen with two units of insulin per manufacturer's directions prior to administering insulin to the resident. 4. During an interview on 01/22/25 at 9:22 A.M., RN F said he/she never primes push pens, but when he/she does prime a needle, he/she uses one unit of insulin. During an interview on 01/17/25 at 4:35 P.M., the Director of Nursing and Assistant Director of Nursing said they would expect insulin pens to be primed per manufacturer's instructions before administering the prescribed dose.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 46460 Based on interview and record review, the facility failed to have a Quality Assurance and Performance Improvement (QAPI, a program to improve the processes for the delivery of health care and quality of life for the residents) program in place with policies and protocols describing how the facility will identify and correct its own quality deficiencies. This deficient practice had the potential to affect all residents in the facility. The facility's census was 74. The facility did not provide a QAPI policy or any documentation related to a QAPI program. During an interview on 01/15/25 at 12:30 P.M., the Assistant Director of Nursing (ADON) said they don't have QAPI meetings. During an interview on 01/16/25 at 3:36 P.M., the Administrator said he has no QAPI policy or plan, nor does he have a list of the QAPI committee members. He knows he should be doing something more formal. They do have a daily stand up meeting. During an interview on 01/17/25 at 4:35 P.M., the Administrator, Director of Nursing (DON), and ADON said they would expect to have a QAPI policy, QAPI plan, and a program to monitor and track any quality deficiencies and have Performance Improvement Plans (PIPs) in place for those deficiencies. They would also expect to have QAPI meetings at least quarterly with the required members including the Medical Director, Administrator, DON, Infection Preventionist, and two other staff members.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46460 Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. This had the potential to affect all residents in the facility. The facility's census was 74. The facility did not provide a QAPI policy or any documentation related to a QAPI program. During an interview on 01/15/25 at 12:30 P.M., the Assistant Director of Nursing (ADON) said they don't have QAPI meetings. During an interview on 01/16/25 at 3:36 P.M., the Administrator said he has no QAPI policy or plan. He knows he should be doing something more formal. They do have a daily stand up meeting. During an interview on 01/17/25 at 4:35 P.M., the Administrator, Director of Nursing (DON), and ADON said they would expect to have a QAPI policy, QAPI plan, and a program to monitor and track any quality deficiencies and have Performance Improvement Plans (PIPs) in place for those deficiencies.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46460 Based on interview and record review, the facility failed to maintain quarterly Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI) committee meetings with the required members. The facility's census was 74. The facility did not provide a QAPI policy or any documentation related to a QAPI program. During an interview on 01/15/25 at 12:30 P.M., the Assistant Director of Nursing (ADON) said they don't have QAPI meetings. During an interview on 01/16/25 at 3:36 P.M., the Administrator said he has no QAPI policy or plan, nor does he have a list of the QAPI committee members. He knows he should be doing something more formal. During an interview on 01/17/25 at 4:35 P.M., the Administrator, Director of Nursing (DON), and ADON said they would expect to have a QAPI policy, QAPI plan, and a program to monitor and track any quality deficiencies and have Performance Improvement Plans (PIPs) in place for those deficiencies. They would also expect to have QAPI meetings at least quarterly with the required members including the Medical Director, Administrator, DON, Infection Preventionist, and two other staff members.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39360 Based on observation, interview, and record review, the facility failed to implement a risk management process specific to Legionnaires' disease (a severe type of pneumonia caused by the Legionella bacteria) which had the potential to affect all residents, staff, and the public. The facility failed to maintain infection control practices to prevent the development and transmission of infection during peri care (washing the genital and anal areas of the body) for one resident (Resident #23) out of one sampled resident. The facility failed to implement enhanced barrier precautions (EBP) during wound care for one resident (Resident #1) out of one sampled resident when the policy was not followed to ensure personal protective equipment (PPE) was available outside or near the rooms of those residents on EBP and proper PPE for EBP applied before and during care. The facility's census was 74. 1. Review of the facility's Water Management Program to Reduce Legionella Growth Policy, undated, showed: - Facility will develop and implement a water management program to inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens; - Facility will create a water management committee which will consist of the Administrator, Director of Nursing (DON), and Maintenance Director; - The committee will conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system; - The committee will implement a water management program that includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens; - The water management committee will specify testing protocols and acceptable ranges for control measures and document results of testing and corrective actions taken when control limits are not maintained. Review of the facility's weekly water temperature logs for the previous six months showed the water temperatures to be within range. Review on 01/17/25 at 10:04 A.M. showed a checklist for a monthly water management inspection which included: - Water heater temperatures and visual inspection; - Hot water storage tanks temperature and inspection; - Cold water storage tank temperature and inspection; - Inspections of pipes, valves, and fittings to assure no biofilm or sediment; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Shower head visual inspections to assure no biofilm or sediment; - Visual inspections of faucets to assure no biofilm or sediment; - Inspections of ice machines to assure no biofilm or sediment; - Inspection of eyewash stations to assure no biofilm or sediment; - Every water system on closed halls, circulated; - Visual inspection of decorative fountains to assure no biofilm or sediment; - Visual inspection of water filters to assure no biofilm or sediment; - Visual inspection of expansion tanks to assure no biofilm or sediment; - Visual inspection of faucet flow restrictors to assure no biofilm or sediment; - Visual inspection of aerators, non-steam aerosol generating humidifiers, cooling towers and heating, air conditioning units, to assure no no signs of biofilm or sediment. During an interview on 01/16/25 at 10:10 A.M., the Maintenance Director said he/she did not have anything in place for Legionella or for rooms that stood empty. He/She only did random water temperatures to ensure they were within range. During an interview on 01/17/25 at 10:04 A.M., the Maintenance Director said he does not do a checklist and only checked the water temps. During an interview on 01/17/25 at 4:35 P.M., the Administrator, DON, and Assistant Director of Nursing (ADON) said they would expect the Legionella Water Management Program to be followed per policy and the checklist to be completed monthly. During an interview on 02/05/2025 at 11:41 A.M., the DON said they do not have a committee, but they were working on putting one together. The committee would include herself, the Administrator, Maintenance Director, ADON and the Housekeeping Supervisor, as he also assists with the maintenance issues. The DON had said the temperatures had always been within range, but if temperature ranges had been off, they would check with the Infection Preventionist's binder, and follow protocols, such as they would work with the local health department, and superheat (raise water temps to 160-170 degrees) and flush each outlet for five minutes. However, that would be in a case where Legionella was detected or a resident would test positive, not just if the temperatures were off. 2. Review of the facility's Handwashing Policy, dated March 2015, showed: - Handwashing is used to reduce the transmission of organisms from resident to resident, nursing staff to resident and resident to nursing staff; - Policy did not address when to wash hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Glove Policy, dated March 2015, showed: - Gloves are worn when it can be reasonably anticipated that hands will be in contact with mucous membranes, non-intact skin, any moist body substances such as blood, urine, feces, wound drainage, oral secretions, or items/surfaces soiled with these substances; - Gloves must be changed between residents and between contact with different body sites of same resident. Review of the facility's Enhanced Barrier Precaution to Infection Control Guidance Policy, revised March 2024, showed: - To prevent broader transmission of multidrug-resistant organisms (MRDO-common bacteria that have developed resistance to multiple types of antibiotics); - Help protect patients with chronic wounds and indwelling devices (a medical device that is left inside the body for a period of time, such as urinary catheters- a flexible tube that drains urine from the bladder and collects urine in a drainage bag or feeding tube- a small flexible tube that provides nutrition, fluids and medication to someone that is unable to eat or drink by mouth); - EBP should be implemented for the period of stay or until wounds have resolved or indwelling medical devices have been removed; - Residents known to be infected with MRDO, have an indwelling device or wounds, should require EBP; - EBP should be used when providing high contact resident care activities such as bathing, showering, transferring, providing hygiene, changing bed linens, changing briefs or assisting with toileting, caring for an indwelling catheter or performing wound care; - Guidelines for EBP include conducting proper hand hygiene before starting; - Gloves and donning/doffing (applying/removing) of gowns are required when conducting high-contact resident care activities; - Gloves and gowns should be removed and discarded after each resident encounter; - EBP should be followed when performing transfers or when anticipating close physical contact while assisting with transfers or mobility; - Residents that are placed on EBP should have personal protective equipment (PPE) in close proximity outside the door and trash can in resident's room for disposal prior to leaving room; - Multi-resident medical equipment must be sanitized between resident uses. Observation of peri care provided to Resident #23 on 1/17/24 at 11:26 A.M. showed: (continued on next page)

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	265514	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claru Deville Nursing Center	105 Spruce Street Fredericktown, MO 63645

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Certified Nursing Assistant (CNA) C and CNA D entered Resident #23's room, did not wash or sanitize hands, and applied gloves; - CNA C and CNA D cleaned the resident's peri area. CNA C and CNA D removed gloves and applied clean gloves without washing or sanitizing hands; - CNA C rolled the resident onto his/her side while CNA D cleaned the buttock area and placed a clean brief under the resident; - CNA D removed gloves and applied new gloves without washing or sanitizing hands, applied barrier cream to buttocks, removed gloves, and applied clean gloves without washing or sanitizing hands; - CNA C rolled the resident onto his/her back. CNA C and CNA D pulled the brief and blanket up and over the resident; - CNA C and CNA D removed gloves, and did not wash or sanitize hands; - CNA C the call light beside the resident and raised the head of the bed; - CNA C removed the bag of soiled linen from the room without washing or sanitizing hands; - CNA D removed the bag of trash from the room without washing or sanitizing hands; - CNA C and CNA D took the trash and linens to the soiled utility room, then walked to the shower room and washed hands. During an interview on 1/17/25 at 11:35 A.M., CNA D said he/she normally uses hand sanitizer in between glove changes, but the resident would get impatient so he/she did not this time. He/She normally sanitizes before entering a room and washed hands at the sink before leaving but nerves got him/her. During an interview on 1/17/25 at 11:35 A.M., CNA C said he/she always washed hands before moving on to another resident. Observation of wound care provided to Resident #1 on 01/17/25 at 11:20 A.M. showed: - Registered Nurse (RN) G placed the treatment cart outside of Resident #1's room; - RN G did not wash his/her hands, applied hand sanitizer, and applied gloves; - RN G cleansed a pair of scissors with Microkill bleach wipes, then wrapped the scissors in a bleach wipe and placed them on top of the treatment cart, using appropriate kill time; - RN G entered Resident #1's room to provide wound care without proper EBP precautions. There was no sign regarding EBP and no PPE located near or outside of the resident's door; - RN G wiped the bedside table with Microkill bleach wipes and let air dry; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- RN G removed gloves and sanitized his/her hands; - RN G exited Resident #1's room and gathered wound supplies and scissors, that were still wrapped in a Microkill wipe, off of the treatment cart; - RN G placed supplies on the bedside table without a barrier; - RN G applied gloves and picked up a soiled dressing off of the roommates's bedside table and threw the dressing in the trash; - RN G removed gloves; - RN G sanitized hands and applied gloves; - RN G opened gauze pads and sprayed pads with wound cleanser, then cleansed the wound with three separate pads from the center of the wound outwards; - RN G removed gloves, sanitized hands and applied clean gloves; - RN G opened a gauze pad, placed it on the bedside table, and applied three creams to the gauze pad; - RN G placed gauze pad with creams in his/her hand, opened several long handled cotton swabs, and applied creams to cotton swabs and applied to wound; - RN G repeated the process three times; - RN G removed gloves, sanitized hands and applied gloves; - RN G opened petroleum gauze package, removed gauze, cut to size with scissors and placed scissors on bedside table; - RN G removed gloves, sanitized hands, and applied gloves; - RN G opened foam dressing, cut to size without cleaning the scissors and placed on wound; - RN G removed gloves, sanitized hands, and applied gloves; - RN G opened border gauze, removed from packaging and placed on the bedside table, dated and marked time of dressing change and placed on wound; - RN G removed gloves, sanitized hands, and applied gloves; - RN G picked up creams, scissors and unused dressings from bedside table and placed them by the sink area; No barrier was used; - RN G washed his/her hands in Resident #1's room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- RN G picked up supplies by the sink and took them out of the room and placed supplies back in the treatment cart. During an interview on 01/22/25 at 10:03 A.M., RN G said he/she should wash his/her hands before and after providing wound care. He/she typically does not use a barrier for clean supplies, but instead just wipes the bedside table with bleach wipes. He/She should use EBP on residents with catheters and wounds and he/she should wear a gown and gloves while providing wound care. During an interview on 01/17/25 at 4:35 P.M., the Administrator, DON, and ADON said they would expect staff to wash/sanitize hands when going from dirty to clean, toileting, providing peri care, touching blankets, call lights, etc. and before leaving resident rooms. They would expect proper EBP to be utilized per regulation.