

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2025
NAME OF PROVIDER OR SUPPLIER Webco Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1687 West Washington Marshfield, MO 65706	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETES HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on interviews and record review, the facility failed to ensure all residents' families or representatives were notified of all significant changes and potential changes in care when staff did not notify two residents' (Resident #1 and #2) family/representative after a change in condition/allegation of abuse. The facility census was 54.</p> <p>Review showed the facility did not provide a policy regarding notification of resident representatives.</p> <p>1. Review of Resident #1's face sheet (admission data) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included unspecified dementia (loss of memory), psychotic disturbances (mental health condition that causes people to lose touch with reality, and depression (feelings of sadness).</p> <p>Review of the resident's care plan, last revised on 12/11/24, showed the following:</p> <p>-The resident had communication problems as evidenced by his/her impaired hearing. He/she usually understands;</p> <p>-The resident had mood problems;</p> <p>-Staff to establish trusting relationship with resident and encourage resident to verbalize feelings, concerns, fears, and clarify misconceptions;</p> <p>-Staff to notify the physician as needed if mood problems become worse;</p> <p>-Resident at risk for delirium as evidenced by signs and symptoms of inattention and disorganized thinking;</p> <p>-Cognitive loss/dementia as evidence by signs and symptoms of inattention and disorganized thinking. Resident has a diagnosis of dementia.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's progress note dated 12/23/24, at 9:10 P.M., showed Registered Nurse (RN) G documented the resident exhibited inappropriate touching of residents of the opposite sex this shift. Staff observed resident putting hands in crotch of pants of another resident. Staff intervened and removed the resident to another table. Staff will continue to monitor. (Staff did not document notification of the resident's family/representative regarding the change of condition/abuse allegation.)</p> <p>2. Review of the facility's investigation, dated 12/26/24, showed the following:</p> <p>-During the manager's meeting on the morning of 12/26/24, documentation from RN G dated 12/23/24 and timed at 9:10 P.M., was noted by manager and brought to the attention of those present for discussion. The nurse's note in question stated inappropriate touching of other residents this shift. Resident observed putting hands in crotch of another resident (Resident #2). Staff intervened and removed the resident to another table. Staff will continue to monitor;</p> <p>-Interim administrator phoned DHSS office to report the incident;</p> <p>-Neither the interim administrator, or the DON were notified of the incident.</p> <p>(Staff did not document notification of the either residents' family/representative regarding the change of condition/allegation of abuse.)</p> <p>3. Review of Resident #2's face sheet showed the following:</p> <p>-admitted [DATE], readmitted [DATE];</p> <p>-Diagnoses included acute kidney failure (kidneys lost their ability to filter waste products from the blood), major depression, dementia, cognitive communication deficit, weakness, and acute respiratory disease (lungs are damaged making it difficult to exchange oxygen).</p> <p>-The resident had durable power of attorney invoked.</p> <p>Review of the resident's medical record showed staff did not notify the durable power of attorney of the change of condition/potential abuse.</p> <p>During interviews on 12/31/24, at 2:45 P.M., and on 01/02/25, at 1:35 P.M., the NOK for the resident said the MDS Coordinator called him/her a day or two before Christmas, about a wound on the resident's heel and also mentioned another resident was following Resident #2 around. Staff did not call the NOK related to the incident that occurred on 12/23/24.</p> <p>4. During interviews on 12/31/24, at 11:07 A.M., and on 01/02/25, at 10:25 A.M., Licensed Practical Nurse (LPN) B said the family should be notified of the incident on 12/23/24. He/she didn't know if the families were notified of the situation with Resident # 1 and Resident #2.</p> <p>During an interview on 12/31/24, at 11:22 A.M., LPN E said the if the residents are not their own person, or have the capacity to consent, he/she would notify the next of kin or guardian of sexual behavior. He/she doesn't believe Resident #1 understands his/her behavior.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/02/25, at 10:12 A.M., LPN K said when a resident touches another resident's private parts, the residents should be separated and they would do an investigation and families are notified.</p> <p>During an interview on 12/31/24, at 3:11 P.M., RN G said he/she did not notify the resident's (Resident #1 and Resident #2) families of the incident on 12/23/24.</p> <p>During interviews on 12/31/24, at 12:09 P.M., and on 01/02/25, at 11:30 A.M., the Social Services Director said he/she was told in the care plan meeting on 01/02/25, Resident #1's family was notified over the weekend, either 12/28/24 or 12/29/24, of the incident that occurred on 12/23/24.</p> <p>During interviews on 12/31/24, at 11:35 A.M., and on 01/02/25, at 11:33 A.M., the Director of Nursing (DON) said the following he/she did not notify the families of Resident #1 or Resident #2 regarding the incident on 12/23/24.</p> <p>During interviews on 12/31/24, at 12:50 P.M., and on 01/02/25, at 11:37 A.M., the Interim Administrator said the families of the residents should be notified of allegations regarding potential abuse. He/she didn't know if Resident #1's or Resident #2's families had been notified.</p> <p>During interviews on 01/02/25, at 8:55 A.M. and 11:50 A.M., the RN Consultant, Administrator, and DON said the following:</p> <ul style="list-style-type: none"> -When a resident-to-resident incident occurred, social services, the nurse, DON, or Administrator should notify the families of all residents; -They did not believe the families were notified of the incidents involving Resident #1 and Resident #2. <p>During an interview on 01/02/25, at 10:48 A.M., with the Administrator said the following:</p> <ul style="list-style-type: none"> -Resident to resident incidents should be reported to the charge nurse and the charge nurse should tell the DON. The nurse should notify the NOK of the incident. <p>MO00247124</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on interviews and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to management and within two hours to the state licensing agency (Department of Health and Senior Services - DHSS) when staff failed to report two allegation of sexual abuse involving three residents (Resident #1, #2, and #3) to management and DHSS in a timely fashion. The facility census was 54.</p> <p>Review of the facility's policy titled, Abuse and Neglect-Clinical Protocol, revised July 2017, showed the following:</p> <ul style="list-style-type: none"> -Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse; -Sexual abuse is the non-consensual contact of any type with a resident. <p>Review of the facility's policy titled, Abuse Prevention Program, revised December 2021, showed the following:</p> <ul style="list-style-type: none"> -Purpose to protect residents from abuse by anyone, including but not necessarily limited to, facility staff, other residents; - Investigate and report any allegations of abuse within timeframes as required by federal requirements. <p>1. Review of Resident #1's face sheet (admission data) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included unspecified dementia (loss of memory), psychotic disturbances (mental health condition that causes people to lose touch with reality), and depression (feelings of sadness). <p>Review of the resident's care plan, last revised on 12/11/24, showed the following:</p> <ul style="list-style-type: none"> -He/she had communication problems as evidenced by his/her impaired hearing, He/she usually understands; -He/she had activities of daily living (ADL) functional problems as evidenced by the need for staff assistance with ADLs. Resident balance wasn't always steady, but he/she was able to stabilize without staff assistance; -He/she had mood problems; <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff to establish trusting relationship with resident. Staff to encourage resident to verbalize feelings, concerns, fears, and clarify misconceptions;</p> <p>-Staff to notify the physician as needed if mood problems become worse;</p> <p>-Resident at risk for delirium as evidenced by signs and symptoms of inattention and disorganized thinking;</p> <p>-Resident had cognitive loss/dementia.</p> <p>Review of the resident's progress note dated 12/23/24, at 9:10 P.M., showed Registered Nurse (RN) G documented inappropriate touching of other residents this shift. Resident observed putting hands in crotch of pants of another resident. Staff intervened and removed him/her to another table. Staff will continue to monitor. (The RN did not document notification of facility administration or DHSS of the allegation of abuse.)</p> <p>2. Review of Resident #2's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included acute kidney failure (kidneys lost their ability to filter waste products from the blood), major depression, dementia, cognitive communication deficit, weakness, and acute respiratory disease (lungs are damaged making it difficult to exchange oxygen).</p> <p>Review of the resident's care plan, last revised on 11/22/24, showed the following:</p> <p>-He/she did not always remember he/she was in the nurse facility;</p> <p>-He/she has cognitive loss/dementia;</p> <p>-At risk for psychosocial well being problems as evidenced by previously admitting that he/she had little interest of pleasure in doing things.</p> <p>Review of the resident's medical record showed staff did not document regarding the incident with Resident #1 on 12/23/24, or notification of manage or DHSS of the incident.</p> <p>3. Review of the facility's investigation, dated 12/26/24, showed the following:</p> <p>-During the managers' meeting on the morning of 12/26/24, documentation from RN G, dated 12/23/24 and timed at 9:10 P.M., was noted by manager and brought to the attention of those present for discussion. The nurse's note in question stated inappropriate touching of other residents this shift. Resident observed putting hands in crotch of another resident. Staff intervened and removed Resident #1 to another table and staff will continue to monitor;</p> <p>-Interim Administrator phoned DHSS office to report the incident;</p> <p>-Neither the Interim Administrator, or the Direct of Nursing (DON) were notified of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Review of DHSS records showed the facility self-reported the allegation of possible abuse between Resident #1 and Resident #2 on 12/26/24, at 2:58 P.M. (three days after staff became aware of the allegation of possible abuse).</p> <p>5. Review of Resident #3's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included acute kidney failure, major depressive disorder, chronic pain, dementia, and cognitive communication deficit. <p>Review of the resident's care plan, last revised on 10/28/24, showed the following:</p> <ul style="list-style-type: none"> -Resident at risk for delirium as evidenced by his/her inattention, disorganized thinking; -Resident had mood problems and diagnosis of major depressive disorder; -Resident had ADL functional problems as evidenced by the need for staff to assist with ADLs; -At risk for remembering past trauma events; -Resident at risk for psychosocial well being problems as evidenced by previously admitting that he/she has little interest of pleasure in doing things. <p>During interviews on 12/31/24, at 3:39 P.M., and on 01/02/24, at 10:57 A.M., the Activities Assistant said the following:</p> <ul style="list-style-type: none"> -He/she was not completely certain of the date, but believes it was 12/11/24, or one day close to this date; -He/she was close the Administrator's door in the common area writing down the names of residents participating in the activity; -He/she heard another resident yell at Resident #1, that's not your spouse. When he/she looked at Resident #1, the resident had his/her hand on Resident #3's groin, and the resident had laid his/her head in Resident #3's lap; -He/she told Resident #1 that Resident #3 was not his/her spouse and Resident #1 said it was his/her spouse; -He/she moved Resident #1 close to the nurses' station and the MDS Coordinator asked why the Activities Assistant brought Resident #1 to the nurses' station. He/she told the MDS Coordinator what happened; -The Activities Assistant and the MDS Coordinator went to the RN Consultant and told the RN Consultant what happened between Resident #1 and Resident #3; <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she considered inappropriate touching possible abuse and he/she was supposed to report this to the charge nurse and it's then reported to the state within 24 hours.</p> <p>Review of Resident #3's medical record showed no documentation of the incident with Resident #1.</p> <p>Review of DHSS records showed the home did not self-report the allegation of possible abuse between Resident #1 and Resident #3.</p> <p>6. During an interview on 12/31/24, at 11:13 A.M., Nurse Aide (NA) C said the following:</p> <p>-If he/she saw a resident touch another resident's private parts, he/she would separate the two residents and tell his/her charge nurse;</p> <p>-If a resident touches another resident's private area this would be considered abuse and it should be reported within two hours to the state.</p> <p>During an interview on 12/31/24, at 11:01 A.M., Certified Nurse's Aide (CNA) A said the following:</p> <p>-If he/she witnessed a resident putting their hands on another resident's private area, he/she would separate the residents and tell his/her charge nurse;</p> <p>-If a resident puts their hand on another resident's private area, this could be abuse and should be reported to the state within two hours.</p> <p>During an interview on 12/31/24, at 11:19 A.M., CNA D said if he/she saw a resident touching another resident's private area, and it's unwanted, he/she would separate the residents and report it to the charge nurse. He/she would write out a statement and ensure it's reported to the state in less than two hours.</p> <p>During an interview on 12/31/24, at 3:24 P.M., CNA I said the following:</p> <p>-On 12/23/24, around 4:30 P.M. or 4:45 P.M., Resident # 1 and Resident #2 were both in the common area close to the time for the staff to begin bringing the residents into the dining room to eat dinner;</p> <p>-He/she walked into the common area and saw Resident #1 leaning forward in in his/her wheelchair, and Resident #1's hand was on Resident #2's inner left thigh with the fingertips touching Resident #2's groin;</p> <p>-He/she separated the two residents;</p> <p>-He/she said two other residents had told another aide that Resident #1 had Resident #2's jogging pants at the top stretched out, and was reaching into Resident #2's pants;</p> <p>-He/she reported the incident to RN G;</p> <p>-He/she was told by Activities Assistant that Resident #1 had inappropriate behaviors with two other residents, one of which was Resident #3;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she would consider this potential abuse, that should be investigated and reported to the state within two hours. He/she doesn't believe it was reported to the state.</p> <p>During an interview on 01/02/25, at 10:08 A.M., CNA J said the following;</p> <p>-If He/she saw a resident touching another resident's private area, he/she would separate the residents and notify the charge nurse;</p> <p>-Depending on the situation, if the residents are able to consent or not, would determine if it's abuse and needs to be reported to the state in two hours.</p> <p>During interviews on 12/31/24, at 11:07 A.M., and on 01/02/25, at 10:25 A.M., Licensed Practical Nurse (LPN) B said the following:</p> <p>-If he/she saw a resident put their hands on another resident's private parts, he/she would separate the residents and if the residents don't understand their actions, or if its not mutual, the incident should be reported to the supervisor and it should be reported to the state within 2 hours.</p> <p>During an interview on 12/31/24, at 11:22 A.M., LPN E said the following:</p> <p>-If he/she saw a resident touch another resident's private parts, he/she would separate the two residents and notify the DON and ensure the Administrator knew as well;</p> <p>-If the resident's can't consent, it could be abuse and should be reported to the state within two hours.</p> <p>During an interview on 01/02/25, at 10:12 A.M., LPN K said when a resident is touching another resident's private parts, the residents should be separated and the State is notified within two hours.</p> <p>During an interview on 12/31/24, at 3:11 P.M., RN G said the following:</p> <p>-He/she said an aide, he/she is not certain which aide, said Resident #1 was acting up again. The resident grabbed another resident's crotch;</p> <p>-He/she didn't know whose crotch Resident #1 grabbed;</p> <p>-He/she did not notify the DON, Administrator, or the resident's families;</p> <p>-He/she knows that in these types of situations it would be considered abuse and he/she should've called the DON and the Administrator;</p> <p>-He/she knew the state was supposed to be notified of abuse within two hours.</p> <p>During interviews on 12/31/24, at 12:09 P.M., and on 01/02/25, at 11:30 A.M., the Social Services Director (SSD) said the following:</p> <p>-If a resident was touching another resident's body parts, he/she would separate the residents and notify his/her supervisor;</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she knew an allegation of abuse should be reported in two days.</p> <p>During interviews on 01/02/25, at 10:17 A.M., and on 01/03/25, the MDS Coordinator, said the following;</p> <p>-In resident to resident incidents, with inappropriate touching, he/she would separate the residents, notify the DON and there would be an investigation completed;</p> <p>-The State was notified in two hours.</p> <p>During interviews on 12/31/24, at 11:35 A.M., and on 01/02/25, at 11:33 A.M., the DON said the following:</p> <p>-If staff see a resident touching another resident in their private area, the staff should separate and notify the DON and the Administrator immediately;</p> <p>-He/she didn't find out until 12/26/24 when it was read in Resident #1's medical record that Resident #1 touched Resident #2 inappropriately;</p> <p>-He/she knows these incidents are supposed to be reported to the state within two hours and this incident was not reported within two hours;</p> <p>-He/she would have expected RN G to notify him/her and or the Administrator of the incident between Resident #1 and Resident #2. It should have been called into the state within two hours.</p> <p>During interviews on 01/02/25, at 8:55 A.M. and 11:50 A.M., the RN Consultant, Administrator and DON said the following;</p> <p>-They were not aware of other incidents with Resident #1 being inappropriate;</p> <p>-An incident with Resident #1 touching Resident #3 in the groin area was not reported to management.</p> <p>During interviews on 12/31/24, at 12:50 P.M., and on 01/02/25, at 11:37 A.M., the Interim Administrator said the following:</p> <p>-He/she expected staff to intervene if a resident was touching another resident inappropriately;</p> <p>-He/she expected staff to investigate the incident and report to the state within two hours;</p> <p>-The incident between Resident #1 and Resident #2 happened on 12/23/24, but he/she wasn't aware until 12/26/24 so it was not reported timely to the state;</p> <p>-He/she was not aware Resident #1 touched Resident #3's groin. This incident should've been reported to the charge nurse, DON, and or Administrator and the state called in two hours.</p> <p>-Resident is touching another resident in the private area He/she would expect staff to separate the two residents, notify the Administrator and DON, and begin an investigation;</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on interview and record review, the facility staff failed to immediately begin an investigation of possible abuse when staff witnessed one resident (Resident #1) touch another resident (Resident #3) in the groin area. The facility census was 54.</p> <p>Review of the facility's policy titled, Abuse and Neglect-Clinical Protocol, revised July 2017, showed the following:</p> <ul style="list-style-type: none"> -Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse; -Sexual abuse is defined as non-consensual contact of any type with a resident; -Staff, with the physician's input as needed, will investigate alleged occurrences of abuse and neglect to clarify what happened and identify possible causes. <p>Review of the facility's policy titled, Abuse Prevention Program, revised December 2021, showed the following:</p> <ul style="list-style-type: none"> -Purpose to protect residents from abuse by anyone, including but not necessarily limited to, facility staff, other residents; -Identify and assess all possible incidents of abuse; -Investigate and report any allegations of abuse within timeframes as required by federal requirements; -Protect residents during abuse investigations. <p>1. Review of Resident #1's face sheet (admission data) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included unspecified dementia (loss of memory), psychotic disturbances (mental health condition that causes people to lose touch with reality), and depression (feelings of sadness). <p>Review of the resident's care plan, last revised on 12/11/24, showed the following:</p> <ul style="list-style-type: none"> -The resident had communication problems due to impaired hearing, He/she usually understands; -The resident had activities of daily living (ADL) functional problems. Balance wasn't always steady, but he/she was able to stabilize without staff assistance; -Resident had mood problems; <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Webco Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1687 West Washington Marshfield, MO 65706	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff to establish trusting relationship with resident. Staff to encourage resident to verbalize feelings, concerns, fears and clarify misconceptions;</p> <p>-Resident at risk for delirium;</p> <p>-Resident had cognitive loss/dementia.</p> <p>2. Review of Resident #3's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included acute kidney failure, major depressive disorder, chronic pain, dementia, cognitive communication, and deficit.</p> <p>Review of the resident's care plan, last revised on 10/28/24, showed the following:</p> <p>-Resident was at risk for delirium;</p> <p>-Resident had mood problems;</p> <p>-Resident had ADL functional problems;</p> <p>-Resident at risk for remembering past trauma events.</p> <p>3. During interviews on 12/31/24, at 3:39 P.M., and 01/02/24, at 10:57 A.M., the Activities Assistant said the following:</p> <p>-He/she was not completely certain of the date, but believed it was 12/11/24, or one day close to this date;</p> <p>-He/she was close the Administrator's door, in the common area, writing down the names of residents participating in the activity;</p> <p>-He/she heard another resident yell at Resident #1, that's not your spouse. When he/she looked at Resident #1, the resident had his/her hand on Resident #3's groin, and the resident had laid his/her head in Resident #3's lap;</p> <p>-He/she told Resident #1 that Resident #3 was not his/her spouse and Resident #1 said it was his/her spouse;</p> <p>-He/she moved Resident #1 close to the nurses' station and the MDS Coordinator asked why the Activities Assistant brought Resident #1 to the nurses' station. He/she told the MDS Coordinator what happened;</p> <p>-The Activities Assistant and MDS Coordinator went to the RN Consultant and told the RN Consultant what happened between Resident #1 and Resident #3.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Review of Resident #1 and Resident #3's records showed staff did not document investigating the allegation of possible abuse.</p> <p>Review of DHSS records showed the facility did not provide an written investigation of the allegation of possible abuse.</p> <p>5. During an interview on 12/31/24, at 11:13 A.M., Nurse Aide (NA) C said the following:</p> <p>-If he/she sees a resident touch another resident's private parts, he/she would separate the two residents and tell his/her charge nurse;</p> <p>-If a resident touches another resident's private area this would be considered abuse.</p> <p>During an interview on 12/31/24, at 11:01 A.M., Certified Nurse's Aide (CNA) A said the following:</p> <p>-If he/she witnessed a resident putting their hands on another resident's private area, he/she would separate the residents and tell his/her charge nurse;</p> <p>-If a resident puts their hand on another resident's private area, this could be abuse.</p> <p>During interviews on 12/31/24, at 11:07 A.M., and on 01/02/25, at 10:25 A.M., Licensed Practical Nurse (LPN) B said the following:</p> <p>-If he/she saw a resident put their hands on another resident's private parts, he/she would separate the residents and if the residents don't understand their actions, or if its not mutual, the incident should be reported to the supervisor;</p> <p>-The facility does an investigation on allegations of abuse. He/she believes the Director of Nursing (DON) or Administrator completes the investigation.</p> <p>During an interview on 12/31/24, at 11:22 A.M., LPN E said if he/she sees a resident touch another resident's private parts, he/she would separate the two residents and notify the DON, ensure the Administrator knows as well and they do an investigation.</p> <p>During interviews on 12/31/24, at 11:35 A.M., and on 01/02/25, at 11:33 A.M., the DON said the following:</p> <p>-If staff see a resident touching another resident in their private area, the staff should separate and notify the DON and the Administrator immediately;</p> <p>-Investigations are completed on allegations of abuse. He/she was not aware of the incident between Resident #1 and Resident #3 and an investigation was not completed.</p> <p>During interviews on 12/31/24, at 12:09 P.M., and on 01/02/25, at 11:30 A.M., Social Services Director said the following:</p> <p>-If a resident touched another resident's body parts, he/she would separate the residents and notify his/her supervisor;</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The facility does investigate allegations of abuse. He/she has assisted in these in the past but usually doesn't anymore.</p> <p>During interviews on 01/02/25, at 10:17 A.M., and on 01/03/25, at 10:45 A.M., with the MDS Coordinator said the following;</p> <p>-In resident to resident incidents, with inappropriate touching, he/she would separate the residents, notify the DON, and there would be an investigation completed;</p> <p>-He/she is not aware of an incident between Resident #1 and Resident #3.</p> <p>During interviews on 12/31/24, at 12:50 P.M., and on 01/02/25, at 11:37 A.M., the Interim Administrator said the following:</p> <p>-He/she expected staff to intervene if a resident was touching another resident inappropriately;</p> <p>-He/she expected staff to investigate incidents of abuse;</p> <p>-He/she was not aware of the incident between Resident #1 and Resident #3 until today;</p> <p>-He/she was not aware Resident #1 touched Resident #3's groin. This incident should've been reported to the charge nurse, DON, and/or Administrator, and an investigation completed.</p> <p>During an interview on 01/02/25, at 10:48 A.M., the Administrator said resident to resident incidents should be reported to the charge nurse. The charge nurse should tell the DON, and the DON should begin the investigation.</p> <p>MO00247124</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on record review and interview, the facility failed to maintain a comprehensive person-centered care plan for all residents when staff failed to update the care plan for one resident (Resident #1) to include two incidents of the resident touching other residents inappropriately. The facility's census was 54</p> <p>Review showed the facility did not provide a policy on updating care plans.</p> <p>1. Review of Resident #1's face sheet (admission data) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included unspecified dementia (loss of memory), psychotic disturbances (mental health condition that causes people to lose touch with reality), and depression (feelings of sadness).</p> <p>Review of the resident's care plan, last revised on 12/11/24, showed the following:</p> <p>-The resident had communication problems as evidenced by his/her impaired hearing. He/she usually understands;</p> <p>-The resident had activities of daily living (ADL) functional problems as evidenced by the need for staff assistance with ADLs due to my diagnosis of (nothing added). Balance wasn't always steady, but he/she was able to stabilize without staff assistance;</p> <p>-The resident had mood problems;</p> <p>-Staff to establish trusting relationship with resident and encourage resident to verbalize feelings, concerns, fears, and clarify misconceptions;</p> <p>-Staff to notify the physician as needed if mood problems become worse;</p> <p>-At risk for delirium as evidenced by signs and symptoms of inattention and disorganized thinking;;</p> <p>-Cognitive loss/dementia as evidenced by signs and symptoms of inattention and disorganized thinking. Resident had diagnosis of dementia.</p> <p>Review of the resident's progress note dated 12/23/24, at 9:10 P.M., showed Registered Nurse (RN) G documented the resident exhibited inappropriate touching of residents of the opposite sex this shift. Staff observed resident putting hands in crotch of pants of another resident. Staff intervened and removed him/her to another table. Staff will continue to monitor.</p> <p>Review of the resident's care plan showed staff did not update the care plan following the incident on 12/23/24.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 12/31/24, at 3:39 P.M., and on 01/02/24, at 10:57 A.M., the Activities Assistant said the following:</p> <ul style="list-style-type: none"> -He/she was not completely certain of the date, but believes it was 12/11/24, or one day close to this date, he/she was close the Administrator's door, in the common area, where he/she was writing down the names of residents participating in the activity. He/she heard another resident yell at Resident #1, that's not your spouse. When he/she looked at Resident #1, the resident had his/her hand on Resident #3's groin, and the resident had laid his/her head in Resident #3's lap; -He/she told Resident #1 that Resident #3 was not his/her spouse and he/she moved Resident #1 away from Resident #3; -He/she moved Resident #1 close to the nurses' station and told the MDS Coordinator what just happened; -The Activities Assistant and the MDS Coordinator went to the RN Consultant and told the RN Consultant what happened between Resident #1 and Resident #3. <p>Review of the resident's care plan showed staff did not update the care plan after the incident between Resident #1 and #3.</p> <p>During an interview on 12/31/24, at 11:13 A.M., Nurse Aide (NA) C said he/she has seen Resident #1 rub Resident #2's arm.</p> <p>During interviews on 12/31/24, at 11:07 A.M., and on 01/02/25, at 10:25 A.M., Licensed Practical Nurse (LPN) B said the following:</p> <ul style="list-style-type: none"> -He/she has seen Resident #1 and Resident # 2 sitting by each other and Resident #1 will pat Resident #2 on the shoulder; -If he/she sees a resident put their hands on another resident's private parts, he/she would separate the residents; -If a resident has sexually inappropriate behavior it should be documented somewhere. The MDS Coordinator does the care plans and he/she would also add that to the care plan; -The MDS Coordinator would learn of changes in resident's behaviors by looking at the charting and attending daily meetings. <p>During an interview on 12/31/24, at 3:11 P.M., RN G said he/she was not aware of Resident #1 having inappropriate touching in the past (prior to 12/23/24).</p> <p>During an interview on 12/31/24, at 3:19 P.M., CNA H said the following:</p> <ul style="list-style-type: none"> -He/she has witnessed Resident #1 holding Resident #2's hands in the lobby area the day of 12/23/24; -He/she was on his/her way into the dining room when the incident occurred; <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-CNA I witnessed the incident between Resident #1 and Resident #2;</p> <p>-CNA I said Resident #1's hand was going towards Resident #2's crotch area.</p> <p>During an interview on 12/31/24, at 3:24 P.M., CNA I said the following:</p> <p>-On 12/23/24, around 4:30 P.M. or 4:45 P.M., Resident # 1 and Resident #2 were both in the common area close to the time for the staff to begin bringing the residents into the dining room to eat dinner;</p> <p>-He/she walked into the common area and saw Resident #1 leaning forward in his/her wheelchair, and Resident #1's hand was on Resident #2's inner left thigh and Resident #1's fingertips were on Resident #2's groin. He/she separated the two residents;</p> <p>-He/she said two other residents had told another aide that Resident #1 had Resident #2's jogging pants at the top pulled out and was reaching into Resident #2's pants;</p> <p>-He/she was told by Activities Assistant that Resident #1 had inappropriate behaviors with two other residents.</p> <p>During an interview on 01/02/25, at 10:08 A.M., CNA J said he/she had access to resident's care plans and inappropriate behavior would be put in there by the nurses.</p> <p>During an interview on 01/02/25, at 10:12 A.M., LPN K said resident behaviors are in the care plans. The MDS Coordinator puts information into the care plans but he/she didn't know how the MDS Coordinator would receive information about residents when they have a change in behavior.</p> <p>During interviews on 12/31/24, at 12:09 P.M., and on 01/02/25, at 11:30 A.M., Social Services Director said if a resident had inappropriate behaviors, it would be care planned. They go over residents with changes during morning meetings and the interdisciplinary meetings that are held weekly. If a resident is having sexually inappropriate behaviors it should be on the care plan. The MDS coordinator is responsible for updating the care plans as needed.</p> <p>During interviews on 01/02/25, at 10:17 A.M., and on 01/03/25, the MDS Coordinator said the following:</p> <p>-He/she is in charge of updating the resident's care plans;</p> <p>-He/she attends the morning stand up meetings held Monday through Friday, as well as PAR (Patients at Risk) and IDT meetings to obtain information about changes on residents that needs to be added to the care plan;</p> <p>-Last week, he/she saw the note in Resident #1's medical record, and during a stand up, stating the inappropriate behavior with another resident;</p> <p>-The behavior probably should be put in the care plan, along with interventions;</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she is responsible for updating the care plans and he/she did not update Resident #1's care plan to reflect the changed behavior.</p> <p>During interviews on 12/31/24, at 11:35 A.M., and on 01/02/25, at 11:33 A.M., the Director of Nursing (DON) said the following:</p> <p>-He/she was not aware Resident #1 having inappropriate behaviors prior to the incident on 12/23/24;</p> <p>-The MDS Coordinator was responsible for updating the care plans when there are changes in resident's behaviors;</p> <p>-Inappropriately touching another resident, would be a behavior that should be in the care plan;</p> <p>-The MDS Coordinator attends the PAR and IDT meetings, as well as stand up;</p> <p>-The MDS Coordinator was made aware of the inappropriate behaviors of Resident #1 on 12/26/24;</p> <p>-The care plan should have been updated.</p> <p>During interviews on 12/31/24, at 12:50 P.M., and on 01/02/25, at 11:37 A.M., with the Interim Administrator, said the following:</p> <p>-He/she said the incident with Resident #1 and Resident #2 occurred around dinnertime on 12/23/24, but He/she was not made aware until 12/26/24;</p> <p>-He/she was not aware of the incident between Resident #1 and Resident #3, until today;</p> <p>-The MDS Coordinator is responsible updating the resident's care plans;</p> <p>-The MDS Coordinator is aware of resident changes by reading the documentation, and there should be communication between staff on changes in resident behaviors;</p> <p>-The MDS Coordinator also attends PAR meetings weekly;</p> <p>-The MDS Coordinator was made aware of the incident on 12/26/24 and was told to update the care plan to reflect the incident between Resident #1 and Resident #2.</p> <p>During an interview on 01/02/25, at 10:48 A.M., with the Administrator, said the following:</p> <p>-Sexually inappropriate behaviors would be discussed at the PAR meetings and the IDT;</p> <p>-The MDS Coordinator is involved in the PAR meetings and is responsible of updating the care plan when residents have changes in behavior;</p> <p>-He/she is not sure if Resident #1's care plan has been updated, but it should have been.</p> <p>MO00247124</p>		