STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265571	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ash Grove Healthcare Facility	401 North Medical Drive Ash Grove, MO 65604

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40769 Based on record review and interview, the facility failed to protect one resident's (Resident #1) right to be free from verbal/emotional abuse by staff when one staff (Certified Nurse Aide (CNA) A) yelled and cursed at the resident. The facility census was 80. The Administrator and Director of Nursing (DON) were notified on the evening of 03/02/24 of the Past Non-Compliance which occurred earlier on 03/02/24. On 03/02/24, The CNA left for the night and the staff monitored the residents. On 03/03/24, in-services of all staff was started. Staff began the full investigation on 03/04/24 and completed resident interviews on 03/05/24. The facility implemented monitoring including weekly interviews with residents. The noncompliance was corrected on 03/05/24. Review of the facility policy titled, Abuse Appendices, SS0S-09, revised 05/2021, showed the following: -Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, including deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physician, mental and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, pain or mental anguish; -Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents, patients, and/or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability; -Examples of verbal abuse include, but are not limited to, threat of harm, saying things to frighten the person, threats of involuntary seclusion and harsh criticism. Review of the facility policy, titled Patient Abuse/Neglect, Elder Abuse and Persons with Disability Abuse, revised 08/2021, showed the following: -The purpose is to guide staff and any mandated reporters within the system in identifying victims of abuse and provide a reporting mechanism in accordance with all local, state, federal laws. To provide safe and efficient care for the residents, To keep residents free from abuse mistreatment and neglect. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #1's face sheet (a snapshot of resident information) showed the following: -admitted [DATE]; -Diagnoses included sepsis (a serious condition in which the body responds improperly to an infection), other chronic pain, difficulty in walking, Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar), need for assistance with personal care, and metabolic encephalopathy (a group of conditions that cause brain dysfunction). Review of the resident's care plan, dated 01/09/23, showed the following: -The resident made the facility their permanent home and is adjusting to the new environment; -The resident wants to live at the facility with pride, dignity, and independence to their fullest potential; -The resident wants to be treated with the same dignity that they would be treated in their own home; -The resident has some cognitive decline and may need extra help at times. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/20/2024, showed the following: -Resident has moderate cognitive impairment; -Resident had exhibited no behaviors in the assessment period; -Resident requires maximal/substantial assistance for sit to stand transfers. Review of the resident's nurses' note dated 03/02/24, at 7:49 P.M., showed the following: -Licensed Practical Nurse (LPN) E said CNA A came out the resident's room crying and said he/she was not going to be treated that way by a resident just for trying to help them. CNA A said the resident called him/her a bitch. He/she told CNA A to take a break and a breather. LPN E went in to talk to the resident who said that he/she did not call him/her a bitch and he/she is tired of being treated bad. The resident said CNA A was saying they know he/she can walk and do things on his/her own, but that changes from day to day that some days he/she just cannot do as much and he/she is not happy about it. The resident and LPN E came to an understanding that if he/she has a problem with a CNA he/she will ask for the charge nurse. During an interview on 03/07/24, at 11:00 A.M., the resident said the following: -He/she reported what happened to the nurse; -CNA A yelled at him that he/she, wished he/she was dead while pointing a finger in his/her face; -He/she believed it happened on the night of 03/02/24; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she felt like CNA A was having temper tantrum. He/she did not like it and wished it had not happened; -He/she thought about it all night; -He/she's roommate was in the room at the time and he/she thought here was another staff in the room. 2. Review of the facility's investigation, undated, showed the following: -On 03/02/24, at approximately 8:14 P.M., CNA A came to LPN E, threw his/her badge down, and said, I quit. CNA A said Resident #1 called him/her a f***** b**** and that he/she was too emotional and needed to leave. LPN E told him/her to take a break, walk away, and assured him/her that he/she could switch halls for the night. CNA A chose to leave instead; -At 9:33 P.M., CNA B reported to the Director of Nursing (DON) and charge nurse that CNA A also allegedly yelled back at the resident; -The Administrator was notified immediately and asked LPN E to interview the resident to ensure the resident felt safe. -The resident was interviewed and did express feeling safe knowing CNA A was out of the building for the night; -Department of Senior Services (DHSS) Online Report submitted between 10:00 P.M. and 10:30 P.M. on 03/02/24 by the Administrator. The Administrator followed up with DHSS the next morning. 3. Review of the Resident #2's quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; -Resident has severe cognitive impairment; -Diagnoses included cancer, hypertension (high blood pressure), anxiety disorder, and depression. During an interview on 03/07/24, at 11:17 A.M., the resident said the following: -There was an incident in his/her room that he/she shares with Resident #1 about a week ago; -He/she could not remember exactly what was said, but a staff member yelled at Resident #1; -He/she only heard the last part of the argument, but it was loud and CNA A was not being nice; -He/she did not think it was an appropriate interaction. 4. Record review of the Resident #3's quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident has moderate cognitive impairment; -Diagnoses included hemiplegia/hemiparesis (paralysis or semi-paralysis of one side of the body), aphasia (is a disorder that affects how you communicate), and cerebral vascular accident (stroke). During an interview on 03/07/24, at 11:12 A.M., the resident said the following: -He/she heard loud talking and yelling coming from Resident #1's room on the night shift around bedtime, around a week ago; -He/she heard a voice that he/she assumed was a staff member yell, I hope you fucking die. He/she sounded, pissed off; -He/she was laying in bed and could not see who came out of Resident #1's room; -He/she asked CNA B what had happened and he/she said CNA A had lost his/her temper when Resident #1 told CNA A he/she needed to go back to school. 5. Review of the Resident #4's quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; -Resident had moderate cognitive impairment; -Diagnoses included cellulitis (skin infection caused by bacteria) of right lower leg, heart failure, manic depression (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and post traumatic stress disorder (PTSD- Symptoms caused by trauma). During an interview on 03/07/24, at 2:50 P.M., the resident said the following: -CNA A said some things to a resident that he/she should not have said, the other night; -He/she heard CNA yell the word fuck and he/she wished that Resident #1 would die; -He/she does not like to hear cursing. 6. During an interview on 03/11/24, at 4:11 P.M., CNA B said the following: -He/she was working with CNA A on the overnight shift a little over a week ago; -They went to Resident #1's room to assist him/her getting into bed. CNA B got mad at Resident #1 and said, You can walk. Resident #1 said, Some days are better than others. CNA said he/she would have to use the lift. Resident #1 replied, okay, that's your cop out., -CNA was moving the lift around the resident's bed and the wheel got stuck because the bed was too low. Resident #1 got upset and began arguing back and forth with CNA A. They eventually got the bed raised up and got him/her to the bed. CNA was moving Resident #1's legs and he/she said CNA A was trying to make him/her fall; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she could see CNA A was visibly getting upset. He/she told CNA A to leave the room and take a break but he/she refused to leave; -CNA A then called the resident a, lazy mother fucker, and yelled, I hope you die. -CNA A then walked out of the room; -He/she continued getting the resident comfortable and as he/she was walking out of the room Resident #2 asked if he/she had done something wrong. He/she reassured Resident #2 that everything was okay and he/she then went and told LPN E what CNA A had said to Resident #1; -He/she felt like what she witnessed was verbal abuse towards Resident #1. 7. During an interview on 03/07/24, at 12:43 P.M., CNA A said the following: -On 03/02/24. on the overnight shift, he/she noticed Resident #1 was in a bad mood. Resident #1 wanted to be assisted to bed but wanted him/her and CNA B to pull him/her up by his/her pants. They told him/her that was not safe and they needed to use the sit to stand lift. Resident #1 did not like that and got pissed but agreed. He/she got the lift and the one of the wheels got stuck on the side of the bed. Resident #1 yelled at him /her something like god dammit and just put me in bed. When he/she was putting Resident #1 in the bed he/she called him/her, a fucking bitch; -Resident #1 was yelling at him/her and he/she did yell back at him. He/she could not remember what he/she said to him/her, but he/she may have cursed at Resident #1; -He/she knows that yelling at Resident #1 was not appropriate and should not have happened. 8. During an interview on 03/07/24, at 1:49 P.M., LPN E said the following: -On 03/02/24, around 8:00 P.M., CNA A came out of a resident's room crying and trying to hand his/her badge to him/her. CNA A said Resident #1 called him/her a bitch; -CNA left the building. He/she went to check on Resident #1. Resident #1 initially said CNA had fussed at him saying that he was being lazy and he/she knew he/she could do more; -CNA B later said he/she heard CNA A tell Resident #1 that he/she was a lazy son of a bitch and he/she wished he/she would die; -He/she went to talk to Resident #1 again and this time and he/she said the same thing as CNA B; -He/she felt that it could be considered verbal abuse. The resident did not like it. He/she reported the allegation to the DON. 9. During an interview on 03/07/24, at 12:14 P.M., Certified Medication Tech (CMT) D said the following: -He/she has received training by the facility regarding abuse; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It is not appropriate to yell or curse at residents. It could be considered abuse. 10. During an interview on 03/07/24, at 11:40 A.M., RN C said the following: -The facility staff are educated about abuse including verbal abuse; -He/she would consider any staff yelling or cursing at residents to be verbal abuse. He/she would also consider telling a resident to die to be abuse and he/she would report it immediately to the DON or Administrator. 11. During an interview on 03/07/24, at 11:53 A.M., the DON said the following: -On 03/02/24. at around 8:14 A.M., LPN E reported to her that CNA A had provided poor customer service to Resident #1. Resident #1 had called him/her a bitch. CNA immediately left the facility after speaking with LPN E. An hour later CNA B let him/her know that it was a two way interaction and CNA A used inappropriate language when talking to Resident #1. -He/she could not remember exactly what the staff reported was said by CNA A; -CNA B told CNA A to leave the resident's room; -It is not appropriate for a staff to yell or curse at residents. If staff suspect abuse has occurred they should report to their immediate supervisor immediately. 12. During an interview on 03/07/24, at 3:13 P.M., the Administrator said the following: -The facility staff receive abuse training regularly and received it again following the incident; -He/she would consider a staff member saying to a resident, I wish you would fucking die to be abuse; -It is not appropriate for staff to yell at residents; -Staff should immediately report allegations of abuse to their supervisor. MO00232634