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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265577 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/17/2025 |
| NAME OF PROVIDER OR SUPPLIER Marshfield Care Center for Rehab and Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 800 South White Oak 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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <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** 31464</p> <p>Based on interview and record review, the facility failed to ensure all allegations of abuse and neglect were reported immediately to facility management and to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required two-hour time frame when staff failed to immediately report an allegation of employee to resident verbal abuse of involving one resident (Resident #1). The facility census was 48.</p> <p>Review of the facility's Abuse and Neglect Policy, revised September 2024, showed the following:</p> <p>-It is the policy of the home to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person;</p> <p>-If there is any allegation of abuse, then the facility must report immediately to the administrator and State Survey Agency, no later than two hours;</p> <p>-Abuse is any act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury to a resident. This includes verbal or mental/psychological abuse;</p> <p>-Mental/psychological abuse within the definition of abuse means to inappropriately treat or exploit a resident, not resulting in physical harm, including, but not limited to , humiliation, harassment, threats of punishment, deprivation or intimidation;</p> <p>-Verbal abuse is the use of oral, written, or gestured language that includes disparaging derogatory terms to a resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability.</p> <p>1. Review of Resident #1's face sheet (gives basic profile information) showed the following:</p> <p>-Re-admitted [DATE];</p> <p>-Diagnoses included age-related physical debility, mild cognitive impairment of uncertain or unknown cause, and generalized anxiety disorder.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 11/02/24, showed the following information:</p> <ul style="list-style-type: none"> -Moderately impaired cognition; -Utilized a wheelchair for mobility; -Required assistance for toileting, dressing, personal hygiene, and mobility. <p>Review of the resident's care plan, last reviewed 11/02/24, showed the following:</p> <ul style="list-style-type: none"> -Communication problems as evidenced by impaired hearing; -Cognitive loss; -Staff should introduce themselves during interactions and establish an environment of mutual trust and respect. <p>Review of the facility's investigation documentation showed the following:</p> <ul style="list-style-type: none"> -Nurse Aide (NA) A's handwritten statement, dated 01/11/25, showed he/she witnessed NA B walk into the resident's room and say to him/her, (called the resident by his/her first name), stop being a fucking brat, and stop calling your fucking family when you don't get your way. -NA A noted he/she notified the charge nurse of the allegation between 10:15 P.M., and 10:20 P.M.; -Staff did not find documentation of the allegation by the charge nurse Registered Nurse (RN C) on duty on 01/10/25, at 10:15 P.M. - 10:20 P.M.; -Staff did not document interviews with staff other than NA B; -Staff did not write a summary statement or document notification to the State Agency (DHSS). <p>Review of the resident's nurses' notes showed staff did not document information pertaining to the allegation made by NA A or notifications made to the Administration, physician, or resident's family.</p> <p>Review of DHSS records showed an online report was made of the allegation by Licensed Practical Nurse ([NAME] D) on 01/11/25, at 6:27 A.M. (the day after the alleged event).</p> <p>During a phone interview on 01/21/25, at 3:01 P.M., NA B said it was wrong to curse at or in front of any resident.</p> <p>During an interview on 01/17/25, at 3:00 P.M., Certified Nurse Aide (CNA) G said cursing would be considered a type of abuse and should be reported immediately to the charge nurse or Director of Nursing (DON). The facility has two hours to report abuse allegations to the State.</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>During an interview on 01/17/25, at 3:08 P.M., CNA J said he/she would report allegations of abuse to the charge nurse. All allegations of abuse should be called in to the State within two hours of the incident.</p> <p>During an interview on 01/17/25, at 11:53 A.M., Certified Medication Technician (CMT) E said staff should report any allegation of abuse immediately to the charge nurse, DON, or the Administrator. The facility must report all abuse allegations to the State within two hours.</p> <p>During an interview on 01/17/25, at 2:10 P.M., Graduate Practical Nurse (GPN) F said cursing at a resident would be considered verbal abuse. All allegations of abuse should be reported immediately to the charge nurse or DON to investigate and must be reported to the State within two hours.</p> <p>During an interview on 01/17/25, at 3:15 P.M., GNP H said cursing at a resident is verbal abuse. If staff witnesses verbal abuse by another staff to a resident, they should immediately report it to the DON or charge nurse. All allegations of abuse should be reported to the State within two hours.</p> <p>During an interview on 01/17/25, at 2:55 P.M., LPN I said staff should report any allegation of abuse immediately to their supervisor. The facility must report all abuse allegations to the State within two hours.</p> <p>During an interview on 01/17/25, at 3:55 P.M., with the Administrator and the DON, the following was said:</p> <p>-On the morning of 01/17/25, LPN D had come to the facility to drop off a family member for work. At that time, NA A told LPN D about the allegation and said he/she had told the on-duty charge nurse, RN C, at the time of the incident around 10:15 P.M. to 10:20 P.M.;</p> <p>-LPN D called the Administrator and the DON to confirm they were aware of the abuse allegation. The Administrator said he/she had not seen the notification text sent to him/her by RN C at 1:08 A.M. that morning and told LPN D to do an investigation. The Administrator said LPN D had NA B write a statement and LPN D conducted and documented the resident interviews;</p> <p>-The Administrator and the DON said RN C should have verified contact with either of them to ensure a timely report to the State and an investigation started.</p> <p>-They said the reported incident would be verbal abuse and should be reported to the State within two hours and an investigation started immediately.</p> <p>MO00247859</p> <p>51882</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** 31464</p> <p>Based on interview and record review, the facility failed to document a timely and thorough investigation of verbal abuse when staff did not begin an immediate investigation into an allegation of staff cursing at one resident (Resident #1) and failed to document interviews with multiple staff as part of the investigation. A sample of ten residents was reviewed. The facility had a census of 48.</p> <p>Review of the facility's Abuse and Neglect Policy, revised September 2024, showed the following:</p> <ul style="list-style-type: none"> -It is the policy of the home to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person; -Within five business days of the incident, the facility must provide in its report sufficient information to describe the results of the investigation and indicate any corrective actions taken if the allegation was verified. It is important that the facility provides as much information as possible, to the best of its knowledge at the time of submission of the report; -Abuse is the act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury to a resident. This includes verbal or mental/psychological abuse; -Mental/psychological abuse, within the definition of abuse, means to inappropriately treat or exploit a resident, not resulting in physical harm, including, but not limited to , humiliation, harassment, threats of punishment, deprivation or intimidation; -Verbal abuse is the use of oral, written, or gestured language that includes disparaging derogatory terms to a resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability; -The home's administration will conduct and investigate allegations of crimes, abuse, neglect, or misappropriation of property, and will provide notification and release of information to the proper authorities, in accordance with federal and state regulations. <p>1. Review of Resident #1's face sheet (gives basic profile information) showed the following:</p> <ul style="list-style-type: none"> -Re-admitted [DATE]; -Diagnoses included age-related physical debility, mild cognitive impairment of uncertain or unknown cause, and generalized anxiety disorder. <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 11/02/24, showed the following information:</p> <ul style="list-style-type: none"> -Moderately impaired cognition; <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>-Utilized a wheelchair for mobility;</p> <p>-Required assistance for toileting, dressing, personal hygiene, and mobility.</p> <p>Review of the resident's care plan, last reviewed 11/02/24, showed the following:</p> <p>-Communication problems as evidenced by impaired hearing;</p> <p>-Cognitive loss;</p> <p>-Staff should introduce themselves during interactions and establish an environment of mutual trust and respect.</p> <p>Review of the facility's investigation documentation showed the following:</p> <p>-Nurse Aide (NA) A's handwritten statement, dated 01/11/25, showed he/she witnessed NA B walk into the resident's room and say to him/her, (called the resident by his/her first name), stop being a fucking brat, and stop calling your fucking family when you don't get your way.</p> <p>-On the statement, NA A noted he/she notified the charge nurse on 01/10/25, between 10:15 A.M. and 10:20 P.M.;</p> <p>-Questionnaires were filled out showing interviews with seven residents, dated 01/11/25 (unsigned), regarding their feelings of safety in the facility and whether or not anyone had ever hurt them there.</p> <p>(Investigative staff did not document any additional staff interviews.)</p> <p>Review of the resident's nurses' notes showed staff did not document information pertaining to the allegation made by NA A or notifications made to the administration, physician, or resident's family.</p> <p>During an interview on 01/17/25, at 11:53 A.M., Certified Medication Technician (CMT) E said staff should report any allegation of abuse immediately to the charge nurse, DON, or the Administrator so they could start an investigation.</p> <p>During an interview on 01/17/25, at 2:10 P.M., Graduate Practical Nurse (GPN) F said cursing at a resident would be considered verbal abuse. All allegations of abuse should be reported immediately to the charge nurse or DON to investigate.</p> <p>During an interview on 01/17/25, at 2:55 P.M., Licensed Practical Nurse (LPN) I said staff should report any allegation of abuse immediately to their supervisor and remove the resident from the situation. Administration is responsible for investigating allegations of abuse.</p> <p>During an interview on 01/17/25, at 3:00 P.M., Certified Nurse Aide (CNA) G said cursing would be considered a type of abuse and should be reported immediately to the charge nurse or DON. The CNA said he/she wasn't sure who conducted 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>During an interview on 01/17/25, at 3:08 P.M., CNA J said the Administrator or DON investigates allegations of abuse.</p> <p>During an interview on 01/17/25, at 3:15 P.M., GNP H said cursing at a resident is verbal abuse. All allegations of abuse should be investigated.</p> <p>During an interview on 01/17/25, at 3:55 P.M., with the Administrator and the DON, the following was said:</p> <p>-On the morning of 01/11/25, LPN D had come to the facility to drop off a family member for work. At that time, NA A told LPN D about the allegation and said he/she had told the on-duty charge nurse, RN C, at the time of the incident around 10:15 P.M. to 10:20 P.M.;</p> <p>-LPN D called the Administrator and the Director of Nursing (DON) to confirm they were aware of the abuse allegation. The Administrator said he/she had not seen the notification text sent to him/her by RN C at 1:08 A. M. that morning. He/she directed LPN D to begin an investigation;</p> <p>-LPN D interviewed a sample of residents regarding possible abuse and gave them the documentation regarding those interviews. LPN D told them NA A was the only witness to the alleged incident. There were no other staff witness statements obtained;</p> <p>-The Administrator and the DON said RN C should have verified contact with either of them to ensure a timely report to the State and an investigation started immediately;</p> <p>-They said the investigation should include witness statements and interviews with the named resident and any others that may have been under the care of the same alleged staff member.</p> <p>MO00247859</p> <p>51882</p> | | |