STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265611	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silex Community Care	111 Duncan Mansion Road Silex, MO 63377

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. 36185 Based on interview and record review, the facility failed to ensure the facility protected one resident (Resident #1), in a sample of five residents from abuse. Certified Nurse Assistant (CNA) A made inappropriate sexual comments about his/her own personal life within hearing distance of the resident and CNA A directly asked the resident inappropriate sexual questions. The resident had a history of aggressive sexual behaviors, and after the incident, the resident pulled his/her pants down and exposed himself/herself to another resident in the hall and grabbed a staff member inappropriately while receiving a shower. The facility census was 49. On 2/14/24 at 4:30 P.M., the administrator was notified of the past non-compliance that occurred on 2/3/24. CNA A (agency staff) had inappropriately spoken to the resident in a sexual manner. Corrective measures were put in place on 2/3/24 and an investigation began immediately. The resident's family and physician were notified of the allegation of abuse. A self report was made to the state agency and statements were obtained from all staff involved. Residents were interviewed regarding abuse. Facility staffing coordinator was notified to cancel any shifts CNA A was scheduled to work and CNA would not return to the facility. All staff were re-educated on the abuse policy and protocol. One on one education was provided to staff directly involved regarding immediately reporting an allegation of abuse. Licensed Practical Nurse (LPN) E was educated on what was considered abuse, reporting abuse and immediately suspending the alleged staff involved. Staff provided increased monitoring of the resident involved. The allegation of abuse was substantiated and the staffing agency representative was notified of the incident and a copy of the investigation was provided. The past noncompliance was corrected on 2/9/24. Review of the facility's undated Abuse Policy showed it was the policy of the facility that each resident would be free from abuse. Abuse could include verbal, mental, sexual, or physical abuse. Additionally, each resident would be protected from abuse, neglect and harm while they were residing at the facility. No abuse or harm of any type would be tolerated and residents and staff would be monitored for protection. Review of the facility's policy, Abuse Prohibition, dated November 2016, showed the following: (continued on next page)

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	-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 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 facilitated by technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm; -Verbal abuse is defined as any use of oral, written or body language that includes disparaging or derogatory terms to resident or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. 1. Review of Resident #1's care plan, last revised 11/1/23 showed the following: -The resident exhibits impaired thought process/decision making abilities, confusion and forgetfulness related to anoxic brain injury (a brain injury when the brain is deprived of oxygen), keep explanations simple, ask yes and no questions; -The resident exhibits behaviors of resistance to care, history of sexually inappropriate behavior, analyze behavior for possible cause and effect, use calm approach when inappropriate behavior is exhibited. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 1/17/24, showed the following: -Clear speech, distinct intelligible words; -Sometimes understands, responds adequately in simple, direct communication only; -Understands, clear comprehension; -Severe cognitive impairment; -No behavioral symptoms exhibited. Review of the resident's physician order sheet (POS), dated February 2024, showed diagnoses included anoxic brain injury, major depressive disorder (a mental disorder characterized by persistently depressed mood), and epilepsy (seizure disorder). Review of the facility investigation, dated 2/5/24, showed the following: -CNA A spoke to the resident inappropriately during dinner. The words spoken to him/her were sexual in nature; -When CNA A was questioned about the incident, CNA A said, Oh yes, he/she did ask the resident if he/she liked someone and the resident would growl anytime they walked by; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident in question will be sexually inappropriate at times but is easily redirected. After this event, the nurse aide (NA) B who gave the resident's shower said the resident was more inappropriate than normal. The resident grabbed NA B in the shower and the resident pulled his/her incontinence brief down and exposed himself/herself in front of another resident; -The incident with CNA B was found to be substantiated and he/she would not return to the facility for any future shifts and the staffing agency was notified and would be provided a copy of the report. Review of CNA C's statement dated 2/3/24 at 8:54 P.M., obtained by the facility, showed the following: -CNA A was talking about his/her sex life and asked the resident a very vulgar comment (question), he/she should have done more to stop it, but CNA A's mouth was very reckless and he/she just sat there; -CNA A asked the resident who he/she would fuck which was extremely inappropriate. Review of a CNA D's written statement dated 2/3/24 (untimed), obtained by the facility, showed the following: -During dinner CNA A asked Resident #1 what type of women/men would he/she would like to fuck; -The resident extended his/her arm moving his/her fingers like he was counting; -CNA A attempted to tune out what was said and continued feeding a resident. Review of LPN E's statement obtained by the facility, (undated) at 11:45 A.M. showed the following: -When LPN E was asked about the incident and what occurred on Saturday 2/3/24 during supper, LPN E said CNA A was rambling about his/her personal life which then led to CNA A asking Resident #1 inappropriate questions. CNA A asked would you like this person or that person, (but utilized curse word for sex). During an interview on 2/14/24 at 1:15 P.M., the administrator asked the resident if he/she recalled an incident from February 3, 2024 where an employee questioned him/her during supper if he/she preferred black or white women/men; the resident hesitated and nodded his/her head yes (the resident turned his/her head away and would not make eye contact or respond to any other questions asked). During an interview on 2/14/24 at 11:16 A.M., CNA C said on 2/3/24 during the supper meal he/she was feeding the resident. CNA A was seated at the same table. CNA A discussed his/her personal sex life within hearing distance of the resident. CNA A asked the resident, Would you fuck him/her? while CNA A pointed his/her finger at different staff members that were in the area. CNA A also asked the resident, Do you prefer to fuck black or white men/women? The resident understood what CNA A said and pointed to the skin color on his/her arm, indicating the color he/she preferred. The situation made him/her (CNA C) feel very uncomfortable. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/24 at 11:36 A.M., CNA D said while he/she was assisting residents during the supper meal on 2/3/24, CNA A asked the resident, Would you like to fuck black or white men/women? The resident pointed at his/her arm indicating the skin color he/she preferred. The resident heard what was said and was attempting to answer the question. CNA A was very inappropriate. During an interview on 2/14/24 at 12:00 P.M., LPN E said while he/she was assisting residents during the supper meal on 2/3/24, CNA A was talking to CNA C and CNA D about his/her own personal sex life at the table. CNA A asked the resident, Would you like to fuck him/her? CNA A pointed his/her finger at different staff members and residents in the area. The resident laughed out loud. He/She (LPN E) told CNA A that was inappropriate to say. During an interview on 2/14/24 at 2:30 P.M., with the resident's power of attorney (POA) he/she was very upset the resident was spoken to like this and felt it was abuse. The resident would be upset and offended if asked if he/she preferred to sleep with black or white women/men. During an interview on 2/14/24 at 3:40 P.M., the Director of nursing (DON) said what CNA A said to the resident was considered abuse. During an interview on 2/14/24 at 4:00 P.M., the administrator said the incident between CNA A was substantiated abuse by CNA A towards the resident. MO231327