

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Strafford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 West Evergreen Strafford, MO 65757	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on interview and record review, the facility failed to ensure all residents were treated in a dignified manner when a staff member moved one resident (Resident #1) by pulling him/her across the floor by his/her feet while the resident laid on the floor. The facility census was 64.</p> <p>Record review of the facility's policy titled Resident's Rights, undated, showed residents shall be treated with consideration and respect, with full recognition of their dignity and individuality.</p> <p>1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included bipolar disorder (mental condition marked by alternating periods of elation and depression), anxiety disorder (causes excessive feelings of fear, dread, worry that persist over time), dementia with behavioral disturbances (loss of memory and behaviors), cerebrovascular disease (affects blood flow to the brain), chronic obstructive pulmonary disease (COPD - lung disease that makes it difficult to breathe), and metabolic encephalopathy (brain dysfunction caused by an imbalance in the body's chemicals).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/21/24, showed the following:</p> <p>-Severe cognitive impairment on short and long term memory;</p> <p>-Required supervision with sit to lying, lying to sitting, sit to stand, and chair to bed transfers;</p> <p>-Required supervision when walking 10 feet;</p> <p>-Required partial supervision when walking 50 to 150 feet.</p> <p>Review of the resident's care plan, revised on 12/09/24, showed the following information:</p> <p>-Staff assist resident with adult daily living needs;</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident has altered cognition, resulting in behavior issues, such as putting self on the floor during said behaviors, usually without injury.</p> <p>-Staff to keep bed against the wall, fall mat in place, help to keep resident busy, increase monitoring, give reminders to not put self on the floor, and staff to increase monitoring to ensure safety.</p> <p>-Resident at risk for falls due to decline in strength and weakness, non compliant with directions from therapy and staff.</p> <p>-Resident voluntarily puts self on the floor and slides out of the wheelchair.</p> <p>-Staff to encourage resident to ask for assistance, remind to use call light, offer toileting assistance every two hours and as needed, assist to bed when tired, monitor location for safety, and encourage to take rest periods when ambulating and remind to slow down when ambulating.</p> <p>Review of the facility's investigation summary, dated 12/09/24, showed the following:</p> <p>-On 12/08/24, Assistant Administrator received a call at 3:59 P.M. from Certified Medication Technician (CMT) I;</p> <p>-CMT I said he/she was walking into the memory care unit around 3:45 P.M. when he/she witnessed the resident lower himself/herself to the floor inside the nurses' station;</p> <p>-Certified Nurse Aide (CNA) A was in the nurses' station at the time that the resident lowered him/herself to the floor;</p> <p>-CNA A preceded to roll the resident onto his/her back and then took the resident's feet and pulled the resident back into the day room;</p> <p>-During an interview by the Assistant Administrator CMT I said the resident dropped to his/her knees then to his/her side. CMT I watched CNA A moved the resident to his/her back and then pulled the resident by his/her ankles about ten feet from the inside of the nurses' station to the outside doorway.</p> <p>-During an interview by the Assistant Administrator CNA A said the resident put him/herself on the floor in the doorway to the nurses' station. He/she pulled the resident out of the doorway of the nurses' station because there was a narrow passage between the door and the medication cart. He/she could not lift the resident from that position and he/she did not want to try to lift the resident to his/her knees in the doorway because he/she was afraid it would be dangerous and he/she might get hurt.</p> <p>Review of CMT I's written statement, dated 12/09/24, showed the following:</p> <p>-CMT I walked into the memory care unit. He/she saw the resident put him/herself on the floor;</p> <p>-The resident dropped to his/her knees and then to his/her side;</p> <p>(continued on next page)</p>		

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