

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 649 South Walnut Saint Elizabeth, MO 65075	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>37131</p> <p>Based on interview and record review, facility staff failed to ensure one resident (Resident #2) remained free from verbal and emotional abuse, when Certified Nurse Aid (CNA) E threatened to take the resident to the floor, blocked and refused to leave the resident's room after repeated requests made by the resident. The facility census was 58.</p> <p>1. Review of the facility's policy titled Abuse and Neglect , dated 06/12/24, showed abuse is the willful infliction, injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Verbal abuse includes speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner in a resident's presence. Mental abuse includes humiliation, harassment, threats of punishment or deprivation, or abuse that is facilitated or caused by nursing home staff. Verbal abuse includes the use of verbal conduct by staff to cause the resident to experience agitation. This includes hovering over a resident with the intent to intimidate, threatening and isolating the resident.</p> <p>2. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/31/24, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> -Intact cognition; -Rejection of care not exhibited; -Behaviors not exhibited; -Received antipsychotic medication seven days out of the seven day look back period; -Post Traumatic Stress Disorder (PTSD), anxiety and flashbacks triggered by traumatic event, Bipolar disorder and Depression. <p>Review of the resident's care plan, revised 09/17/24, showed staff documented the resident as:</p> <ul style="list-style-type: none"> -Emotional distress is triggered by overwhelming emotions, feelings, or memories; <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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 649 South Walnut Saint Elizabeth, MO 65075	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> -Poor impulse control with restlessness and increased anxiety, agitation and aggressive behavior; -History of PTSD, encourage resident to express emotions in a safe environment; -A safe environment should be free from actual or perceived judgement and physical or perceived danger; -Listen to what the resident is saying and establish trust with the resident; -Behave in a calm manner around the resident, especially when the resident has a high level of anxiety; -Resident is triggered by people being to close and gets angry when people don't listen; -Residents with PTSD are often fearful, providing a calm and relaxing environment can help lessen, or relieve anxiety and promote a feeling of safety; -May often have difficulty communicating due to racing thought or inability to concentrate; -Avoid rushing the resident and allow them more time to answer, or respond to promote security; -Do not argue, or become defensive with the resident; -Do not get into a power struggle with the resident. <p>2. Review of the facility's investigation, dated 11/02/24, showed the resident notified the Director of Nursing (DON) on 11/1/24 Certified Nurse Aide (CNA) E abused him/her when CNA E would not leave the resident's room after being asked to leave multiple times, and blocked the doorway from the resident. Review showed Nurse Aide (NA) C statement showed he/she witnessed CNA E and resident yelling at each other and CNA E would not leave after the Licensed Practical Nurse told CNA E to leave. Review showed LPN D documented he/she heard yelling from the resident and CNA E. LPN D asked CNA E to leave the resident's room multiple times and instructed CNA E to go behind the unit doors. LPN documented CNA E left the room but not the unit. LPN D documented the resident left his/her room and CNA E approached the resident and stood abdomen to abdomen. The LPN notified the DON on 11/2/24 at. Review showed the DON notified the administrator on 11/2/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 649 South Walnut Saint Elizabeth, MO 65075	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/06/24 at 11:03 A.M., the resident said the incident happened on 11/02/24 he/she thinks. The resident said he/she asked CNA E to please get out of his/her room. The resident said CNA E said no, he/she is not leaving. The resident said he/she asked CNA E to leave his/her room approximately eight times. The resident said CNA E had his/her arms spread across the door frame and said he/she can do this for 12 more hours and smiled at him/her. The resident said he/she became frustrated and told CNA E to get out of his/her room, or he/she will put CNA E out of his/her room. The resident said CNA E then said he/she would put the resident on the floor. The resident said he/she became more agitated, and grabbed hot sauce packets and threw them in the hall and the CNA stood in the door frame and blocked him/her from leaving the room. The resident said Licensed Practical Nurse (LPN) D and Nurse Aide (NA) C came to his/her room. The resident said LPN D told CNA E to get out of the resident's room several times and CNA E would not leave the resident's room. The resident said after this incident CNA E continued to walk past his/her room and smile at him/her to frustrate him/her. The resident said he/she walked down the hall, yelled at CNA E and the CNA turned around walked back up to him/her and got face to face.</p> <p>During an interview on 11/06/24 at 12:45 P.M., CNA E the resident yelled he/she was going to beat the CNA's ass and for the CNA to leave the room. The CNA said LPN D told him/her to get out of the resident's room and he/she told LPN D he/she couldn't because the resident had him/her pinned. The CNA said he/she stayed in the resident's room, after the resident told him/her to leave, because he/she tried to calm the resident down.</p> <p>During an interview on 11/06/24 at 1:23 P.M., NA C said he/she and LPN D were at the nurse's station and heard yelling coming from the resident's room. NA C said he/she and LPN D went to the resident's room. NA C said when he/she got to the room CNA E and the resident were face to face and abdomen to abdomen. NA C said LPN D told CNA E to walk away several times and CNA E wouldn't. NA C said CNA E yelled several times that he/she could do this for 12 hours and smiled at the resident.</p> <p>During an interview on 11/06/24 at 2:00 P.M., the resident said when CNA E would not leave his/her room and had blocked his/her door, it made him/her feel trapped and unsafe, Like I was a prisoner in my own room. The resident said it made him/her really agitated and upset, because he/she couldn't get out of his/her room and CNA E would not leave the room.</p> <p>During an interview on 11/06/24 at 2:26 P.M., the DON said LPN D called him/her on 11/01/24 and said the resident yelled that he/she was going to beat the shit out of the CNA. The DON said LPN D called him/her again and said the resident left his/her room and went after the CNA. The DON said he/she took statements the next day and the staff statements were different from what he/she had been told over the phone. The DON said CNA E should have respected the resident's wishes and left the room. The DON said CNA E should have removed himself/herself from the situation. The DON did not say whether or not CNA E abused the resident.</p> <p>During an interview on 11/06/24 at 2:54 P.M., the administrator he/she investigated the resident's behavior and he/she should have investigated it as abuse. The administrator said he/she terminated CNA E because he/she would not listen to LPN D and stood in the resident's room to continually agitate the resident. The administrator said what CNA E did could increase the resident's agitation and cause further behaviors. The Administrator did not say whether or not CNA E abused the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 649 South Walnut Saint Elizabeth, MO 65075	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/07/24 at 7:45 A.M., LPN D said CNA E went into the resident's room and that is when he/she heard the resident yell get out, get out. LPN D said he/she heard CNA E say, I will take you to the floor. LPN D said the resident told CNA E to get out of his/her room several times but CNA E would not leave the room. LPN D said he/she told CNA E to leave the resident's room and CNA E would not leave the room. LPN D said CNA E stayed face to face with the resident. LPN D said CNA E could have left the room at any time.</p> <p>MO00244704</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 649 South Walnut Saint Elizabeth, MO 65075	
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 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>37131</p> <p>Based on interviews and record review, facility staff failed to report an allegation of employee to resident emotional abuse to the Department of Health and Senior Services (DHSS) within the two hour timeframe for one resident (Resident ##2) who reported an allegation of abuse. The facility census was 58.</p> <p>1. Review of the facility's policy titled Abuse and Neglect , dated 06/12/24, showed the licensed nurse will protect the resident from further incident and remove the accused employee from resident care areas. The nurse will then notify the administrator or designee. Should the incident be a reportable event, the administrator should notify appropriate agencies immediately, as soon as possible, but no later that 24 hours after the discovery of the incident. In case of serious bodily injury, no later than two hours after discovery or forming the suspicion.</p> <p>2. Review of the facility's investigation, dated 11/02/24, showed the resident notified staff on 11/1/24 that Certified Nurse Aide (CNA) E abused him/her when CNA E would not leave the resident's room after being asked to leave multiple times, and blocked the doorway from the resident. Review of Nurse Aide (NA) C's statement showed he/she witnessed CNA E and the resident yelling at each other and CNA E would not leave after the Licensed Practical Nurse (LPN) D told CNA E to leave the resident's room. Review showed LPN D documented he/she heard yelling from the resident and CNA E. LPN D asked CNA E to leave the resident's room multiple times and instructed CNA E to go behind the unit doors. LPN D documented CNA E left the room but not the unit. LPN D documented the resident left his/her room and CNA E approached the resident and stood abdomen to abdomen. The LPN notified the DON on 11/2/24. Review showed the DON notified the administrator on 11/2/24. Review showed facility staff did not notify the state agency with in the two hour timeframe as required.</p> <p>During an interview on 11/06/24 at 1:23 P.M., NA C said when he/she got to the resident's room CNA E and the resident were face to face. NA C said he/she knows there is a two hour timeframe for reporting allegations of abuse. The NA said he/she is not aware if it was reported to the state.</p> <p>During an interview on 11/06/24 at 2:26 P.M., the DON said he/she did not know he/she is supposed to call state, he/she said he/she called the administrator on 11/2/24, and the administrator takes care of reporting. The DON said it was reported to him/her the staff shoved the resident. The DON said he/she did not know the timeframes.</p> <p>During an interview on 11/06/24 at 2:54 P.M., the administrator said he/she investigated the resident's behavior and he/she should have investigated it as abuse. The administrator said he/she considers what CNA E did as trying to get a rise out of the resident and staff should not be doing that, as it could increase the resident's agitation and cause behaviors. The administrator said he/she contacted his/her regional administrator and told the regional administrator. The regional administrator told him/her to get statements and go from there. The administrator said he/she got statements and called the regional administrator and left a voicemail and did not receive a call back. The administrator said he/she knows now that he/she should have called state.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 649 South Walnut Saint Elizabeth, MO 65075	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/07/24 at 7:45 A.M., LPN D said he/she heard the resident yell get out, get out. LPN D said he/she heard CNA E say, I will take you to the floor. LPN D said the resident continued to tell CNA E get out of my room and CNA E would not leave the room. LPN D said he/she told CNA E to leave the resident's room and CNA E would not leave the room, CNA E stayed face to face with the resident. LPN D said staff have two hours to report abuse allegations to state. LPN D said the DON told him/her they needed to ask corporate if they had to report it. LPN D said he/she is not aware if it was reported to state. LPN D said the resident reported to him/her that CNA E shovedhim/her.</p> <p>MO00244704</p>		