

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265737	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Laurie Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 610 Highway O Gravois Mills, MO 65037	

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 - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>43024</p> <p>Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from sexual abuse when Resident #2 touched Resident #1's chest without Resident #1's consent. The facility census was 48.</p> <p>1. Review of the facility's policy, Abuse Prevention Program, revised December 2016, showed all residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This includes but not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 1/15/24, showed staff assessed the resident with short and long term memory problems, severely impaired cognitive skills for daily decision making, required extensive assistance and two person assist for transfers, and had diagnoses of dementia (a group of thinking and social symptoms that interferes with daily function), anxiety, and stroke (damage to the brain from interruption of it's blood supply).</p> <p>Review of Resident #1's plan of care, dated 4/01/24, showed staff are directed to monitor and observe the resident's surroundings for his/her safety.</p> <p>Review of Resident #1's nurse's notes, dated 3/29/24, showed the Director of Nursing (DON) documented he/she and the administrator called the resident's durable power of attorney to notify him/her about residents incident with another resident, voicemail left to call Administrator back.</p> <p>Review of Resident #2's Admission MDS, showed staff assessed the resident as severely impaired cognitive skills for daily decision making, required partial assistance and setup only for transfers, and had diagnoses of Alzheimer's and dementia.</p> <p>Review of Resident #2's plan of care, dated 1/24/22, showed staff assessed the residents at risk for behavioral episodes due to cognitive changes related to diagnoses. Review showed staff updated the plan of care on 4/01/24 to address the resident's sexual behavior toward another resident.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's nurse's notes, dated 3/28/24, showed Licensed Practical Nurse (LPN) A documented he/she walked up 600 hall and saw resident #2 bending over with face near resident #1's chest with shirt pulled over and down a little bit. Residents were separated, and he/she notified the DON and Assistant Director of Nursing (ADON).</p> <p>Review of the facility investigation, dated 3/29/24, showed LPN A reported to the DON and ADON he/she witnessed Resident #2 bending over with his/her face near Resident #1's chest, possibly kissing his/her chest area, and staff separated the residents. Review showed staff documented neither resident could recall the incident.</p> <p>Review of the facility's video footage from 3/29/24 showed Resident #2 walk past Resident #1 in the common area and pull his/her shirt up. Review showed Resident #2 came back and pulled Resident #1's shirt over and down, he/she then leaned down to the resident's chest. Review showed LPN A intervened immediately and seperated the resident's.</p> <p>During an interview on 4/1/24 at 2:17 P.M., Resident #2 said he/she does not remember an incident with another resident.</p> <p>During a phone interview on 4/3/24 at 12:05 P.M., LPN A said he/she was walking up the 600 hallway and saw Resident #2 leaning over Resident #1's chest area. He/She yelled Resident #2's name and he/she stood up and the residents were immediately separated. Resident #1's shirt was pulled to the side and down a little bit, with his/her chest exposed. A skin assessment was performed on Resident #1 and there was no trauma or redness to the area, the resident's behavior did not change and he/she did not remember the incident. He/She interviewed Resident #2 and he/she did not remember the incident. He/She said he/she has never seen Resident #1 have any sexual behaviors. LPN A said Resident #2 can be handsy with personal cares and staff but never witnessed sexual behaviors with other residents.</p> <p>During an interview on 4/1/23 at 12:15 P.M., the DON said he/she was not in the building when the incident between the residents but the LPN responded appropriately by immediately seperating the residents, notifying him/her, and they started the investigation was started.</p> <p>During an interview on 4/1/23 at 12:15 P.M., the administrator said he/she was not in the building when this occurred between the two residents but that the LPN responded appropriately by immediately seperating the residents, and notifying the DON. He/She said they started an investigation, notified the proper authorities. The administartor said the one thing he/she did not do was in-services immediately, but the in-service was scheduled for 4/4/24.</p> <p>MO00233963</p>		