STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265799	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighborhoods at Quail Creek, The	1514 West Lark Springfield, MO 65810

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43193 Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported immediately, but not later than two hours after the allegation was made, to the State Survey Agency (Department of Health and Senior Services - DHSS) when staff failed to report an allegation of possible physical abuse made my one resident (Resident #1) out of seven sampled residents. The facility census was 97. Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 01/01/23, showed the following: -It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property; -The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes; -Reporting timeframes: immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included dementia, delusional disorder, depression, and anxiety. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/23/23, showed the following: -The resident had severe cognitive impairment; (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had no behaviors or delusions; -The resident required maximum assistance from staff for oral hygiene, toilet hygiene, showering and upper body dressing and was dependent on staff for lower body dressing, putting on and taking off footwear and personal hygiene; -The resident required maximum assistance from staff for bed mobility, transfers and locomotion and used a wheelchair for locomotion. Review of the resident's current care plan showed the following: -He/she was resistive to care related to adjustment to a nursing home, anxiety and dementia. If he/she resisted activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting), please reassure him/her that he/she was okay, leave and return five to ten minutes later and try again. -Provide consistencies with his/her cares to promote comfort with ADLs. Please maintain consistency in timing of ADLs, caregivers and routine as much as possible. Review of the resident's nurse's progress note dated 03/07/24, at 9:59 A.M., showed, in part, the following: -The resident was having behaviors this morning with care staff. The resident was oriented to task at hand, agreeable at first, then changed his/her mind and began yelling and screaming at staff. He/she did get physically combative, but a family friend was able to re-direct him/her after all staff were out of the immediate reach of the resident; -The resident has had increasing frequency of behaviors, increase in delusions, and made accusations against staff for trespassing, stealing his/her clothes and purse, taking his/her car keys and pinching him/her on purpose; -Investigation performed with these reports and the resident was accounted for by multiple staff members and often times by this RN as the resident stays in the living room outside of this RN's office door and is in direct line of sight or sound; -Verified locations of alleged stolen items, which are all accounted for by the family member. Review of the facility's investigation, dated 03/07/24, showed the following: -On 03/07/24, at approximately 9:59 A.M., the resident was in the living room, in line of sight by Registered Nurse (RN) A, and stated that staff were trespassing on her property, stealing her clothes, taking her car keys, and pinching him/her on purpose. The RN immediately reported the resident's statements to Administrator; -The resident is noted per physician and staff documentation to have issues with anxiety, hallucinations, and intermittent confusion. The skin assessment completed on 03/07/24 and 03/09/24 showed no signs of pinching while the family member disproved the stolen items; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Within two hours of RN A notifying the Administrator, the Interdisciplinary Team (IDT) concluded that there was no abuse, neglect, or exploitation. Through interviewing staff, residents, family, and physician, it was determined that the root cause of the incident was hallucinations. During an interview on 05/14/24, at 1:18 P.M., RN A said the following: -On 03/07/24, the resident reported staff putting water down his/her throat during a shower, misappropriation, and staff pinching him/her on purpose. The resident alleged trespassing, stealing, and physical abuse; -All allegations of abuse should be reported; -The resident's allegation of abuse should have been reported to DHSS within two hours. During an interview on 05/14/24, at 10:59 A.M., Licensed Practical Nurse (LPN) C said the following: -If a resident reported abuse to a certified nursing assistant (CNA) or certified medication technician (CMT), they ensured the resident was safe and then reported to the charge nurse immediately. The charge nurse notified the Administrator immediately and the Administrator reported to DHSS immediately. During an interview on 05/14/24, at 11:16 A.M., CNA E said the following: -If a resident reported abuse to him/her, he/she reported this to the charge nurse immediately; -Administration reported to DHSS immediately. During an interview on 05/14/24, at 12:10 P.M., RN B said the following: -If a resident reported abuse, he/she got the resident to safety and then immediately reported to the Director of Nursing (DON) or Administrator; -The DON or Administrator reported to DHSS within two hours. During an interview on 05/14/24, at 12:15 P.M., CMT D said the following: -If a resident reported abuse to him/her, he/she made sure the resident was safe and then immediately reported to the charge nurse; -The Administration reported to DHSS within two hours. During an interview of 05/14/24, at 1:09 P.M., CNA F said the following: -If a resident reported abuse to him/her, he/she made sure the resident was safe and reported to the charge nurse immediately; -The DON reported to DHSS within two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/24, at 1:55 P.M., the DON said the following: -The resident's allegation of staff intentionally pinching the resident was reported to the Administrator; -Types of abuse included physical, emotional, exploitation and verbal; -If a resident reported abuse to a CNA, they reported to the charge nurse. The charge nurse reported to her and the Administrator; -The Administrator and DON completed an investigation and if they did not find the allegation of abuse happened, they did not report to DHSS; -Only suspected allegations of abuse, neglect, or exploitation needed reported to DHSS within two hours and this depended on if the resident was confused or delusional. During an interview on 05/14/24, at 2:19 P.M., the Administrator said the following: -RN A reported the resident's allegations to him; -The RN completed an investigation and skin assessment and notified the physician and resident's responsible party. The RN also got the psychologist involved in the resident's care and the physician adjusted the resident's medications due to the resident's hallucinations; -He did not report the allegation to DHSS because the RN investigated and found the allegation unsubstantiated so there was no suspected abuse, neglect, or exploitation of the resident; -If a resident reported abuse to staff, staff reported this to him. He had two hours to come to a conclusion on reporting the allegation; -If he could disprove the allegation within the two hours, he did not have to report to DHSS. MO00235926