

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2024
NAME OF PROVIDER OR SUPPLIER  Bellevue Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1616 Weisenborn Road Saint Joseph, MO 64507	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</b></p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe/functional/homelike environment, when the facility failed to recognize and repair a leak in one resident room and one adjacent utility room, causing water to run into the room, puddle on the floor and a mold like substance to form on the ceiling and bedroom walls and in the ceiling of the utility room on the Special Care Unit. Additionally, the facility failed to adequately maintain resident safety by preventing access to the affected area. The facility census was 82.</p> <p>The facility did not provide a policy on wall maintenance or safety.</p> <p>Observation on 11/4/24 at 11:10 A.M., of room [ROOM NUMBER] showed:</p> <ul style="list-style-type: none"> <li>-The door was closed. There was no stop sign, wet floor sign, or do not enter sign;</li> <li>-The door knob turned easily, and the door swung open with little force;</li> <li>-The room had water running down the left side wall forming a large puddle approximately 6 feet across on the floor;</li> <li>-The left side wall had multiple dark, black/gray/brown, spotty mold like substance areas along the top of the wall and the ceiling tiles;</li> <li>-The left side wall had a patch of peeling sheet rock at the ceiling juncture, approximately a foot in length;</li> <li>-The left side wall was bubbled and misshaped from the ceiling juncture to mid-wall, where it was saturated;</li> <li>-The front wall window frame showed gaps with daylight shining through between the sheet rock and the window frame at the top of the window;</li> <li>-Rain water was running into the room from the gap above the window;</li> <li>-Above the window at the ceiling juncture, was approximately a foot long area of peeling, bulging sheet rock;</li> </ul> <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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The wall above the windows showed multiple dark, black/gray/brown, spotty mold like substance areas along the top of the wall at the juncture of the ceiling tiles;</p> <p>-An electric bed was plugged into an outlet on the left side wall;</p> <p>-Multiple folded towels were lying, saturated, in the window sill;</p> <p>-A large saturated gray blanket was on the floor, near the large puddle.</p> <p>Observation on 11/4/24 at 11:15 A.M., of the un-numbered Utility Room (adjacent to room [ROOM NUMBER]) showed:</p> <p>-An approximately one foot circumference area of dark gray/black/spotty mold like substance next to the ceiling light fixture;</p> <p>-The one foot area of the ceiling was bulging and peeling;</p> <p>-An approximately 18 inch circumference area of yellow/dark gray/black/spotty mold like substance on the ceiling near the sprinkler head.</p> <p>During an interview on 11/4/24 at 1:00 P.M., the Certified Medication Technician A said:</p> <p>-He/She had started working on the memory care unit the last week of October;</p> <p>-room [ROOM NUMBER] had been leaking water since the day he/she started work on the memory care unit.</p> <p>During an interview on 11/4/24 at 1:08 P.M., Nurse Aide A said:</p> <p>-room [ROOM NUMBER] had been leaking for at least two weeks or more;</p> <p>-The door was kept shut to keep resident's out;</p> <p>-Residents have to be reminded at times not to open room [ROOM NUMBER]'s door.</p> <p>During an interview on 11/4/24 at 12:30 P.M., the Administrator said:</p> <p>-The facility would be getting a new roof by the end of the month;</p> <p>-There was a leak in room [ROOM NUMBER] and the area was cordoned off and not being used by residents;</p> <p>-He was not aware of any mold in the building.</p> <p>During an interview on 11/4/24 at 12:34 P.M., the Corporate Nurse said:</p> <p>-He was not aware of any current leaks;</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-There had been a small leak in the roof of the memory care unit, about two weeks ago that had been repaired, to his knowledge.</p> <p>During an interview on 11/4/24 at 1:12 P.M. the Administrator said:</p> <p>-He had checked the utility room next to room [ROOM NUMBER] (on 11/4/24).</p> <p>-He was not aware of any mold like substance in the utility room before then;</p> <p>-The ceiling was scraped and a mold killing spray was used;</p> <p>-The contract for the roof did not include fixing room [ROOM NUMBER] and the utility room.</p> <p>During an interview on 11/4/24 at 2:17 P.M. the Contractor said:</p> <p>-He/She had the bid to replace the roof;</p> <p>-The bid did not include any dry wall maintenance;</p> <p>-He/She had been working with the facility for a couple to three months on the roof project;</p> <p>-He/She was not aware the roof was leaking into the building;</p> <p>-He/She was waiting on payment to start the project.</p> <p>MO243710</p>		

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<p>F 0600</p> <p>Level of Harm - 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395</b></p> <p>Based on interview and record review, the facility failed to ensure one resident (Resident #2) was free from abuse when a staff member forcibly fed the resident his/her meal when the resident expressed he/she did not want to eat. The resident was visibly emotionally upset and tearful when describing the actions to staff. This affected one of six sampled residents (Resident #2). The facility census was 82.</p> <p>Review of the facility provided policy Abuse, Neglect, and Exploitation, dated 8/22/22, showed:</p> <p>-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;</p> <p>-Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and if verified could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse;</p> <p>-Mistreatment means inappropriate treatment of a resident.</p> <p>Review of the facility provided Policy Resident Rights, dated 9/1/22, showed:</p> <p>The resident has the right to:</p> <p>-Request, refuse, and/or discontinue treatment;</p> <p>-A dignified existence;</p> <p>-Exercise his/her rights as a resident of the facility;</p> <p>-Be treated with respect and dignity;</p> <p>-Make choices about aspects of his/her life in the facility.</p> <p>1. Review of Resident #2's Admission Minimum Data Set (MDS:a federally mandated assessment tool completed by facility staff), dated 10/18/24, showed:</p> <p>-Brief Interview of Mental Status (BIMS) 15, indicating no cognitive deficits;</p> <p>-Set up assistance by staff for eating;</p> <p>-No swallowing/chewing difficulty;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses of Congestive Heart Failure (where the heart can't pump enough blood to meet the body's needs), Hypertension (high blood pressure), Muscle Weakness, Type 2 Diabetes Mellitus (where the body does not use or does not produce enough insulin to meet needs), and Gastroesophageal Reflux (when stomach contents leak into the esophagus, causing irritation).</p> <p>Review of the resident's admission care plan showed the resident did not need assistance with eating.</p> <p>Review of the facility Grievance Reporting form, dated 10/28/24 and untimed, showed:</p> <p>-Physical Therapy Assistant (PTA) A attempted to work with Resident #2;</p> <p>-The resident was crying and frustrated;</p> <p>-The resident reported that he/she had been force fed by a staff member on the evening of 10/27/24;</p> <p>-The form was completed by the Director of Therapy (DOT) and signed by the Administrator.</p> <p>Review of the Investigation Summary, dated 10/31/24, completed by the Administrator, showed:</p> <p>-Resident #2 had complained a staff member pushed him/her to eat a meal, when he/she was able to feed himself/herself and refuse food if he/she did not want to eat;</p> <p>-The resident reported he/she kept telling the staff member that he/she did not want to eat, the staff kept trying to feed him/her manually and eventually stopped;</p> <p>-The Administrator assured the resident he/she would not have to work with the staff member again as the administrator felt the staff member acted inappropriately;</p> <p>-During an interview with Certified Nurse Aide (CNA) A, he/she said he/she was assisting the resident, because the resident seemed weak and was not eating. The resident told him/her to stop, but kept eating when helped;</p> <p>-The facility felt this did not elevate to the level of abuse, but the staff member acted inappropriately.</p> <p>During an interview on 11/12/24 at 2:50 P.M., Resident #2 said:</p> <p>-He/She feeds himself/herself;</p> <p>-CNA A entered his/her room at supper time on 10/27/24;</p> <p>-CNA A broke his/her sandwich into pieces and began sticking it into his/her mouth;</p> <p>-CNA A told Resident #2 he/she had to eat, because he/she was going to get sick;</p> <p>-He/She tried to turn his/her head away, CNA A followed and kept pushing the sandwich between his/her lips;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #2 reported to him/her that CNA A brought the evening meal tray to his/her room, broke the grilled cheese sandwich into pieces, pushed it into his/her mouth, and when the resident tried to say no, pushed the piece of sandwich between his/her lips. The resident was concerned he/she would choke, so he/she chewed and swallowed the pieces. After a few pieces the CNA took the tray and left the room;</p> <p>-He/She felt this was abuse, so he/she notified the Administrator immediately;</p> <p>-The Administrator said he/she would deal with it later;</p> <p>-The Administrator did not tell him/her to send CNA A home.</p> <p>During an interview on 11/12/24 at 1:42 P.M., PTA A said:</p> <p>-On 10/28/24, he/she arrived to Resident #2's room for therapy. The resident was visibly emotionally upset and tearful;</p> <p>-The resident said he/she did not like how he/she was treated by nursing staff;</p> <p>-The resident said he/she was force fed by nursing staff during the evening meal on 10/27/24;</p> <p>-He/She notified LPN A on 10/28/24 what the resident reported to him/her, who said that was impossible as the resident feeds himself/herself;</p> <p>-He/She then immediately went to his/her supervisor and reported what Resident #2 said;</p> <p>-The resident did not have any physical injuries on his/her face that he/she noticed.</p> <p>During an interview on 11/14/24 at 4:47 P.M., LPN A said he/she did not remember being notified by staff that Resident #2 complained of being force fed.</p> <p>During an interview on 11/12/24 at 1:25 P.M., the DOT said:</p> <p>-PTA A completed the Grievance Report for Resident #2 on 10/28/24;</p> <p>-When PTA A reported Resident #2 said force fed, he/she knew it needed to be addressed immediately;</p> <p>-He/She did not work with Resident #2, but had seen him/her working in the gym, and the resident had no problems with his/her hand/arm movement.</p> <p>During an interview on 11/12/24 at 1:10 P.M., the Administrator said:</p> <p>-Once he spoke with the resident, he felt the issue was customer service, not abuse;</p> <p>-The comment of force fed was staff taking liberties with words;</p> <p>-The report that came to him said force fed;</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>-He explained to the resident force fed was holding the resident's head and pushing food into his/her mouth, and he/she said that did not happen;</p> <p>-The staff member thought he/she was helping the resident;</p> <p>-The staff member should have stopped feeding the resident when the resident told him/her to stop;</p> <p>-The resident had the right to refuse the meal.</p> <p>MO245023</p>		

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<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>44395</p> <p>Based on interview and record review, the facility failed to ensure an alleged violation of potential physical abuse was reported immediately, but not later than two hours after the allegation was made, to officials in accordance with State law, including the Survey Agency for one sampled resident (Resident #2) out of six sampled residents. The facility census was 82 residents.</p> <p>Review of the facility provided policy Abuse, Neglect, and Exploitation, dated 8/22/22, showed:</p> <p>-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;</p> <p>-Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and if verified could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse;</p> <p>-Mistreatment means inappropriate treatment of a resident;</p> <p>-Reporting of all alleged violations to the state agency, adult protective services and all other required agencies within the specified timeframe's: Immediately, but no later than two hours after the allegation is made if the event that cause the allegation involve abuse or result in serious bodily injury;</p> <p>-The Administrator will follow up with government agencies during business hours to confirm the initial report was received and to report the results of the investigation when final within five working days of the incident.</p> <p>1. Review of Resident #2's Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff), dated 10/18/24, showed:</p> <p>-Brief Interview of Mental Status (BIMS) 15, indicating no cognitive deficits;</p> <p>-Set up assistance by staff for eating;</p> <p>-No swallowing/chewing difficulty;</p> <p>-Diagnoses of Congestive Heart Failure (where the heart can't pump enough blood to meet the body's needs), Hypertension (high blood pressure), Muscle Weakness, Type 2 Diabetes Mellitus (where the body does not use or does not produce enough insulin to meet needs), and Gastroesophageal Reflux (when stomach contents leak into the esophagus, causing irritation).</p> <p>Review of the resident's admission care plan showed the resident did not need assistance with eating.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility Grievance Reporting form, dated 10/28/24 untimed, showed:</p> <ul style="list-style-type: none"> <li>-Physical Therapy Assistant (PTA) A attempted to work with Resident #2.</li> <li>-The resident was crying and frustrated.</li> <li>-The resident reported that he/she had been force fed by a staff member on the evening of 10/27/24.</li> <li>-The form was completed by the Director of Therapy (DOT) and signed by the Administrator.</li> </ul> <p>Review of the Investigation Summary, dated 10/31/24 completed by the Administrator, showed:</p> <ul style="list-style-type: none"> <li>-Resident #2 had complained a staff member pushed him/her to eat a meal, when he/she was able to feed himself/herself and refuse food if he/she did not want to eat it;</li> <li>-The resident reported he/she kept telling the staff member that he/she did not want to eat, the staff kept trying to feed him/her manually and eventually stopped;</li> <li>-The Administrator assured the resident he/she would not have to work with the staff member again as he felt the staff member acted inappropriately;</li> <li>-During an interview with Certified Nurse Aide (CNA) A, he/she said he/she was assisting the resident, because the resident seemed weak and was not eating. The resident had told him/her to stop, but kept eating when helped;</li> <li>-The facility felt this did not elevate to the level of abuse, but the staff member acted inappropriately.</li> </ul> <p>During an interview on 11/12/24 at 2:50 P.M. Resident #2 said:</p> <ul style="list-style-type: none"> <li>-He/She feeds himself/herself;</li> <li>-CNA A entered his/her room at supper time on 10/27/24;</li> <li>-CNA A broke his/her sandwich into pieces and began sticking it into his/her mouth;</li> <li>-CNA A told the resident, he/she had to eat, because he/she was going to get sick;</li> <li>-He/She tried to turn his/her head away, CNA A followed and kept pushing the sandwich between his/her lips;</li> <li>-He/She told CNA A to stop, but CNA A kept pushing it between his/her lips;</li> <li>-When he/she would open his/her mouth to say no or stop, CNA A would shove a piece of the sandwich in his/her mouth;</li> <li>-Once he/she had eaten about half the sandwich, CNA A took the tray and left the resident's room;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She did not report anything that day, but reported to the night nurse;</p> <p>-The Administrator told him/her, he/she would not have to work with CNA A again;</p> <p>-CNA A forced him/her to eat and he/she did not want to. CNA A would not take no as an answer.</p> <p>During an interview on 11/14/24 at 5:02 P.M., Licensed Practical Nurse (LPN) B said:</p> <p>-He/She worked the night shift on 10/27/24;</p> <p>-He/She worked with Resident #2;</p> <p>-Resident #2 reported to him/her that CNA A brought the evening meal tray to his/her room, broke the grilled cheese sandwich into pieces, pushed it into his/her mouth, and when the resident tried to say no, pushed the piece of sandwich between his/her lips. The resident was concerned he/she would choke, so he/she chewed and swallowed the pieces. After a few pieces the CNA took the tray and left the room;</p> <p>-Resident #2 reported this event to LPN B the evening of 10/27/24;</p> <p>-He/She felt this was abuse so he/she notified the Administrator immediately;</p> <p>-The Administrator said he/she would deal with it later;</p> <p>During an interview on 11/12/24 at 1:42 P.M., PTA A said:</p> <p>-He/She arrived to Resident #2's room for therapy on 10/28/24 . The resident was visibly emotionally upset and tearful;</p> <p>-The resident said he/she did not like how he/she was treated by nursing staff;</p> <p>-The resident said he/she was force fed by nursing staff during the evening meal on 10/27/24;</p> <p>-He/She notified LPN A on 10/28/24 what the resident reported to him/her, who said that was impossible as the resident feeds himself/herself;</p> <p>-He/She then immediately went to his/her supervisor (DOT) and reported what Resident #2 had said;</p> <p>-The resident did not have any physical injuries on his/her face that he/she noticed.</p> <p>During an interview on 11/12/24 at 1:10 P.M. the Administrator said:</p> <p>- Once he spoke with the resident he felt the issue was customer service, not abuse. And did not feel it needed to be reported to the State Agency;</p> <p>-He could not recall the date when he spoke with the resident;</p> <p>-The comment of force fed was staff taking liberties with words;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2024
NAME OF PROVIDER OR SUPPLIER  Bellevue Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1616 Weisenborn Road Saint Joseph, MO 64507	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The report that was made indicated the resident said force fed;</p> <p>-The resident said he/she was force fed by the CNA, but the Administrator explained to the resident force fed was holding the resident's head and pushing food into his/her mouth, and he/she said that did not happen;</p> <p>-The staff member should have stopped feeding the resident when he/she said to stop;</p> <p>-The resident had the right to refuse the meal;</p> <p>-He should report allegations of abuse to the State Agency, then investigate the incident.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>44395</p> <p>Based on interview and record review, the facility failed to follow their policy to maintain documentation and complete a thorough investigation of an alleged violation of resident abuse after informed by a staff member that one resident (Resident #2) reported a certified nurse aide (CNA) force fed him/her. This affected one of six sampled residents. The facility census was 82.</p> <p>Review of the facility provided policy Abuse, Neglect, and Exploitation, dated 8/22/22, showed:</p> <ul style="list-style-type: none"> <li>-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;</li> <li>-Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and if verified could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse;</li> <li>-Mistreatment means inappropriate treatment of a resident;</li> <li>-An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur;</li> <li>-Procedures for investigations include: identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent and cause and;</li> <li>- Providing complete and thorough documentation of the investigation.</li> </ul> <p>1. Review of Resident #2's Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff), dated 10/18/24, showed:</p> <ul style="list-style-type: none"> <li>-Brief Interview of Mental Status (BIMS) 15, indicating no cognitive deficits;</li> <li>-Set up assistance by staff for eating;</li> <li>-No swallowing/chewing difficulty;</li> <li>-Diagnoses of Congestive Heart Failure (where the heart can't pump enough blood to meet the body's needs), Hypertension (high blood pressure), Muscle Weakness, Type 2 Diabetes Mellitus (where the body does not use or does not produce enough insulin to meet needs), Gastroesophageal Reflux (when stomach contents leak into the esophagus, causing irritation).</li> </ul> <p>Review of the resident's admission care plan showed the resident did not need assistance with eating.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility Grievance Reporting form, dated 10/28/24, untimed, showed:</p> <ul style="list-style-type: none"> <li>-Physical Therapy Assistant (PTA) A attempted to work with Resident #2;</li> <li>-The resident was crying and frustrated;</li> <li>-The resident reported that he/she had been force fed by a staff member on the evening of 10/27/24;</li> <li>-The form was completed by the Director of Therapy (DOT) and signed by the Administrator.</li> </ul> <p>Review of seven Resident Questionnaire forms, dated 10/30/24, completed by the Social Service Director showed: other residents were not made to feel uncomfortable, been threatened by anyone, witnessed anyone being mistreated and felt safe in the facility.</p> <p>Review of the Investigation Summary, dated 10/31/24, completed by the Administrator, showed:</p> <ul style="list-style-type: none"> <li>-Resident #2 had complained a staff member pushed him/her to eat a meal, when he/she was more than able to feed himself/herself and refuse food if he/she did not want to eat it;</li> <li>-The resident reported he/she kept telling the staff member that he/she did not want to eat, the staff kept trying to feed him/her manually and eventually stopped;</li> <li>-The Administrator assured the resident he/she would not have to work with the staff member again as he felt the staff member acted inappropriately;</li> <li>-During an interview with CNA A, he/she said he/she was assisting the resident, because the resident seemed weak and was not eating. The resident had told him/her to stop, but kept eating when helped;</li> <li>-The facility felt this did not elevate to the level of abuse but the staff member acted inappropriately.</li> <li>-Further review showed the facility did not complete staff statements or statements from the Alleged Perpetrator (AP).</li> </ul> <p>During an interview on 11/12/24 at 2:50 P.M., Resident #2 said:</p> <ul style="list-style-type: none"> <li>-He/She feeds him/herself;</li> <li>-CNA A entered his/her room at supper time on 10/27/24;</li> <li>-CNA A broke his/her sandwich into pieces and began sticking it into his/her mouth;</li> <li>-CNA A told the resident he/she had to eat, because he/she was going to get sick;</li> <li>-He/She tried to turn his/her head away, CNA A followed and kept pushing the sandwich between his/her lips;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She told CNA A to stop, but CNA A kept pushing it between his/her lips;</p> <p>-When he/she would open his/her mouth to say no or stop, CNA A would shove a piece of the sandwich in his/her mouth;</p> <p>-Once he/she had eaten about half the sandwich, CNA A took the tray and left the resident's room;</p> <p>-He/She did not report anything that day, but reported to the night nurse;</p> <p>-The Administrator told him/her, he/she would not have to work with CNA A again;</p> <p>-CNA A forced him/her to eat and he/she did not want to. CNA A would not take no as an answer.</p> <p>During an interview on 11/14/24 at 2:09 P.M., CNA A said:</p> <p>-The Administrator called him/her several days later and informed him/her the facility was severing his/her work environment.</p> <p>-He/She was unaware of any problems with Resident #2 until he/she was called by the Administrator 4 or 5 days after the incident.</p> <p>During an interview on 11/14/24 at 5:02 P.M. Licensed Practical Nurse (LPN) B said:</p> <p>-He/She worked the night shift on 10/27/24;</p> <p>-He/She worked with Resident #2;</p> <p>-Resident #2 reported to him/her that CNA A brought the evening meal tray to his/her room, broke the grilled cheese sandwich into pieces, pushed it into his/her mouth, and when the resident tried to say no, pushed the piece of sandwich between his/her lips. The resident was concerned he/she would choke, so he/she chewed and swallowed the pieces. After a few pieces the CNA took the tray and left the room;</p> <p>-He/She felt this was abuse so he/she notified the Administrator immediately;</p> <p>-The Administrator said he/she would deal with it later;</p> <p>-The Administrator did not come in during his/her shift on 10/27/24.</p> <p>-The Administrator did not question him/her about the incident.</p> <p>During an interview on 11/12/24 at 1:42 P.M., PTA A said:</p> <p>-He/She had gone to Resident #2's room for therapy. The resident was visibly emotionally upset and tearful;</p> <p>-The resident said he/she did not like how he/she was treated by nursing staff;</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident said he/she was force fed by nursing staff;</p> <p>-He/She notified the Charge Nurse who said that was impossible as the resident feeds himself/herself;</p> <p>-He/She was not sure of the Charge Nurse's name, he/she just knew to report any complaint of abuse to the Charge Nurse;</p> <p>-He/She then immediately went to his/her supervisor (DOT) and reported what Resident #2 had said;</p> <p>-The Administrator, Social Service Director, or Director of Nursing did not interview or discuss the incident with him/her.</p> <p>During an interview on 11/12/24 at 1:52 P.M. the Social Service Director said:</p> <p>-She had met the resident on admission, only saw him/her in the hall, until 10/30/24 when she talked with the resident about the incident on 10/27/24;</p> <p>-She interviewed the resident by phone, as the resident went to the hospital on Monday 10/28/24 and the incident had occurred over a weekend;</p> <p>-She did interviews with other residents later in the week just to follow up for the filed grievance;</p> <p>-The resident reported to her that he/she was force fed by CNA A;</p> <p>-The resident reported the CNA kept holding the food up to his/her mouth and telling him/her to take it.</p> <p>During an interview on 11/12/24 at 1:10 P.M. the Administrator said:</p> <p>-Once he spoke with the resident he felt the issue was customer service, not abuse.</p> <p>-The comment of force fed was staff taking liberties with words.</p> <p>-The report that came to him did read force fed.</p> <p>-He explained to the resident force fed was holding the resident's head and pushing food into his/her mouth, and he/she said that did not happen.</p> <p>-Residents were interviewed on 10/30/24 by the Social Service Director.</p> <p>-The summary of the incident was written on 10/31/24, but the investigation began immediately.</p> <p>-The staff member should have stopped feeding the resident when the resident said to stop;</p> <p>-The resident had the right to refuse the meal.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He should investigate the incident immediately.</p> <p>-He did not obtain staff statements and statements from the AP as he did not feel this was abuse and did not need a full investigation.</p> <p>During an interview on 11/12/24 at 1:52 P.M. the Social Service Director said:</p> <p>-She had met the resident on admission, only saw him/her in the hall, until 10/30/24 when she talked with the resident about the incident on 10/27/24;</p> <p>-She interviewed the resident by phone as the resident went to the hospital on Monday 10/28/24 and the incident had occurred over a weekend;</p> <p>-She did interviews with other residents later in the week just to follow up for the filed grievance;</p> <p>-The resident reported to her that he/she was force fed by CNA A;</p> <p>-The resident reported the CNA kept holding the food up to his/her mouth and telling him/her to take it.</p>