STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265832	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senath South Health Care Center	300 East Hornbeck Street Senath, MO 63876

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 31057 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #1) was free from physical abuse when Resident #2 repeatedly hit Resident #1 in the head with a porcelain toilet tank lid causing serious injuries. Resident #1 and Resident #2 had a history of conflict with each other and Resident #1 exhibited increasingly agitated verbally aggressive behaviors throughout the day, prior to the event. The unit where the residents resided did not have staff directly on the unit at the time the incident occurred, and no interventions were in place at the time to address Resident #2's increased behaviors. Resident #1 was sent to the hospital and diagnosed with an intracranial intraparenchymal hemorrhage (bleeding in the brain) and a hypertensive (high blood pressure) emergency due to assault. The facility census was 132. The Administrator was notified on 07/15/24, of an Immediate Jeopardy (IJ) which began on 07/12/24. The facility began updating their crisis intervention plan, completing in-services for all staff that included the abuse and neglect policy, behavior crisis management response plan in-servicing for all department heads, a psychosocial post-incident impact questionnaire on all residents residing on the step-down unit and providing crisis counseling. Staff began education ensuring visual line of sight throughout the corridors. Centers for Medicare and Medicaid (CMS) imposed a temporary manager remedy at the facility effective 7/19/24. The temporary manager reviewed and verified on 7/19/24, the removal plans were initiated, and on-going. Review of the facility's policy titled, Abuse and Neglect, dated 11/28/16, and revised 06/12/24, showed: - Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress; - Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations; - Physical abuse is purposely beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner; (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The facility will develop operational policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences; - Staff training includes how to assess, prevent, and manage aggressive, violent, and or catastrophic reactions of residents in a way that protects both residents and staff; - As a part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis; - On a regular basis, supervisors will monitor the ability of staff to meet the needs of residents and staff understanding of individual resident care needs. Situations such as inappropriate language, insensitive handling, or impersonal care will be corrected as they occur. Incidents short of willful abuse will be handled through counseling, training, and if necessary or repeated, the facility progressive discipline policy. 1. Review of Resident #1's medical record showed: - Diagnoses of bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), schizoaffective disorder, bipolar type (a disorder of schizophrenia and mood disorder), psychotic disorder with delusions due to psychological condition (severe mental disorders that cause abnormal thinking and perceptions, people with psychoses lose touch with reality), traumatic hemorrhage of cerebrum (a brain bleed), generalized anxiety disorder, hyperactivity attention deficit disorder (mental health disorders that impact the way you think and feel about yourself and others, causing problems functioning in everyday life), migraines (headache), and irritability with anger. Review of the resident's Pre-Admission Screening and Resident Review (PASRR - a federal requirement to ensure that individuals are not inappropriately placed in long term care), dated 11/29/21, showed: - Resident required assessment and implementation of a behavioral support plan; - Medication therapy and monitoring services; - Structured environment; - Activities of daily living (ADL's) program; - Crisis intervention services; - Development of personal support networks; - Assess and plan for discharge. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's care plan, updated on 06/08/23, showed: - At the time of the PASRR, the resident was deemed safe for admission to a skilled nursing facility; - The resident had a history of behavioral challenges that required protective oversight in a secure setting. Review of the resident's hospital records, dated 07/13/24 through 07/15/24, showed: - The resident arrived via a life flight due to multiple scalp lacerations (deep cut or tear) received during an assault at the nursing facility where the resident resided and an elevated blood pressure; - Multiple lacerations to the scalp, left shoulder and left upper arm required staples in the emergency room before being placed in the intensive care unit (ICU) with a diagnosis of traumatic intracranial bleeding (bleeding within the brain); - Lacerations to the left shoulder/arm measured 3.5 centimeters (cm) x 0.2 cm which required two staples for closure, 4 cm x 1.3 cm x 0.2 cm, and 3 cm x 0.1 cm; - Lacerations to the scalp measured 9 cm x 0.1 cm which required 10 staples for closure, 3.5 cm x 0.3 cm x 0 cm which required three staples for closure, and 0.1 cm x 7.5 cm x 0 cm which required eight staples for closure; - Upon admission to ICU, the resident was non-verbal, lethargic (not easily aroused) and unable to move his/her right side equal to the left side. During an interview on 07/15/2024 at 3:50 P.M., the resident's Guardian said Resident #1 was in the ICU. The ICU staff were having a problem keeping him/her awake. The hospital staff said Resident #1 had a brain bleed. Resident #1 had been happy at the facility and kept to him/herself. The facility had informed him/her the resident had been injured, but he/she was not aware of the extent injuries. 2. Review of Resident #2' medical record showed: - Diagnoses of schizoaffective disorder, antisocial personality disorder (a mental health condition in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others) bipolar disorder, border line personality disorder (a mental health condition that affects the way people feel about themselves and others, making it hard to function in everyday life), oppositional defiant disorder (uncooperative, defiant, and hostile behavior toward peers, parents, teachers, and other authority figures), and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and loss of interest in activities that once brought joy); - Resided on the step-down unit, which was the unit with the least restrictions and still located within the secured building. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's PASRR, dated 10/18/22, showed: - Resident required assessment and implementation of a behavioral support plan; - Medication therapy and monitoring services; - Structured environment; - ADL's program; - Crisis intervention services; - Development of personal support networks; - Assess and plan for discharge. Review of the resident's care plan, dated 01/03/24, showed: - At the time of the PASRR, the resident was deemed safe for admission to a skilled nursing facility; - A history of behavioral challenges that required protective oversight in a secure setting; - A history of teasing or instigating peers, thought it was funny when peers were mad at him/her; - Independent for meeting emotional, intellectual, physical and social needs; - Manipulative, verbally aggressive and self-harming; - A history of physical and verbal aggressive behaviors. Review of the resident's monthly nurses notes, dated 07/08/24, showed: - The resident with an indicator of delirium through disorganized thinking; - The resident exhibited verbal behavioral symptoms directed toward others. Review of the resident's progress notes, date 07/13/24, showed: - At 6:45 P.M., the resident had become verbally aggressive towards other residents and staff. He/She was upset that his/her broken toilet was repaired, and now it was broken again. Nursing staff tried to calm the resident with no luck. The Guardian was called with no answer. The physician was notified and gave an order to send the resident out; - At 7:15 P.M., late entry, the resident had a laceration to the left palm, approximately 4 centimeters (cm) and approximately 1-2 cm deep; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- At 7:20 P.M., staff responded to a Code [NAME] (a term used by the facility to describe a behavioral emergency), other nursing staff were already assessing the aggressive resident. Staff removed the aggressor (Resident #2) from the hall and assessed his/her wounds to the left hand while other staff contacted the local police department. Resident #2 threatened staff and said he/she was going to get out of the building and off the current hall he/she was on. Staff stayed with the resident until police arrived; - At 7:55 P.M., staff reported an altercation occurred with Resident #2 and Resident #1. Resident #2 was upset and said he/she didn't want to be there. Staff immediately intervened and separated the residents. Resident #2 was taken into custody by the local police. Review of the facility's Incident Investigation, dated 07/13/24, showed: - Resident #1 was in an altercation with Resident #2. Resident #1 had blood coming from his/her head and staff administered first aid; - Resident #1 reported standing in his/her doorway when Resident #2 just came up and hit him/her. Observation of the facility video recording for 07/13/24 at 7:00 P.M., showed: - Resident #2 walked down the step-down unit hall with no staff present; - Resident #2 went into his/her room, came out of the room carrying a toilet tank lid in his/her right hand; - Resident #2 entered Resident #1's room and Resident #1 immediately shoved Resident #2 into the hallway; - Resident #2 hit Resident #1 over the head multiple times with the toilet tank lid until the lid broke into several pieces onto the floor; - Resident #2, still holding a piece of the broken tank lid, threw the piece of the broken tank lid and struck Resident #1 in the right side of the head; - One staff member ran down the hallway toward the residents after the two residents separated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/15/24 at 4:00 P.M., Certified Medication Technician (CMT) G said he/she worked the day shift (7 A.M. to 7 P.M.) on 07/13/24. On that day, Resident #2 had been upset all day due to his/her toilet sat too high or something like that. Resident #2's behavior started before lunch and he/she was still mad after lunch. Resident #2 had an issue with Resident #1 for a long time, but was unsure what the issue might be. The staff attempted to keep Resident #1 and Resident #2 apart, and kept them re-directed away from each other at all times. Before this incident occurred, the staff had been trying to send Resident #2 out for an evaluation and had him/her sitting in the front lobby area away from the hall. When the ambulance arrived to the facility a different resident had a medical emergency so the emergency personal took that resident instead of Resident #2 and another ambulance was called to transfer Resident #2. CMT G was not sure how Resident #2 got out of the locked lobby, but obviously he/she did because that was when the incident occurred. At the time Resident #2 attacked Resident #1, CMT G was in the hall by the Director of Nursing's (DON) office counting medications with the oncoming shift and was unable to see down the step down unit. CMT G heard someone say, Oh my God, so he/she ran down the hall and saw what happened but it was over with. At that time, there were no other staff on the hall. During an interview on 07/15/24 at 4:45 P.M., the Maintenance Contractor (MC) said they had started repairs on Resident #2's room at 11:30 A.M. on 7/12/24. The toilet had been leaking due to what appeared to have been the resident shaking it loose from the wall. They did not pay any attention to the resident or any of the other resident conflicts. They knew the porcelain tank was heavy but the facility wanted it to be more homelike. During an interview 07/15/24 at 5:25 P.M., Licensed Practical Nurse (LPN) H said he/she had just arrived to work when the incident occurred. LPN A reported to LPN H that Resident #2 had been upset over his/her toilet issues all day and they were attempting to send him/her out for an evaluation when Resident #2 refused to go. At that time, Resident #2 was sitting in the front lobby, calm and asking for a cigarette. The staff were discussing whether or not to place the resident one on one. LPN H was unsure how Resident #2 exited the front lobby, but that was when he/she attacked Resident #1. During an interview on 07/15/24 at 1:30 P.M., the Assistant Director of Nursing (ADON) said a staff member was running late for work on the evening of 07/13/24, so another staff member was staying over and had moved his/her medication cart to the hallway entering the dining room, out of eye view of the step down unit, when the incident occurred. Resident #2 had been verbally aggressive all day regarding his/her toilet in his/her room. Discussions were had with staff about sending Resident #2 out, but he/she refused to go at the time the ambulance arrived. This all happened at shift change, around 7 P.M. A staff member should have been present on the hall at all times. Resident #2 probably targeted Resident #1 because he/she knew Residents #1 would not fight back. During an interview on 07/15/24 at 3:30 P.M., the ADON said Resident #2 refused to be taken by ambulance to the emergency room upon it's arrival to the facility. The staff should have documented the resident's refusal, notified the physician of the refusal and provided additional interventions to keep the resident calm. The decision to place Resident #2 one on one was not needed at the time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/15/24 at 12:30 P.M., the Administrator said on 07/13/24, Resident #2 was verbally aggressive regarding his/her toilet being repaired and had complained all day. Resident #2 said he/she wished the facility would close down. Resident #2 was standing with staff during the shift change and walked away. The Administrator was not sure how this happened. The resident walked into his/her room, took the tank lid off the toilet, and walked into Resident #1's room resulting in an unprovoked assault on Resident #1. Resident #2 was no longer in the facility and being held in the county jail. Resident #1 typically did not fight back. Complaint #MO238939

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31057 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #3) did not exit a locked behavioral unit without staff supervision. Facility staff failed to monitor an unlocked exit door and failed to arm the alarm on the outside courtyard gate door. The resident exited the back door of the 600 Hall secured unit, onto the locked courtyard and kicked the lock on the courtyard door until it opened to the outside. The temperatures were in the upper 80's with high humidity. The behavioral unit provided supervision to ambulatory, cognitively impaired residents with mental health diagnoses. The facility census was 132. On 07/16/24 at 3:00 P.M., the Administrator was notified of the immediate jeopardy (IJ) which began on 07/12/24. The facility began updating their crisis intervention plan, completing in-services for all staff that included elopements and wandering residents policy, resident shiftly safety assessment policy and completing behavior crisis management response plan in-servicing for all department heads. The facility began a system to ensure magnetic door locks would be checked shiftly, all audible alarms were checked routinely, and staff were educated on protective oversight and ensuring visual line of sight throughout the corridor. Centers for Medicare and Medicaid (CMS) imposed a temporary manager remedy at the facility effective 07/19/24. The temporary manager reviewed and verified on 07/19/24, the removal plans were initiated, and on-going. Review of the facility's policy titled, Elopements and Wandering Residents, dated 06/12/24, showed: - Elopement occurs when a resident leaves the premises or a safe area without authorization and/or supervision; - The facility is equipped with door locks/alarms to help avoid elopements; - Alarms are not replacement for necessary supervision; - The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness. 1. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 06/05/24, showed: - The resident had a diagnosis of traumatic brain dysfunction (TBD - an injury to the brain causing a wide range of physical and psychological effects including adverse behaviors); - The resident was ambulatory; - Level of cognition not addressed; - No wandering behavior exhibited. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's plan of care, last updated on 07/12/24, showed: - Not identified as an elopement risk; - Impulse control issues; - A history of suicidal ideations; - A history of aggressive behavior towards staff and other residents; - Diagnoses of impulse disorder (a failure to resist temptation, an urge or an impulse) and paranoid schizophrenia disorder (a mental health condition that affects how people think and behave); - Coping skills of smoking, talking with staff, walking outside, coloring, being offered a snack, particularly candy. Review of the resident's Pre-Admission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals who have a mental disorder are not inappropriately placed in nursing homes for long term care), dated 01/19/23, showed: - A history of aggressive behaviors; - Would just walk away when angry or upset; - Attempted to elope from the psychiatric unit; - Believed that he/she had a bad demon in his/her head; - Became anxious and would self harm. Review of the resident's nursing note, dated 07/11/24, showed: - Resided on a secured unit and exhibited delusional, paranoid behaviors which was out of his/her baseline behavior; - Shut him/herself in the shower and was yelling loudly; - Was unable to be redirected; - Told staff he/she felt like a monster and continued talking/yelling; - An as needed (PRN) medication was given at the time for delusional behaviors and agitation; - Continued yelling and became angrier; - Was transported to the emergency room and returned later to the facility after he/she had calmed down. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's investigation report, dated 07/12/24, showed: - On 07/12/24 at 5:01 P.M., the staff reported to the Assistant Director of Nursing (ADON), that while addressing the needs of the other residents on the 600 Hall secured unit, Resident #3 left the hallway. The staff noticed the locked and alarmed door to the gate on the courtyard was open. They started a head count and concluded Resident #3 was missing. They immediately called for a Code [NAME] (a term used by the facility to alert staff of a missing resident) and notified the ADON and Administrator. All staff started to search and the resident was located within 15 minutes at approximately two blocks from the facility. During an interview on 07/15/24 at 12:10 P.M., the Administrator said Resident #3 waited for the shift change to occur at 7:00 P.M., on 07/12/24. The resident exited the back door of the 600 Hall secured unit and repeatedly kicked the door lock on the courtyard gate until the door loosened and he/she exited the courtyard. The resident was located within a few minutes and was a couple blocks away walking back to the facility. During an interview on 07/15/24 at 12:30 P.M. Resident #3 said staff did not listen to him/her when he/she told them he/she needed to calm down. He/She asked to go for a walk repeatedly prior to leaving the facility, but the staff would not help the resident. The staff were always on their phones. The resident said he/she had anxiety and they wouldn't help him/her. The resident said he/she got out and would attempt to do it again. The resident could not say what time the elopement had been, but it was shift change from the day to evening staff. The staff were helping the other residents make cups of noodles in the microwave, so he/she used the opportunity to leave. He/She was able to kick the lock on the door until it gave way and he/she exited. During an interview on 07/15/24 at 12:50 P.M., the ADON said the resident had told the staff he/she wanted to go for a walk. She was not sure why the resident was not taken outside at that time. The resident was known to like to walk outside and had been outside earlier with staff and other residents and walked around the facility. On 07/16/24 at 10:45 A.M., the ADON said the staff had been helping other residents on 07/12/24, by cooking noodles in the microwave and getting sodas for those with cash from the front lobby. The microwave was located on the 600 Hall secured unit about midway down the hall. The exit door on the hall was left unlocked for the residents to come and go outside when they wanted. The staff did go outside if the residents went out. She did not believe staff was required to always monitor the exit door, just during smoke breaks. She thought it had been around 6:00 P.M., when the resident exited the building and the evening shift starts at 7:00 P.M., on 07/12/24. During an interview on 07/16/24 at 2:45 P.M., the Maintenance Supervisor (MS) said the magnetic locks were checked daily on all the exit doors, including the door/gate the resident exited through. The magnetic lock on 600 Hall secured unit door that Resident #3 went out of was compromised and no longer worked. Resident #3 said he/she kicked the door until it opened. That door/gate also had an audible alarm box which should have sounded and would have alerted staff immediately, but the alarm had been turned off. The MS did not know how or when the alarm had been turned off. During an interview on 07/16/24 at 3:50 P.M., Certified Nurse Aide (CNA) B said there was always supposed to be one staff member that monitored the front of the 600 Hall and one staff member that monitored the back of the hall by the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/16/24 at 3:55 P.M., CNA C said if a resident went out the back door on the 600 Hall, staff was supposed to go out and sit until all the residents came back in. The staff were always supposed to monitor the back door area to make sure a resident did not go outside alone. During an interview on 07/16/24 at 4:00 P.M., CNA D said staff were always supposed to monitor the back door on the 600 Hall to watch and see if the residents went outside. During an interview on 07/16/24 at 4:35 P.M., Licensed Practical Nurse (LPN) A said on the day shift of 07/12/24, he/she was in the nurses' office preparing for shift change and the night shift had not arrived. He/She was not aware of which staff were working on the 600 Hall or what the staff were doing at the time of the elopement. He/She believed the resident was missed prior to the evening shift coming on, but did not know what time the resident had exited the building. He/She believed staff were supposed to monitor the 600 Hall back exit door to make sure if residents went outside, staff went with them. During an interview on 07/16/24 at 4:45 P.M., CNA F said the resident eloped at the shift change on 07/12/24, but did not know the actual time or how long the resident had been gone. He/She was not sure what the staff were doing during the elopement. The evening shift entered the facility and the resident had already left. Complaint #MO238975