

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/18/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48247</b></p> <p>Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff when staff had a verbal altercation with one resident (Resident #1) out of three sampled residents. The staff member cursed at the resident and physically jerked the resident around in their wheelchair. The facility census was 46.</p> <p>Review of the facility's policy titled, Abuse, dated 08/01/22, showed:</p> <ul style="list-style-type: none"> <li>- Physical abuse includes hitting, slapping, pinching, kicking, or controlling behavior;</li> <li>- Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents and their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability;</li> <li>- The Human Resources department will ensure the facility does not employ individuals who: have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment; have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; have a disciplinary action in effect against their professional license by a state licensure body from a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of property.</li> </ul> <p>1. Review of Resident #1's face sheet showed:</p> <ul style="list-style-type: none"> <li>- The resident was admitted on [DATE];</li> <li>- Diagnoses of schizophrenia (a mental disorder affecting thinking, feeling and behavior), bipolar-manic (chronic mood disorder involving excessively heightened mood and behavior), traumatic brain dysfunction (injury to the brain caused by external force), moderate protein calorie malnutrition (imbalance of essential nutrients in the body), hypertension (high blood pressure), and diabetes mellitus II (condition of high blood sugar in the blood).</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the staff), dated 3/30/24, showed the resident was cognitively intact.</p> <p>Review of the facility's investigation, dated 09/05/24, showed:</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 09/05/24 at approximately 3:40 P.M., the Administrator heard a verbal altercation in the dining room/courtyard area. The Administrator observed Dietary Staff A and Resident #1 having a verbal altercation. Resident #1 was upset Dietary Staff A did not give him/her a cigarette fast enough during the smoke break. The Administrator instructed Dietary Staff A to walk away from the situation. Dietary Staff A walked through the door to the dining room and went back into the kitchen. The Administrator exited the area. Less than a minute later, the Administrator heard Dietary Staff A and Resident #1 arguing again. The Administrator entered the dining room and witnessed Dietary Staff A pull Resident #1's wheelchair backwards and then to the side using excessive force. The Administrator removed Dietary Staff A from the area and escorted him/her out of the building. The Administrator instructed Dietary Staff A not to return to the facility.</p> <p>Review of Dietary Staff A's personnel file showed:</p> <ul style="list-style-type: none"> <li>- Hire date of 06/29/24;</li> <li>- The facility's Abuse Inservice policy signed by Dietary Staff A, dated 07/11/24.</li> </ul> <p>During a telephone interview on 09/18/24 at 12:58 P.M., CNA C said he/she was in the dirty utility room on the 300/400 Hall when an unknown male resident reported that Dietary Staff A and Resident #1 had gotten into an argument and Dietary Staff A had gone off on Resident #1. CNA B saw Dietary Staff A walking down towards the dining room saying loudly, I'm never smoking another [expletive] ever again. Resident #1 mouthed something to Dietary Staff A in the dining room then Dietary Staff A lost it and started fast walking towards Resident #1. Dietary Staff A said to Resident #1, [Expletive] you [expletive], get me, [expletive] fight me, you can't do anything. Dietary Staff A used arm gestures and cursed Resident #1. Dietary Staff A and Resident #1 were yelling face to face at each other. Dietary Staff A placed his/her hands on Resident #1's wheelchair handles, pushed it off the ground from facing the door to facing the hallway, pushed the wheelchair back and to the side. Dietary Staff A stormed out of the dining room towards the Administrator's office. Resident #1 was mad and cursing at Dietary Staff A. CNA B went to get help.</p> <p>During a telephone interview on 09/18/24 at 1:05 P.M., CNA D said he/she witnessed Dietary Staff A get angry with Resident #1. As Dietary Staff A went into the dining room, he/she started yelling at Resident #1. Dietary Staff A yelled, Do something about it nigger. Right after, Dietary Staff A angrily went up to Resident #1's wheelchair, picked it up a little off the ground and jerked it roughly pulling him/her around 180 degrees by the wheelchair handles.</p> <p>During an interview on 09/18/24 at 1:15 P.M., Resident #1 said he/she went outside to smoke on 09/05/24. He/She asked for his/her cigarettes and Dietary Staff A took too long to pass them out to everyone. Resident #1 asked for his/her cigarettes and Dietary Staff A started cussing him/her. Dietary Staff A left and went into the dining room. When Resident #1 went into the dining room, Dietary Staff A said, [Expletive], you better shut up talking to me like that. Dietary Staff A grabbed Resident #1's wheelchair, jerked it hard and spun it around. Resident #1 told Dietary Staff A to calm down and Dietary Staff A said, No. Resident #1 said, Do you have a beef with me? Dietary Staff A went crazy cussing him/her in front of everyone and said what he/she would and wouldn't do. Resident #1 said he/she was mad and did not understand why Dietary Staff A treated him/her that way.</p> <p>(continued on next page)</p>		

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<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 09/18/24 at 1:25 P.M., the Administrator said she would expect all staff to follow policies on abuse, neglect, exploitation and misappropriation. Dietary Staff A was terminated on 09/05/24, following the incident.</p> <p>Complaint #MO241832</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>48247</p> <p>Based on interview and record review, the facility failed to ensure the Nurse Aide (NA) Registry was checked prior to hire to ensure the employee did not have a Federal Indicator (a marker given by the federal government to individuals who have committed abuse/neglect) for five employees (Dietary Staff A, Registered Nurse (RN) F, Activity Director G, Housekeeping Supervisor H, Maintenance Supervisor I) out of seven sampled employees. The facility's census was 46.</p> <p>Review of the facility's policy titled, Hiring, revised January 2008, showed:</p> <ul style="list-style-type: none"> <li>- The Human Resources (HR) Director will conduct any applicable investigations and determine whether the applicant is legally eligible to work in the United States and what appropriate background investigations may be conducted on persons making application of employment with the facility and on current employees;</li> <li>- Within 10 days of hire, recall, or rehire, the HR Director will provide the following information to the state new hire directory for each newly hired, recalled, or rehired employee: employee's name, employee's address, employee's social security number, employer's name, employer's address, and employer's federal employment identification number;</li> </ul> <p>1. Review of Dietary Staff A's personnel record showed:</p> <ul style="list-style-type: none"> <li>- Hire date of 06/29/24;</li> <li>- No documentation of NA Registry was checked prior to hire.</li> </ul> <p>2. Record review of RN F's personnel record showed:</p> <ul style="list-style-type: none"> <li>- Hire date of 08/25/23;</li> <li>- No documentation the NA Registry was checked prior to hire.</li> </ul> <p>3. Record review of Activity Director G's personnel record showed:</p> <ul style="list-style-type: none"> <li>- Hire date of 12/15/23;</li> <li>- No documentation the NA Registry was checked prior to hire.</li> </ul> <p>4. Record review of Housekeeping Supervisor H's personnel record showed:</p> <ul style="list-style-type: none"> <li>- Hire date of 06/14/23;</li> <li>- No documentation the NA Registry was checked prior to hire.</li> </ul> <p>5. Review of Maintenance Supervisor I's personnel record showed:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Hire date of 06/10/24;</p> <p>- No documentation of NA Registry was checked prior to hire.</p> <p>During an interview on 9/19/24 at 1:40 P.M., the Administrator said NA Registry checks should be completed on any new employee before they were hired and repeated quarterly.</p>