STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26E084	A. BUILDING _____ B. WING _____	05/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MYERS NURSING & CONVALESCENT CENTER	2315 WALROND AVENUE KANSAS CITY, MO 64127

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident was safe from verbal abuse when a staff member cussed and threatened the resident while in the facility, out of three sampled residents. The facility census was 63 residents. Record review of the facility's Abuse and Neglect policy and procedure updated 2016, showed the purpose was to ensure the resident's rights are respected. These rights protect the resident from physical and mental abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for the purpose of discipline or convenience of staff. All employees of the facility are considered staff. Also to ensure each resident is treated with dignity and care, free from abuse and neglect and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect. The policy showed: -The definition of verbal abuse was any use of oral, written or gestured language that willingly includes any disparaging terms to residents or their families, or within hearing distance regardless of their age, ability to comprehend or disability. Examples of verbal abuse include but are not limited to: threats of harm, saying things to frighten a resident. Emotional/psychological abuse is the verbal or non-verbal infliction of anguish, pain or distress that results in mental or emotional suffering that includes demeaning statements, harassment, threats, insults, humiliation and intimidation. -The facility is responsible to prevent not only abuse, but also those practices and omission, neglect and misappropriation that may lead to abuse without thorough investigation. -All suspicious crime including abuse, neglect .shall be reported to the Administrator immediately. -All suspected incidents must be investigated immediately. -Employees who are involved with the suspect shall be suspended or terminated immediately. Employees who are involved with the incident shall be suspended upon investigation -All suspicious crime including abuse and neglect must be reported to the law enforcement agency and/or the state surveyor agency in a timely manner. -Procedure: Anything that appears remotely suspicious should be reported immediately including all unexplained incidents of physical or verbal abuse. -Time frame for individual reporting is: if the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion. If the events that cause reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion. 1. Record review of Resident #1's Face Sheet showed he/she was admitted to the facility on [DATE], with diabetes, high blood pressure, depression, [MEDICAL CONDITION] (irregular heartbeat) and [MEDICAL CONDITION] (blood clots usually in the thigh and lower leg). Record review of the resident's Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 4/8/20, showed he/she: -Was alert and oriented and had no cognitive issues. -Was independent with transfers, mobility, bathing, dressing, toileting, grooming and used a wheelchair for mobility. -Did not have any mood or behavioral issues. Record review of the resident's Nursing Notes from 5/24/20 to 5/27/20, showed there were no nursing notes showing he/she had any behavioral issues and there was no documentation of the incident. Record review of the resident's Summary of Investigation dated 5/28/20, showed: -On 5/26/20, Resident #1 reported that on 5/24/20 he/she had bumped the leg of Licensed Practical Nurse (LPN) A around lunch time. -LPN A cursed at the resident and threatened to 'go to his/her trunk to get something to take care of him/her.' The resident said he/she cursed LPN back and expressed anger resulting from the incident. -The resident had no injuries and nor did LPN A. -The incident was witnessed by another resident (Resident #2) who was interviewed and concurred Resident #1's report. -LPN A was very apologetic and upon interview about what happened, he/she said that he/she, 'pleaded the fifth and did not want to incriminate himself/herself.' -The resident has a history of annoying staff. -Conclusion showed LPN A did in fact threaten Resident #1 and used profane language to (him/her). -Interventions were to continue to observe for any concerning issues and encourage the resident to report them, notify the Department of Health and Senior Services. LPN was suspended on 5/28/20 and terminated on 5/29/20. Record review of LPN A's criminal background screening (to include the Criminal Background Check, Employee Disqualification List and Nurse Aide Registry check) showed there were no prior allegations of abuse or neglect and no prior substantiation of abuse or neglect that would disqualify LPN A for employment. Record review of the resident's employee documentation did not show any disciplinary actions. Observation and interview on 5/30/20 at 10:17 AM, showed the resident was alert and oriented and sitting in his/her wheelchair in his/her room. The resident said: -On Sunday 5/24/20 right after lunch (around 1:00 PM to 1:30 PM) he/she was going backward in his/her wheelchair toward the medication cart (because he/she can only mobilize himself/herself backwards in his/her wheelchair) to obtain his/her medication when he/she bumped his/her wheelchair into LPN A's leg. -LPN A was very angry and began to cuss and said, why don't you go forward. He/she said when he/she told LPN A that he/she could only mobilize backwards in his/her wheelchair, LPN A continued to cuss and called him/her names, like fat son of a derogatory name. -He/she called LPN A a a derogatory name. -LPN A then said he/she would go out to his/her trunk to get something to shut me up and then LPN A walked away. -LPN A did not approach the resident again after that altercation and he/she had no further interaction with LPN A that day. -He/she reported the incident to the Social Service Designee on 5/26/20, because he/she was unable to talk with the Administrator at the time. -He/she was angry but was not afraid of remaining in the facility. He/she said that he/she only saw LPN A again on Thursday 5/28/20, when the Administrator brought him/her, Resident #2 and LPN A into his/her office to discuss the altercation. -During the meeting, LPN A did not say anything and the Administrator said that LPN wanted to apologize for cussing and threatening him/her, but he/she refused to accept LPN's apology. -He/she had not seen LPN A since their meeting with the Administrator. -Resident #2 had discharged from the facility, but there was another witness to incident, Resident #3, who was sitting next to him/her when the incident occurred and there was also a staff who witnessed it. Observation and interview on 5/30/20 at 10:40 AM, Resident #3 was sitting in his/her specialized wheelchair by the nursing station. He/she was alert and oriented and said: -After lunch on 5/24/20, he/she was sitting by the nursing station, LPN A was standing at the medication cart (which was by the nursing station desk) and Resident #1 was wheeling backwards toward the medication cart. -He/she saw the resident accidentally back into LPN A's leg and LPN A immediately became angry and began to cuss. -LPN A said he/she was pissed and then Resident #1 became angry and cussed at LPN A. -LPN A then said that he/she was going to go to his/her car and pop (his/her) trunk, like he/she was going to get something to harm the resident. -He/she was surprised that LPN A said this, and LPN A was very angry, but he/she did not do anything to the resident and walked away. -He/she thought LPN A was very upset about Resident #1 bumping into him/her, but he/she did not think he/she would do anything to the resident, he/she was just angry. -LPN A was wrong to speak to the resident like that. --Record review of Resident#3's quarterly MDS dated [DATE], showed he/she was cognitively intact without any memory problems. During an interview on 5/30/20 at 11:11 AM, Certified Nursing Assistant (CNA) A said: -He/she was sitting at the nursing station on 5/24/20 at the time of the incident between Resident #1 and LPN A. -They had just finished lunch and LPN

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

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.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) A was standing at the medication cart passing medications. Resident #1 was wheeling backwards out of the dining room back onto the unit. -LPN A stated to Resident #1 several times that he/she needed to watch where he/she was going because there were people behind him/her. -Resident #1 said he/she did not care and continue to wheel backwards. -Resident #1, as he/she got closer to the medication cart, wheeled over LPN A's foot. -LPN A said, damn, and pushed the resident's wheelchair off of his/her foot and told the resident he/she told the resident to stop backing up in his/her wheelchair. -Resident #1 then called LPN A a a derogatory name. -He/she did not hear LPN A threaten the resident or say he/she was going to get anything from his/her trunk. -He/she saw LPN A walk away from the resident and he/she went over to the south unit. -He/she told the resident that he/she could not continue to call the nurse names and the resident continued to talk about the incident with Resident #3 and then he/she went over to the south unit, to antagonize LPN A, but staff redirected him/her back to the north unit (where he/she lived). -He/she thought the resident deliberately backed into LPN A and the resident has a history of antagonizing staff. -Resident #2 was one of the residents at the nursing station, but was discharged from the facility on 5/29/20. -It was too bad that LPN A was terminated because he/she was a good nurse. During an interview on 5/30/20 at 11:30 AM LPN B said: -He/she was not working on the day the incident occurred. -On 5/25/20 when he/she returned to work, the resident told him/her that he/she wanted to report an incident regarding LPN A and he/she told the resident to report it to the Administrator. -He/she found out the allegations against LPN A and was aware that LPN A was no longer working at the facility. During a telephone interview on 5/30/20 at 11:29 AM, the Administrator said: -On 5/26/20, he/she was informed that on 5/24/20, LPN A had allegedly cussed at Resident #1 and threatened him/her after he/she bumped into his/her leg. -He/she spoke to LPN A and he/she said he/she pleaded the Fifth Amendment, did not want to incriminate himself/herself and did not answer any questions regarding whether he/she cussed or threatened the resident. -On Thursday 5/28/20, he/she called LPN A, Resident #1 and Resident #2 into his/her office to discuss the situation and both Resident #1 and Resident #2 said that LPN A cussed at Resident #1 and threatened him/her, and LPN did not deny that this occurred but he/she apologized to Resident #1. -Resident #1 refused to accept LPN A's apology. -Upon his/her investigation, he/she found that LPN A cussed and threatened the resident. He/she suspended LPN A on 5/28/20 and terminated him/her on 5/29/20. During an interview on 6/2/20 at 10:35 AM the Social Service Director said: -Resident #1 reported to him/her on 5/26/20, that on 5/24/20, he/she was backing up in his/her wheelchair and accidentally bumped his/her wheelchair into LPN A. LPN A began cussing at the resident and he/she cussed back at LPN A. -He/she did not remember if the resident said that LPN A threatened him/her. -He/she also spoke with Resident #2, who was a witness and said the allegations were true and LPN A had become angry and cussed at Resident #1. -He/she documented the complaint and reported it to the Administrator on 5/26/20. During an interview on 6/2/20 at 11:19 AM, Resident #2 said: -He/She did not remember the date, but on the weekend, he/she was at the nursing station and Resident #1 was wheeling backward in his/her wheelchair and accidentally wheeled into LPN A (who was at the medication cart). -LPN A began to cuss and called Resident #1 a fat derogatory name, and Resident #1 called LPN A a a derogatory name and LPN A said that he/she was going to go and get something from his/her trunk to shut him/her up. -He/she did not see LPN A go get anything or do anything to the resident. -He/she thought it was very inappropriate. -He/she and Resident #1 reported the incident to the Social Service Worker, but he/she did not remember the date. -He/she, Resident #1 and LPN A met with the Administrator about the incident and he/she reported what he/she saw and heard. LPN A tried to apologize to the resident, but the resident would not accept LPN A's apology. -Record review of Resident#2's quarterly MDS dated [DATE] showed he/she was cognitively intact without any memory problems. During an interview on 6/8/20 at 6:30 AM, LPN A said: -On the date of the alleged incident, Resident #1 was wheeling himself/herself backwards in his/her wheelchair towards him/her. -He/she told Resident #1 that he/she needed to watch out because there were other people in the area and so he/she would not back into anyone. -Resident #1 did not listen and continued to wheel backwards, eventually backing his/her wheelchair into him/her. -He/she became angry and began to cuss because it hurt. -The resident began to cuss at him/her also. -He/she asked the resident why he/she would not just go forward in his/her wheelchair. -He/she did not threaten the resident, but he/she did cuss at the resident and was wrong for doing that. -He/she tried to apologize but the resident did not accept his/her apology. -He/she was suspended and then terminated due to the incident. -He/she again stated he/she heard that the resident said that he/she had threatened him/her, but he/she never made any threat of harm to the resident. MO 778
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** Based on observation, interview and record review, the facility failed to report allegations of verbal abuse to the state survey agency in a timely manner for one sampled resident (Resident #1). The facility census was 63 residents. Record review of the facility's Abuse and Neglect policy and procedure updated 2016, showed the purpose was to ensure the resident's rights are respected. These rights protect the resident from physical and mental abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for the purpose of discipline or convenience of staff. All employees of the facility are considered staff. Also to ensure each resident is treated with dignity and care, free from abuse and neglect and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect. The policy showed: -All suspicious crime including abuse, neglect .shall be reported to the Administrator immediately. -All suspected incidents must be investigated immediately. -Employees who are involved with the suspect shall be suspended or terminated immediately. -Employees who are involved with the incident shall be suspended upon investigation. -All suspicious crime including abuse and neglect must be reported to the law enforcement agency and/or the state surveyor agency in a timely manner. -Time frame for individual reporting: if the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion. If the events that cause reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion. 1. Record review of Resident #1's Face Sheet showed he/she was admitted to the facility on [DATE], with diabetes, high blood pressure, depression, [MEDICAL CONDITION] (irregular heartbeat) and [MEDICAL CONDITION] (blood clots usually in the thigh and lower leg). Record review of the resident's Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 4/8/20, showed he/she: -Was alert and oriented and had no cognitive issues. -Was independent with transfers, mobility, bathing, dressing, toileting, grooming and used a wheelchair for mobility. -Did not have any mood or behavioral issues. Record review of the resident's Nursing Notes from 5/24/20 to 5/27/20, showed there were no nursing notes showing he/she had any behavioral issues and there was no documentation of the incident. Record review of the resident's Medical Record showed there were no Social Service Notes regarding the incident in the resident's medical record. Record review of the resident's Summary of Investigation dated 5/28/20, showed: -On 5/26/20, Resident #1 reported that on 5/24/20 he/she had bumped the leg of Licensed Practical Nurse (LPN) A around lunch time. LPN A cursed at the resident and threatened to 'go to his/her trunk to get something to take care of him/her.' The resident said he/she cursed LPN back and expressed anger resulting from the incident. -The resident had no injuries and nor did LPN A. -The incident was witnessed by another resident who was interviewed and concurred Resident #1's report. -The Conclusion showed LPN A did in fact threaten Resident #1 and used profane language to (him/her). -Interventions were to continue to observe for any concerning issues and encourage the resident to report them, and to notify the Department of Health and Senior Services. LPN was suspended on 5/28/20 and terminated on 5/29/20. There was no documentation showing when the Administrator notified the Department of Health and Senior Services (state agency). Observation and interview on 5/30/20 at 10:17 AM, showed the resident was alert and oriented and sitting in his/her wheelchair in his/her room. The resident said: -On Sunday 5/24/20 right after lunch (around 1:00 PM to 1:30 PM) he/she was going backward in his/her wheelchair toward the medication cart (because he/she can only mobilize himself/herself backwards in his/her wheelchair) to obtain his/her medication when he/she bumped his/her wheelchair into LPN A's leg. -LPN A was very angry and began to cuss and called him/her names, and he/she cussed at LPN A. LPN A then threatened to go out to his/her trunk to get something to shut me up and then LPN A walked away. -He/she reported the incident to the Social Service Designee on 5/26/20, because he/she was unable to talk with the Administrator at the time. -He/she was angry but was not afraid of remaining in the facility. He/she said that he/she only saw LPN A again on Thursday 5/28/20, when the Administrator brought him/her, Resident #2 and LPN A into his/her office to discuss the altercation. During a telephone interview on 5/30/20 at 11:29 AM, the Administrator said: -On 5/26/20, he/she was informed that on 5/24/20, LPN A had allegedly cussed at Resident #1 and

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) threatened him/her after the resident bumped into his/her leg with his/her wheelchair. -LPN A was a part time employee and did not work again until Thursday 5/28/20. -On Thursday 5/28/20, he/she called LPN A, Resident #1 and Resident #2 into his/her office to discuss the situation and both Resident #1 and Resident #2 said that LPN A cussed at Resident #1 and threatened him/her, and LPN did not deny that this occurred but he/she apologized to Resident #1. Resident #1 refused to accept LPN A's apology. -Upon his/her investigation, he/she found that LPN A cussed and threatened the resident. He/she suspended LPN A on 5/28/20 and terminated him/her on 5/29/20. -He/she reported the incident to the state survey agency on 5/29/20. -He/she waited to report the allegations because LPN A was a part-time employee, was not scheduled to work again until 5/28/20 (and had no access to the resident from 5/24/20 to 5/28/20) and he/she had not completed the investigation. -He/she was aware of the guidelines regarding the timeframe's for reporting abuse/neglect, but thought he/she was within the timeframe for reporting. During an interview on 5/30/20 at 11:30 AM LPN B said: -He/she was not working on the day the incident occurred. -On 5/25/20 when he/she returned to work, the resident told him/her that he/she wanted to report an incident regarding LPN A and he/she told the resident to report it to the Administrator. -He/she found out the allegations against LPN A and was aware that LPN A was no longer working at the facility. During an interview on 6/2/20 at 10:35 AM, the Social Service Director said: -Resident #1 reported to him/her on 5/26/20, that on 5/24/20, he/she was backing up in his/her wheelchair and accidentally bumped his/her wheelchair into LPN A. LPN A began cussing at the resident and he/she cussed back at LPN A. -He/she documented the complaint and reported it to the Administrator on 5/26/20. MO 778