STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265539	A. BUILDING _____ B. WING _____	03/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLWIN RIDGE HEALTH & REHABILITATION	1441 CHARIC DRIVE WILDWOOD, MO 63021

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat a resident (Resident #1) with respect and dignity when staff transferred him/her out of bed when he/she did not want to get up, for one of three sampled residents. The census was 52. Review of the Resident #1's medical record, showed the following: -admitted [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/14/19, showed the following: -Able to express ideas and wants; -Clear comprehension; -Brief Interview for Mental Status (BIMS, a screening tool used to determine cognitive impairment), score of 11 out of 15 (moderate cognitive impairment); Review of the resident's individualized care plan, dated 3/20/20, showed the following: -Focus: Shows little or no activity involvement related to disinterest. Resident wishes not to participate in most activities. He/she enjoys watching television and laying in his/her bed; -Goal: The resident will express satisfaction with type of activities and level of activity through next review date; -Interventions: Resident prefers to socialize with staff members. Encourage the resident's participation by inviting him/her often. The resident's preferred activities are watching television in his/her room; -Focus: Resident has limited physical mobility related to disease process. Dependent on two staff with the use of a Hoyer lift (full body lift) for all transfers. Resident does not want to get out of bed most times and has to be encouraged by staff; -Goal: Will remain free of complications related to immobility, including contractures, skin-breakdown and fall related injuries through the next review date; -Interventions: Provide gentle range of motion as tolerated with daily care; -Focus: Resident has alteration in hematological (diseases related to blood) status, related to use/side effects of medication; -Goal: Will remain free of complications related to altered hematological status through next review date; -Interventions: Use extreme caution when providing care. Ensure his/her arms and legs are not in the way of being bumped. Do not apply direct pressure to his/her skin as he/she is more prone to receiving bruises; -Focus: Resident has depression and anxiety related to disease process and losing independence. He/she refuses to do things he/she can do for him/herself and insists staff wait on him/her for things he/she is capable of doing. When asked why he/she does not do things him/herself, he/she said he/she is sick and has 27 things wrong with him/her. He/she refused to get up out of bed almost every day. He/she will lay in his/her room and focus on things wrong with him/her and ask the nurse to call the doctor and have certain medications ordered; -Goal: Will exhibit indicators of depression, anxiety or sad mood less than daily by review date; -Interventions: Encourage resident to get up out of bed. Explain that different environment might make him/her feel better. Observation and interview on 3/20/20 at 2:20 P.M., showed the resident lay in bed, on his/her back. A wheelchair with no cushion, sat next to the bed. The resident said certified nurse's aide (CNA) C came into his/her room that morning to get him/her up. The resident knew he/she was there to get him/her up because it had happened a week before. On 3/16/20, the CNA came in his/her room and told him/her, he/she was going to get the resident up. The resident told the CNA he/she did not want to get up as he/she was in pain. The CNA began to push and throw him/her around trying to turn him/her on his/her side to attach the Hoyer lift sling. The CNA pushed hard on his/her shoulder causing him/her pain. The CNA put him/her in the Hoyer lift and then transferred him/her to the wheelchair. The resident does not like to sit in the wheelchair because it is missing a piece and it feels like sitting on raw nerves. The resident told licensed practical nurse (LPN) B what happened, and he/she told the resident he/she would report it to management and the resident would not have to work with CNA C again. On 3/20/20, CNA C came into his/her room, and the resident felt sick to his/her stomach because he/she knew the CNA was going to make him/her get up again. The CNA asked him/her why he/she was on his/her light so much. This upset the resident as he/she is at the facility because he/she needs help. He/she told the CNA he/she was not going to get up, and the CNA told him/her, yes he/she was going to get up and get his/her hair done. He/she forced the resident get up and sit in his/her wheelchair for hours. The resident felt like he/she was a joke to the CNA when he/she was suffering. After the resident came out of his/her room, he/she felt like everyone looked at him/her like he/she was in the [MEDICATION NAME], and it was humiliating. During an interview on 3/20/20 at 3:10 P.M., LPN B said on 3/16/20, he/she told CNA C not to get the resident out of bed because he/she was in pain, and the LPN had just given him/her a pain pill. He/she heard the CNA tell the resident since you are on your call light all night long, you can expect to be getting up every morning regardless. The CNA went in and got the resident up against his/her wishes. The LPN reported the incident to the assistant Director of Nursing (DON) before he/she left that morning and the assistant DON said he/she would investigate the incident. The LPN was shocked when he/she got an email from another staff member on 3/20/20 that CNA C got the resident up again. During an interview on 3/20/20 at 3:30 P.M., the assistant DON said on 3/16/20, she told LPN B, she was surprised to see the resident up as he/she usually refused to get up in the morning. The LPN told her, he/she did not think the resident wanted to get up. When the assistant DON saw the resident, he/she did not complain about getting out of bed or being in pain. She did not investigate the situation any further because he/she did not know the resident did not want to get up. Staff sent her a text message the night before (night shift from 3/19-3/20/20) regarding CNA C removing the resident's call light and putting it on the floor. She was surprised when she arrived at work on 3/20/20, and the resident was up in his/her wheelchair again. The resident told the assistant DON, he/she was tired and sore from the Hoyer lift that morning. He/she did not make a complaint about being made to get out of bed so the assistant DON did not investigate any further. Staff should have reported the incident to her if they felt like the resident was being made to do something he/she did not want to do. During an interview on 3/20/20 at 5:30 P.M., CNA D said on 3/16/20, the resident was on his/her light all night. CNA C had to keep going to his/her room and answer the light. CNA C made the comment that he/she was going to fix the resident and get him/her up in the morning. LPN B told CNA C not to get the resident up because he/she did not want to get up and complained about being in pain. CNA C went to the DON and asked for permission to get the resident up anyway. CNA C asked CNA D for assistance getting the resident up since he/she required a Hoyer lift. CNA C went into the room and told the resident he/she was going to teach him/her about ringing his/her call light all night. The resident told the CNA he/she did not want to get up. On 3/20/20 around 6:00 A.M., when he/she walked past the resident's room, he/she heard the resident yell, Put me down, I don't want to get up. He/she reported this to registered nurse (RN) A. During an interview on 3/21/20 at 6:00 A.M., RN A said CNA D did tell him/her that the resident did not want to get up on 3/20/20 and was upset with CNA C. He/she did not say anything because when he/she saw the resident, he/she did not complain about the CNA or being made to get up. During interviews on 3/20/20 at 4:00 P.M. and at 6:00 P.M., the DON said CNA C came to her on 3/16/20 and told her, he/she got the resident out of bed. The CNA did not mention the resident did not want to get out of bed. When the DON saw the resident, he/she looked happy. On 3/20/20, the DON was shocked to hear the resident got out of bed. The resident did later tell her, he/she was not happy being up and hoped everyone got a good look at him/her. No one told the DON the resident did not want to get out of bed that morning or that staff made him/her get up. CNA C overstepped

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) his/her bounds if the resident did not want to get up. During an interview on 3/20/20 at 6:05 P.M., the administrator said she did not know the resident was upset about being transferred out of bed. She was surprised to see him/her up on 3/16/20 and 3/20/20 because he/she usually refused to get up. Staff should have reported the incident if they felt like the resident was forced to get up. The resident could be confused at times and would change his/her stories. The resident never complained to her about the incidents. Staff should not have got the resident up if he/she did not want to get up. MO 139