STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265565	A. BUILDING _____ B. WING _____	05/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLEASANT HILL HEALTH AND REHABILITATION CENTER	1300 BROADWAY PLEASANT HILL, MO 64080

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 interview and record review, the facility failed to keep one sampled resident free from verbal abuse when a staff member threatened a resident (Resident #2) out of three sampled residents. The facility census was 70 residents. The Administrator was notified on 5/12/20 of the Past Non-Compliance which occurred 5/6/20. Facility staff notified the Department of Health and Senior Services (DHSS) and local law enforcement. Facility staff conducted an investigation and inserviced facility staff related to facility policy on abuse, neglect and misappropriation of property. The noncompliance was corrected on 5/7/20. Record review of the facility's policy and procedure titled, Abuse, Neglect, Misappropriation of Resident/Guest property, Suspicious Injuries of Unknown Source, Exploitation, dated 11/28/17 showed: -Abuse encompasses a broad scope of behavior. -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Verbal abuse is the use of oral, written or gestured communication or sounds that include disparaging and derogatory terms to resident/guest(s) or their families/representatives, or within their hearing distance, regardless of their ages, abilities to comprehend, or the nature of their disabilities. -Examples of verbal abuse could include, but are not limited to: threatening to hurt and saying things to frighten a resident/guest, such as telling a resident/guest that he/she will never be able to see his/her family again; using profanity to a resident/guest, blaming the resident/guest for their condition and employee altercations in front of a resident/guest, mocking, insulting or ridiculing the resident/guest are also examples that could be abuse. 1. Record review of Resident #2 facility face sheet showed he/she admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. -Dorsalgia (physical pain occurring anywhere on the spine or back ranging from mild to disabling). -[MEDICAL CONDITION] disorder (a mental health condition including [MEDICAL CONDITION] and mood disorder symptoms). -[MEDICAL CONDITION]. -Contractures of the muscle left and right hand (a condition of shortening and hardening of muscles, tendons or other tissue). Record review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment tool used by facilities for care planning), dated 5/6/20, showed his/her Brief Interview of Mental Status (BIMS) was a score of 13, and had a intact cognitive response. Record review of the resident's care plan dated 3/31/20 showed: -He/she had episodes of tearfulness and crying. -He/she was observed for changes in psychosocial well-being. -He/She required assistance with bathing, dressing and incontinence care. -He/She required set up help only for meals. Record review of the facility's investigation dated 5/6/20 showed: -Resident #2 was exhibiting behaviors and threatening staff with harm. -Certified Nursing Assistant (CNA) B, stated to Resident #2, if he/she hits him/her, he/she will flat line him/her. -This statement was said in front of two other staff members and CNA B was immediately removed from the situation and sent home. -There was no physical contact between CNA B and Resident #2. -Administrator interviewed Resident #2 on 5/6/20 at 3:30 P.M. -Resident shared that he/she wanted to go outside to sit by the door with the outside light on, but Licensed Practical Nurse (LPN) A was preventing him/her from doing so. -Resident stated that CNA B began to interject his/her thoughts and was yelling across the day room at him/her, stating, to go ahead and spit or put your hands on him/her, he/she is going to jail tonight, say another thing mother [***] and he/she gonna show him/her why he/she lives here, we are the mother [***] ing law up in the [***] and we can make his/her life real hard, and we are the ones who change his/her ass he/she will drop your mother [***] ing ass on the floor. -Resident shared that he/she felt verbally attacked. -Resident states that he/she was never alone with CNA B and that he/she was just getting to know him/her and that he/she was pleasant and smiled all the time, so he/she was not sure why the switch flipped. -Resident stated that CNA B was never near him/her, he/she was standing about 25-30 feet away. -Resident admitted that he/she was saying he/she was going to hit staff and spit on them. -Resident states no other residents were around during the event. -State Agency (SA) notified via online reporting on 5/6/20 at 4:41 P.M. -Physician notified on 5/6/20 at 5:00 P.M. -Resident is responsible for self, and did not want family notified. -Administrator interview with CNA B on 5/6/20 at 5:11 P.M., showed: --Resident #2 came out of his/her room and asked for a cigarette, was told he/she could not have a cigarette and resident got mad. --CNA B reported that he/she went to stand next to LPN A to be a witness because resident threatened to spit and hit staff. --CNA B reported that he/she never said the statements to the resident, but that he/she and CNA C were having a private conversation when he/she said some of the statements. --CNA B shared that they were discussing the challenges of being a CNA while outside smoking on their break. -Immediate resident protection was initiated, CNA B was removed from the situation and sent home. -CNA B employment has been terminated. Record review of the resident's progress notes dated 5/6/20 at 4:20 A.M., written by LPN A showed: -This nurse was asked to come up front due to the resident cursing at the staff and trying to set off the door alarms. -Upon approaching the front, noted the resident at the day room doors yelling and attempting to open the doors. -This nurse asked the resident was was going on? -Resident stated that he/she was going outside anytime he/she wanted. -He/She informed the resident that it was not safe for him/her to go outside alone in the dark. -Resident began cursing at this nurse and calling him/her a [***] . -He/She attempted to speak with the resident regarding safety. -Resident continued to become more agitated and attempted to strike this nurse. -This nurse stepped behind the resident to avoid being hit. -The resident started saying he/she was going to spit on the nurse as he propelled his/her wheelchair backwards until it was pressed against this nurse's foot. -Resident had his/her chair against this nurse with this nurse's back against the wall. -Resident began yelling at this nurse to get away from him/her while calling this nurse a [***] . -Informed the resident that he/she had this nurse against the wall. -Resident moved, but continued yelling. -Signed by LPN A. During an interview on 5/7/20 at 9:00 A.M., CNA B said: -He/she is so glad that SA called, because he/she wants to give his/her side of the story. -The employees always are the ones to get in trouble, and this resident was allowed to get away with everything. -He/she was talking to CNA C on the smoke break and complaining about the resident, and how hard it was to be a CNA with these residents. -He/she said, if you hit him/her, he/she will flat line you. -He/she said , he/she was going to jail tonight if the resident said another word. -He/she said, if the resident said another thing, mother [***] , he/she would show the resident why he/she lives here, we are the (derogatory word) law up in the [***] and we can make your life real hard. -He/she said, we are the ones who change your ass, he/she will drop your (derogatory word) ass on the floor. -CNA B denied stating the verbalizations to the resident. -CNA B confirmed the verbalizations were said to CNA C. -CNA B said that the statements were made to CNA C in the day room, with the resident several feet away. During an interview on 5/7/20 at 9:30 A.M., the Administrator said: -LPN A notified him/her of the incident on 5/6/20 at 4:08 A.M. -CNA B was removed from the situation and sent home. -He/she was new to the facility, just hired on 5/1/20. -He/she had completed orientation and was working with CNA C on the unit. During an interview on 5/7/20 at 9:55 A.M., CNA C said: -CNA B told the resident that he/she was going to flat line him/her and called him/her a mother [***] . -The resident heard everything that CNA B said about him/her. -CNA B said these verbalizations in the day room, a few feet away from the resident. During an interview on 5/7/20 at 10:30 A.M., LPN A said:

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) -He/she heard part of the conversation that CNA B was having, he/she could not hear all of it as the resident was yelling. -When the resident threatened to hit him/her, CNA B came over and started talking with the resident stating he/she would flat line him/her. -He/she told CNA B to step away, and CNA B continued speaking saying he/she wouldn't put up with his/her bullshit and go ahead and hit him/her and see what happens. -Again, instructed the CNA to step away and he/she went out to his/her car to cool off. -When CNA B came back inside, he/she apologized for losing it. -He/she remained in sight of staff while the Director of Nursing (DON) and Administrator were notified. -He/she said the administrator then instructed him/her to send CNA B home immediately. During an interview on 5/7/20 at 10:45 A.M., the resident said: -He/she just told him/her that he/she would flat line me. -He/she call me a (derogatory word). -He/she made me feel very threatened. -He/she didn't even want to go outside to smoke, he/she just wanted to go outside. -He/she was real surprised, because he/she barely even knew CNA B. MO 823