STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265715	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNNYVIEW NURSING HOME & APARTMENTS	1311 E 28TH STREET TRENTON, MO 64683

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 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat one of three sampled residents (Resident #1) with dignity and respect when the administrator took control of the residents walker, moved it, and then grabbed the resident by the arm and forcefully pulled her away from the entrance door to accommodate outside visitors that were entering the facility. The facility census was 82. 1. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/14/20, showed the resident's Brief Interview for Mental Status (BIMS) score was three indicating the resident was severely cognitively confused. [DIAGNOSES REDACTED]. Staff were unable to redirect the resident and the Administrator removed the resident away from the front door and the resident became combative. During an interview on 2/27/20, at 2:28 P.M., Staff Member (SM) A said on 2/25/20, he/she heard a door alarm and went up the hall and saw the resident was standing with a walker trying to leave the facility. The resident occasionally did this and he/she tried to calm the resident down. The maintenance man and a board member were trying to come into the facility and the resident yelled he/she wanted to leave. The Administrator came out of his office and in a stern voice told the resident he/she needed to move. The Administrator took the resident by the arm and pulled the resident away from the door. The resident appeared wobbly and he/she was afraid the resident might fall. During an interview on 2/27/20, at 2:25 P.M., SM B said on 2/25/20, staff were trying to get the resident away from the front door and the resident did not want to move. He/she tried a different approach when the Administrator walked up on the resident's right side and told the resident in a firm voice, he/she needed to move because people were trying to get through the door. This agitated the resident even more. The Administrator took a hold of the resident's left arm and the resident's walker and moved the resident around facing away from the door and then away from the door. It looked like the resident might fall. Additional staff took over at that time and assisted the resident. During an interview on 2/27/20, at 2:15 P.M., SM C said on 2/25/20, the resident was very agitated at the front door and was trying to leave. Staff tried to redirect the resident with coffee without any success. He/she stepped away to call the nurse for assistance. The Administrator walked up to the resident and turned the resident around facing the opposite direction away from the front door. This really set the resident off. The Administrator could have let staff do their job and take the time to get the resident to move on his/her own. Staff were used to dealing with the resident and providing interventions as needed. During an interview on 2/27/20, at 1:43 P.M., SM D said on 2/25/20, the resident was in the hall by the front door. The Administrator tried to redirect the resident because the resident was blocking the front door and people were trying to get in the facility. The more the Administrator tried to redirect the resident, the resident planted his/herself. The Administrator's tone became stern and the Administrator took a hold of the resident's walker and the resident's arm and moved the resident forcefully away from the door. During an interview on 2/27/20, at 1:59 P.M., SM E said on 2/25/20 visitors could not come into the facility because the resident blocked the door. The Administrator came and raised his voice and grabbed the resident forcefully by the arm and removed the resident away from the door while dragging the resident's walker with him and the resident. It looked like the resident was going to fall. The Administrator told the resident he/she needed to go back to his/her room in a hateful tone. Additional staff took over with assisting the resident down the hall. Review of the video footage of the incident on 2/25/20, showed the Administrator approached the resident at the front door of the facility and briefly talked to the resident and then turned the resident and the resident's walker around facing away from the door when the resident raised his/her arm at the administrator and appeared agitated. The administrator held onto the resident by the resident's right arm facing the resident and the resident's walker in his left hand and swiftly moved the resident away from the door. The video showed the resident's normal gait following the incident and the resident's normal gate appeared to be much slower than the speed used during the Administrators assistance. During an interview on 2/27/20, at 3:28 P.M., the administrator said on 2/25/20, he did nothing wrong. There was a board meeting scheduled and there was a board member trying to get into the facility and there were additional board members coming for the meeting. He moved the resident so people could get into the facility. He was unable to identify any additional interventions to remove the resident from the area in a more dignified manner or additional ways visitors could have entered the facility. MO 5
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement an appropriate abuse and neglect policy that included screening, training, prevention, identification, investigation, protection, reporting and response to meet the current regulatory guidelines. The facility census was 82. 1. Review of the facility's undated abuse policy received during the facility investigation on 2/27/20, from the Director of Nursing (DON) showed the purpose of the policy included the nursing facility had zero tolerance of mistreatment, neglect, exploitation and abuse of residents: - The policy applied to all residents, all staff members and visitors of the nursing facility; - Facility staff would not verbally, mentally, sexually or physically abuse, mistreat or involuntary seclude residents; - All staff members were responsible for reporting any suspected incidents or allegations of the above-mentioned behavior. All suspected incident's or allegations of the above-mentioned behavior will immediately be reported to the charge nurse or if the incident concerns the charge nurse, they will be immediately reported to the Administrator; - Upon receipt of a report the charge nurse would investigate and notify the Administrator immediately. If necessary, the employee would be suspended until the investigation was completed; Upon completion of the investigation the Administrator or designee would notify the Division of Aging through the state regional office of the results of the investigation if there was a reasonable cause to believe abuse or neglect occurred; Upon the completion of the investigation the employee would either be disciplined or allowed to return to work or terminated based on the results of the incident. - The facility would not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating individuals by the court of law; - Criminal checks would be conducted on every individual when hired. Employees with files on record with the Division of Family Services would be required to provide in writing the case file to determine employment eligibility; - If determined through the criminal check, an employee was found guilty of abuse, neglect or mistreatment of [REDACTED]. Employee's or a prospective employee with criminal records that may jeopardize the safety of residents will be terminated or not employed; - If an individual's name appeared in the state of Missouri disqualification list the individual would not be hired; - When an individual who came from another state seeks employment as a nurse assistant, the state nursing assistant registry would be called for verification of absence of any disqualification. The policy did not direct staff on how to proceed if the allegation was made against the administrator. During an interview on 2/27/20, at 3:44 P.M., the DON said there was not a lot of information in the facility's current abuse policy. During an interview on 3/5/20, at 3:45 P.M., facility's Board Member

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

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) (BM) A said the facility should have a current abuse and neglect policy to meet the current regulatory guidelines. MO 5
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** Based on observation and interview the facility failed to follow their abuse policy and suspend the Administrator pending the facility investigation of an abuse allegation. The facility census was 82. 1. Review of the facility's undated abuse policy received during the facility investigation on 2/27/20, from the Director of Nursing (DON) showed the purpose of the policy included the nursing facility had zero tolerance of mistreatment, neglect, exploitation and abuse of residents: - The policy applied to all residents, all staff members and visitors of the nursing facility; - Facility staff would not verbally, mentally, sexually or physically abuse, mistreat or involuntary seclude residents; - All staff members were responsible for reporting any suspected incidents or allegations of the above-mentioned behavior. All suspected incident's or allegations of the above-mentioned behavior will immediately be reported to the charge nurse or if the incident concerns the charge nurse, they will be immediately reported to the Administrator; - Upon receipt of a report the charge nurse would investigate and notify the Administrator immediately. If necessary, the employee would be suspended until the investigation was completed; Upon completion of the investigation the Administrator or designee would notify the Division of Aging through the state regional office of the results of the investigation if there was a reasonable cause to believe abuse or neglect occurred; Upon the completion of the investigation the employee would either be disciplined or allowed to return to work or terminated based on the results of the incident. The policy did not direct staff on how to proceed if the allegation was made against the administrator. During an interview on 3/5/20, at 2:57 P.M., the DON said on 2/25/20, the Administrator went to a board meeting following the alleged incident and after the meeting the Administrator went home around 6:20 P.M. On 2/26/20, she met the Administrator at the door when he arrived at work around 9:00 A.M. She told the Administrator he was under investigation. The Administrator said that was ridiculous, nothing happened. Observation on 2/27/20, at 3:28 P.M., showed the Administrator was at the facility in his office. During an interview on 3/5/20 at 3:45 P.M., facility Board Member (BM) A said the Administrator was not suspended pending the investigation. There was another board member present during the alleged allegation who did not feel the incident rose to the level of abuse. During an interview on 3/5/20, at 4:08 P.M., the Administrator said if the allegations had been made against another employee, the employee should have been suspended pending the abuse investigation. He stayed in his office while the investigation was being completed to avoid resident interactions until the investigation was completed. MO 5