

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31370	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/27/2023
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NAME OF PROVIDER OR SUPPLIER WILDWOOD SENIOR LIVING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3002 SOUTH JOHN DUFFY DRIVE JOPLIN, MO 64804
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8022	<p>19 CSR 30-88.010(22) Free From Abuse</p> <p>Each resident shall be free from abuse. Abuse is the infliction of physical, sexual, or emotional injury or harm and includes verbal abuse, corporal punishment, and involuntary seclusion. I</p> <p>This regulation is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure Resident #1 was free from abuse when two staff members (Care Partner (CP) A and CP B) physically forced the resident to shower after the resident voiced he/she did not want to shower, causing the resident distress- including yelling at the staff to stop, crying, and begging staff to stop. The resident physically resisted and staff continued- causing bruising on the resident's right inner forearm, right hand, and scattered bruising on his/her left upper arm. The facility census was 57.</p> <p>Review of the facility's policy titled Abuse and Neglect, Observed or Suspected, revised 01/16/23, showed the following: -Purpose: To ensure the safety and security of residents always and to notify state regulatory agencies when intentional harm is suspected; -It is the policy that residents will not be abused or neglected by anyone at any time while residing at an Arrow Senior Living property. All instances of observed or suspected abuse and/or neglect will be handled as follows: resident will be removed from the situation in which they were observed and put in a protected area until safety and security is restored; all alleged perpetrators will be removed from premises immediately after obtaining written statement. If they do not willingly vacate property police will be called. If the alleged perpetrator is a resident, they shall be separated from other residents if necessary to ensure the safety of others; if staff is involved or suspected</p>	A8022	<p>This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusion drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the Community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedures and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder, or the Community of affiliated companies.</p> <p>It is the policy of The Wildwood Senior Living for each resident to be free from infliction of physical, sexual, or emotional injury or harm, including verbal abuse, corporal punishment, and involuntary seclusion.</p> <p>Corrective Action for Residents affected by cited deficiency: Resident was assessed immediately emotionally and physically. CP A was not on duty but was suspended from the workplace on 4/24/23. CP B was not on duty and during investigation learned of her involvement, was suspended from the workplace on 4/24/23. An in-service on resident abuse was initiated on 4/25/23 that covered, forms of abuse, examples of abuse, who to report abuse to, redirection/de-escalation of an agitated resident, resident rights and rights to refuse. An online video on showering tips for residents with dementia was required for Wellness staff. Once the investigation revealed possible abuse, staff inserving commenced with the current shift. The oncoming night shift (7PM) was inserviced prior to the start of their shift by the Director of Wellness. Starting on 4/26/23 with the 7PM shift, staff was educated prior to the start of their shift. Inservicing continued for all departments until all staff were educated.</p> <p>Action to identify other residents with potential to be affected: In-service for staff included, forms of abuse, examples of abuse, who to report abuse to, redirection/de-escalation of an agitated resident,</p>	

		<p>resident rights and rights to refuse. An online video on showering tips for residents with dementia was required for Wellness and all staff. The in-service for staff started on 4/25/23 by the Director of Wellness and continued until all staff were educated.</p> <p>A generic questionnaire on resident abuse was asked to all memory care residents and random assisted living residents on 4/25/23. The questionnaire was asked to employees on 4/25/23 and was completed for all departments.</p> <p>Procedures put in place to ensure that cited practice does not occur: Residents and employees are randomly selected and asked generic questions on abuse, neglect and resident rights once per week for one month and then quarterly for one year by Director of Wellness.</p> <p>Monitoring to prevent reoccurrence of cited practice: The results of the questionnaire will be presented to the Executive Director monthly and reviewed at the Risk Management meeting with all department directors. Any indication of abuse will be immediately investigated by the Executive Director.</p>	5/1/2023
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Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Daniel Shields Executive Director 05/24/2023

STATE FORM 6899 4ESR11 If continuation sheet 1 of 27

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A8022	<p>Continued From page 1</p> <p>as perpetrators they will be suspended immediately, pending investigation; when abuse or neglect is suspected by community personnel, vendors or visitors, they shall not be left alone one-on-one with the resident for any reason; any witnesses to abuse or neglect will provide a written statement regarding the incident; the Chief Executive Officer (CEO) and the Regional Director of Operations for the community will be notified immediately to assist with the investigation by the Executive Director; State agency will be notified within two hours, or time frame as dictated per state guidelines, of awareness of event or allegation by the community's Administrator or Executive Director; the investigation will be completed within 72 hours and sent to the CEO and the Regional Director of Operations by the Executive Director prior to being submitted to state agencies.</p> <p>Review of the facility's policy titled Resident Rights, revised 02/15/23, showed the following: -As a resident of an Arrow Senior Living Community, you have rights guaranteed to you by state and federal laws. The Community is required to protect and promote your rights. Your rights strongly emphasize individual dignity and self-determination, promoting your independence and enhancing your quality of life. You have the right to exercise all of your rights free from interference, coercion, discrimination or reprisal; -You have the following rights: to be offered choices and allowed to make decisions important to you; to expect the community to accommodate individual needs and preferences; to accept or refuse care and treatment including your doctor or pharmacy; to be valued as an individual, to maintain and enhance your self-worth; to be treated with courtesy, respect and dignity, free from humiliation, harassment or threats; to be</p>	A8022		

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A8022	<p>Continued From page 2</p> <p>free from physical, sexual, mental, verbal and financial abuse; and to be free from chemical ad physical restraints and involuntary seclusion.</p> <p>1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following: -The resident admitted to the facility on 07/27/21; -No diagnoses documented on the face sheet.</p> <p>Review of the resident's change in condition Community Based Assessment (CBA - a required semi-annually and significant change assessment tool completed by a qualified facility staff member), dated 04/18/23, showed the following: -The resident had a cognitive change; -The resident moved into or transferred to a memory care neighborhood that restricted their freedom of movement. -The resident would reside in a safe and appropriate environment; -The resident was independent with oral care and eating, required reminders from staff for continence, grooming and dressing, and partial assistance with bathing to include observations and cues to ensure the body was washed thoroughly and properly, and washing the hard to reach areas like feet, legs and back; -The resident preferred showers; -The resident was independent with transfer ability and mobility; -The resident would receive assistance with behavior impairment of wandering and pacing. Redirect as needed when wandering or pacing. Report exit seeking and specify triggers and redirection techniques.</p> <p>Review of the resident's Individual Service Plan (ISP - plan put in place to indicate the care needs of the resident), revised 04/18/23, showed the</p>	A8022		

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A8022	<p>Continued From page 3</p> <p>following:</p> <ul style="list-style-type: none"> -He/she would reside in a safe and appropriate environment. The resident moved to a memory care neighborhood that restricted his/her freedom of movement; -He/she would maintain independence with his/her speech and communication needs. He/she communicated independently. Staff would report any changes in communication needs; -He/she received assistance with bathing; -He/she would receive assistance with behavior impairment. He/she would not require assistance with expression or mood impairment. Redirect as needed when wandering or pacing. Report if exit seeking; -He/she received assistance with time and place orientation. He/she had current or history of occasional disorientation to person, place, time or situation. He/she required some direction and reminding from others. Supervise behaviors and guide as needed. Provide a supportive environment. <p>Review of the resident's nurse progress notes showed staff documented the following:</p> <ul style="list-style-type: none"> -On 04/23/23, at 7:55 P.M., staff helped resident get into the bathroom for a shower. The resident started to pinch scratch and slap. To deescalate the situation, staff did a two person assist and finished the shower; -On 04/24/23, at 9:19 P.M., staff notified the resident's family member of the resident reporting an abuse allegation on a memory care (MC) staff person. Memory Care Director (MCD) let the family member know that the facility took this very seriously and this allegation was reported to the state of Missouri. The family member asked if he/she believed this happened and the MCD let the family member know they would be conducting an investigation and (would) keep the 	A8022		

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A8022	<p>Continued From page 4</p> <p>family member updated. At this time the resident had bruising of an unknown origin.</p> <p>-On 04/24/23, at 11:00 P.M., CP C notified this nurse in person of bruising noted to the resident's wrist. CP C stated Resident #1 showed the CP bruising on his/her arms and said it was from the staff that gave him/her a shower the other night. This nurse went to the resident's apartment to assess the bruising at approximately 8:15 P.M. A full body skin assessment was completed by this nurse upon arrival. The resident was agreeable and cooperative with the assessment. Resident had a 5.5 centimeter (cm) by 7.5 cm purple/gray bruise on his/her right wrist, a 2 cm by 1 cm purple bruise on his/her left bicep, and a 1.5 cm by 2 cm purple/gray bruise on the top of his/her right hand. This nurse asked the resident if he/she could recall how he/she got the bruises. The resident stated that staff the other night was so rough and made him/her take a shower when he/she did not want to. Staff was swinging him/her around, grabbing and pulling him/her. CP C was in room at time of the assessment. Resident stated to CP C that CP C was the good one and glad CP C was nice to him/her. Resident denied any complaints of pain or discomfort. Resident's level of consciousness, range of motion and vital signs within normal limits of baseline. The MCD and Director of Wellness (DOW) notified via phone at approximately 8:30 P.M. MCD reports he/she will notify the Administrator of the incident. Family notified via phone by this nurse. Physician to be notified during the morning of 04/25/23 during operating hours. Full body skin assessment completed by this nurse. Resident agreeable and cooperative. Resident reassured and offered support. Pain medication offered but resident declined stating he/she was fine and it did not hurt too bad. Will continue to follow up with daily assessments of</p>	A8022		

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A8022	<p>Continued From page 5</p> <p>bruising and offer pain medication if needed. Statements completed by staff and given to the MCD. The MCD, DOW and Administrator to follow up with investigation.</p> <p>-On 04/25/23 at 9:03 A.M., the DOW spoke with the resident in regards to the report from last night (04/24/23). The resident stated the employee who was giving him/her a shower was very rough with him/her. The resident denied hitting, pushing or being verbal. The resident stated the staff member's grab was rough. Skin assessment performed and noted bruising on his/her right inner forearm and top of hand by the thumb. Resident also noted to have scattered bruising on his/her left upper arm.</p> <p>Measurements: right inner wrist 7.5 cm x 6.5 cm, right top of hand by thumb 5 cm x 2 cm, skin tear noted to left elbow. Unable to approximate but noted to be 1.3 cm in length;</p> <p>-On 04/25/23 at 9:52 A.M., physician called and notified of the incident investigation and current skin assessment findings.</p> <p>Review of the facility's video footage, dated 04/23/23, showed the following:</p> <p>-The inspector reviewed the video footage with the Director of Wellness who identified Resident #1, CP A and CP B.</p> <p>-On 04/23/23 at 6:20 P.M., CP A entered Resident #1's room. The resident sat on the side of the bed. CP A approached the resident, interacted with him/her then walked into resident's bathroom. It appeared CP A did something at the sink then turned around and faced where the shower would be in the bathroom. CP A approached the resident and appeared to interact with him/her before touching something on the wall outside the bathroom door (observation of the resident's room showed a thermostat in that same area).</p>	A8022		

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A8022	<p>Continued From page 6</p> <p>-At 6:21 P.M., CP A returned to the resident's bedside as the resident lifted his/her legs onto the bed, laying on his/her back. CP A grabbed the resident's legs and swung them off the bed causing the resident to sit up. CP A then attempted to grab the resident's hands, but the resident laid the top of his/her body across the bed with his/her feet still dangling on the side of the bed. CP A attempted to sit the resident back up, reaching for the resident's head/left shoulder as the resident physically resisted this by pushing CP A's hands away. CP A grabbed at the resident's left wrist but the resident pulled it away multiple times. CPA A then grabbed the resident's right wrist with his/her right hand and placed his/her left hand behind the resident's back and forced the resident from a laying position, to a seated position and then to standing while the resident appeared to resist. The resident attempted to grab at the bed with his/her left hand as the CP held onto the resident's right wrist and forcefully walked the resident to the bathroom and disappeared out of frame;</p> <p>-At 6:22 P.M., the resident appeared in the doorway of the bathroom with CP A behind him/her. It appeared as though the resident grabbed onto the doorframe, trying to leave the bathroom but the CP pulled the resident back into the bathroom. The CP removed the resident's shirt. The resident again, attempted to leave the bathroom holding onto the doorframe as if to pull him/herself away from the CP while the CP attempted to keep the resident in the bathroom and undress the resident. The resident appeared to have his/her pants down around his/her knees. The CP grabbed the resident from behind and forcefully placed the resident into the shower. The CP appeared to take the pants off the resident's legs. The resident continued to resist the CP's actions by pushing at the CP with his/her arms</p>	A8022		

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A8022	<p>Continued From page 7</p> <p>but the CP continued with his/her task.</p> <p>-At 6:26 P.M., CP A left the resident in the shower and exited the room. He/she returned a few seconds later with CP B and both entered the resident's bathroom and appeared to resume the shower;</p> <p>-At 6:33 P.M., CP B exited the bathroom and stood in the bathroom's doorway until 6:34 P.M. when CP A also exited. They both appeared to retrieve clothing items for the resident. CP A reentered the bathroom and CP B remained outside the bathroom near the end of the resident's bed. CP A exited the bathroom to retrieve more items. During this time, the resident remained in the bathroom, out of view of the camera;</p> <p>-At 6:35 P.M., both CPs entered the bathroom (the thermal imaging and position of the camera made it difficult to determine what the CPs were doing in the bathroom).</p> <p>-At 6:41 P.M., CP B assisted the resident to walk out of the bathroom while it appeared CP A attempted to brush the resident's hair as the resident walked with CP B. The resident grabbed at the wall and then his/her bed, attempting to steady himself/herself while CP B assisted him/her to the right side of the bed. CP A exited the room before the resident reached the end of his/her bed. CP B assisted the resident to sit on the edge of the bed. CP B sat to the left of the resident, on the resident's bed.</p> <p>-At 6:42 P.M., CP A reentered the room, gathered items then sat on the edge of the bed on the resident's right side. CP B held the resident's left hand and it appeared CP A held the resident's right hand. The resident continued to attempt to pull his/her hands away from the staff. CP A appeared to perform fingernail care on the resident's right hand;</p> <p>-At 6:45 P.M., CP A and CP B switched sides and</p>	A8022		

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A8022	<p>Continued From page 8</p> <p>interacted with the resident (the thermal imaging and position of the camera made it difficult to determine what CP A was doing).</p> <p>-At 6:47 P.M., CP A sat on the floor and CP B continued to sit on the edge of the bed on the resident's right side. CP A appeared to perform foot and toenail care while CP B periodically rubbed and/or patted the resident's back with his/her left hand;</p> <p>-At 7:01 P.M., CP A exited the resident's room. CP B remained in the room with the resident and appeared to interact with the resident while rubbing the resident's back.</p> <p>Review of the facility's investigation, dated 4/27/23 showed the following:</p> <p>-On 4/24/2023, Resident #1 told employee CP C that he/she was glad CP C was here because the employee last night made him/her take a shower. Resident lifted up his/her right sleeve and showed CP C a bruise. Resident stated he/she received the bruise when an employee made him/her take a shower the night before. Resident described the employee that gave him/her a shower. Resident said he/she told the employee he/she did not want to take a shower. CP C and CP D viewed the bruises on resident's wrist and arm. Licensed Practical Nurse (LPN) D performed a full body assessment and noted one other scattered bruise on (the resident's) left upper arm. Supervisors, family, Department of Health and Senior Services (DHSS) and physician notified. The employee who gave the shower was identified as CP A and was suspended pending outcome of investigation;</p> <p>-Investigation revealed that CP A entered resident's apartment at 6:20 P.M. to give the resident shower as the resident had refused to shower the day before. CP A tried to get the resident out of bed, but the resident refused to</p>	A8022		

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A8022	<p>Continued From page 9</p> <p>shower. CP A took the resident by the left and right arms to assist out of bed and head (go) to the shower, located in resident's apartment. Resident stated he/she did not want a shower and was physically refusing. Once in the shower, CP A stated the resident was hitting and pinching employee. CP A summoned employee, CP B, to assist. CP B stated he/she held the resident's hands down while CP A continued to bathe resident. CP A and CP B assisted with nail care after bathing resident. Upon learning of CP B's involvement, CP B was suspended pending investigation;</p> <p>-During the interview, both CP A and CP B acknowledged the training they received on resident rights, abuse, reporting and neglect. Both employees admitted their approach and handling of the situation was not as they were taught. They acknowledged the resident stated he/she refused a shower and became agitated, yet they proceeded to give the resident a shower and hold his/her hands down;</p> <p>-Based on the investigation, we (administrative staff) believe the incident of abuse, failure to report and resident rights were violated. As a result, employees CP A and CP B will remain suspended until they are terminated.</p> <p>During an observation and interview on 04/26/23 at 9:35 A.M. and an observation on 04/27/23 at 1:02 P.M., the resident said the following:</p> <p>-He/she had a shower and the staff member was rough. The staff member pulled and yanked him/her;</p> <p>-He/she did not know the staff member's name;</p> <p>-The staff member just gave orders like "hold still" and "turn around;"</p> <p>-He/she tried to get away from the staff member;</p> <p>-He/she was scared of the staff member, because the staff member was so rough;</p>	A8022		

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A8022	<p>Continued From page 10</p> <ul style="list-style-type: none"> -He/she told another staff member about the incident, but did not remember that staff member's name; -He/she did not want to shower. He/she preferred to take sponge baths and completed them by him/herself. He/she had always bathed that way; -He/she showed this surveyor his/her right wrist with a large purple bruise approximately 2 inches by 1 ½ inches. -He/she appeared on the verge of tears, his/her eyes watered and voice wavered, when he/she retold the story; -On 04/27/23 the resident sat at a table in the dining room. He/she had a bruise on his/her right wrist and top of right hand near his/her thumb, both purple in color. <p>Review of CP A's written statement, dated 04/25/23, showed the following:</p> <ul style="list-style-type: none"> -The resident was in his/her bed and the CP sat in the resident's chair and notified the resident that it was his/her shower day; -The resident immediately refused due to the shower being slippery and wet; -The resident refused to get out of bed; -He/she took his/her arm/hand to grab the resident's left arm and right arm and assisted the resident out of bed; -The resident said the CP was strong as he/she walked. The CP held the resident's hands while he/she walked the resident to the shower; -Once in the bathroom, he/she assisted the resident to get undressed; -The resident saw the shower on and started to yell and refuse; -The resident attempted to get up and the CP intervened so the resident would not fall; -The resident started moving around and the resident almost hit his/her head on the cabinet above the toilet; 	A8022		

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NAME OF PROVIDER OR SUPPLIER WILDWOOD SENIOR LIVING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3002 SOUTH JOHN DUFFY DRIVE JOPLIN, MO 64804
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A8022	<p>Continued From page 11</p> <ul style="list-style-type: none"> -The CP grabbed the resident's head with both hands and the resident hit and kicked at the CP; -The CP assisted the resident to the shower and the resident squirmed in the shower; -Once the CP had the resident in the shower, the resident pinched the CP's stomach and hit the CP; -The CP attempted to call CP B on the walkie-talkie but did not hear anything back, so he/she walked out of the resident's apartment and yelled for CP B to come and assist him/her; -CP B walked into the resident's apartment and started to provide comfort to the resident; -The resident told CP A he/she could shower him/herself and please stop this, but the CP continued to shower the resident; -The resident said he/she was scared and CP A attempted to comfort the resident by telling the resident to trust the CPs, we will dry you off and apply lotion; -He/she and CP B dried and dressed the resident in the bathroom and the resident appeared fine after the shower; -The resident told him/her that he/she did not like him/her and the resident would never let him/her shower the resident again and that he/she was mean; -CP B did not say anything to CP A, CP B just provided assistance with comfort to the resident; -He/she then told the resident when the resident was on the bed that the resident was going to get his/her fingernails and toenails cut. The resident did not refuse nail care; -CP B held the resident's hands while CP A cut the resident's fingernails; -After he/she completed the resident's nail care, he/she cleaned up the bathroom and left the resident sitting on the bed with CP B. <p>During an interview on 04/26/23, at 12:09 P.M.,</p>	A8022		

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A8022	<p>Continued From page 12</p> <p>CP A said the following: -On 04/23/23 at approximately 7:00 P.M., he/she entered Resident #1's room and asked if he/she could assist the resident with a shower. The resident said no and that it was too slippery in the bathroom. CP A told the resident it had been awhile since he/she (the resident) last had a shower. The resident said he/she had a shower the other day. The CP promised he/she would help the resident, would not let him/her fall and would be with him/her through every step of the shower; -The resident said it was cold so he/she (CP A) adjusted the thermostat in the room; -CP A asked the resident to walk into the bathroom. The resident agreed to walk into the bathroom, but continued to refuse to shower; -He/she assisted the resident into the bathroom with his/her left arm around the resident's shoulders and his/her right hand holding the resident's hand because the resident did not have his/her walker with him/her; -He/she sat the resident on the toilet then turned on the heat lamp, light, and the water in the shower. The resident became distraught when he/she turned on the water in the shower. The resident screamed and yelled for help. The resident threw him/herself back and scratched and pinched CP A's stomach. -CP A placed his/her left arm around the top of the resident's head and his/her right arm around the resident's waist to keep the resident from hitting his/her head on the cupboards above the toilet. The resident rolled a towel holder into the middle of the floor. He/she asked the resident several times to stop moving the towel holder into the middle of the floor because he/she was afraid the resident would fall; -CP A's walkie-talkie did not work for him/her to call for assistance so as soon as the resident</p>	A8022		

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A8022	<p>Continued From page 13</p> <p>wiggled, he/she pulled the resident up from the toilet and moved the resident to the shower chair. The resident continued to scream;</p> <p>-He/she ran out of the resident's room to get assistance. CP B went into the resident's bathroom to talk to the resident. He/she and CP B undressed the resident and placed the resident in the shower. The resident did not resist the shower after this;</p> <p>-He/she believed CP B held the resident's hands during the shower;</p> <p>-CP A and CP B assisted the resident to dress then assisted the resident to his/her bed.</p> <p>-After the shower, he/she (CP A) asked if he/she could cut the resident's finger and toe nails. CP B laid beside the resident on the resident's bed and talked to the resident while he/she (CP A) clipped the resident's finger and toenails;</p> <p>-The resident had the right to refuse a shower. The resident always refused showers. He/she did not force the resident to take a shower. He/she told the resident he/she had to give him/her a shower. The resident had dried feces on his/her skin;</p> <p>-While in the shower, CP A saw a yellowish purple bruise on the resident's left shoulder, but the resident did not have any other bruising;</p> <p>-He/she did not hurt the resident. He/she just tried his/her best to give the resident a good shower. When the resident told him/her no, he/she should have walked out and tried again later;</p> <p>-He/she could not remember if he/she held the resident's arms down.</p> <p>-Prior to the resident's shower, he/she asked other staff how the resident showered, but no staff members could tell him/her;</p> <p>-He/she told LPN F that the resident was upset with him/her, because he/she gave the resident a shower. The resident told him/her that he/she (the resident) would not forgive him/her (CP A) for</p>	A8022		

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A8022	<p>Continued From page 14</p> <p>giving him/her (the resident) a shower.</p> <p>-Residents had the right to refuse. If a resident refused cares, he/she tried to convince the resident to receive them. If the resident refused, he/she re-approached later. If a resident refused a shower he/she tried to convince the resident to take a shower and if they continued to refuse, he/she re-approached later;</p> <p>-He/she did not know if he/she considered giving the resident a shower abuse.</p> <p>Review of CP B's statement, dated 04/25/23, showed the following:</p> <p>-He/she assisted another resident when CP A came in and stated he/she needed assistance with a shower;</p> <p>-CP A appeared flustered and stated Resident #1 scratched and hit him/her;</p> <p>-CP B walked to the resident's apartment and did not say anything;</p> <p>-When he/she entered the apartment, the resident was in the shower, undressed and wet;</p> <p>-The resident cried and said CP A was being mean to him/her and asked why CP A was doing this to him/her;</p> <p>-He/she walked to the resident and CP A asked him/her to hold the resident's hands down, because the resident was swinging his/her hands at CP A;</p> <p>-He/she grabbed the resident's hands and held them down while CP A gave the resident a shower;</p> <p>-The resident yelled do not do that, he/she can do this him/herself;</p> <p>-The resident attempted to tell CP B to stop and said honey please do not do that and the CP continued to hold the resident's hands down;</p> <p>-After the shower, they assisted the resident to sit on the toilet to dry off and get dressed;</p> <p>-The resident cried and refused to get dressed</p>	A8022		

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A8022	<p>Continued From page 15</p> <p>and asked them to stop and said he/she could do it him/herself; -He/she minimally assisted CP A to dress the resident; -He/she walked the resident back to the resident's bed and CP A told the resident that CP A was going to provide nail care and the resident asked that her nails not be cut too short; -He/she sat beside the resident during nail care and saw the resident grimace and say it hurt. He/she stayed quiet and did not say a thing; -After CP A completed the resident's nail care, the CP cleaned up the apartment and left; -He/she stayed with the resident to provide comfort and offered the resident a drink and cookies.</p> <p>During an interview on 04/26/23, at 2:19 P.M., CP B said the following: -He/she was in another resident's room when CP A came to get him/her to assist with Resident #1's shower; -When he/she entered the resident's bathroom, the resident was wet. It appeared the shower was already in progress. CP A got in the shower and continued showering the resident; -The resident swung his/her arms at CP A and told CP A to "stop," "don't do that," and he/she "could do this him/herself;" -CP A asked CP B to hold the resident's hands while he/she (CP A) finished the shower; -He/she (CP B) held down the resident's hands with his/her hands in the resident's lap; -The resident resisted this and squeezed CP B's hands and continued to yell at CP A to "stop", he/she "could do this" and "don't do this." He/she (CP B) did not hold the resident's arms down, he/she just held the resident's hands. While CP B held the resident's hands, the resident tried to move his/her arms free to swing at CP A;</p>	A8022		

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A8022	<p>Continued From page 16</p> <ul style="list-style-type: none"> -The resident broke down in tears two or three times during the shower; -When CP A completed the shower, CP A and CP B assisted the resident out of the shower, dried him/her off and sat him/her on the toilet; -CP A tried to dress the resident but the resident resisted him/her and again told CP A he/she could do this (get dressed) and did not need CP A's help; -CP B talked with the resident trying to console him/her while CP A and CP B dressed him/her. -The resident walked back to his/her bed. -CP A asked CP B to sit with the resident on the bed while he/she (CP A) trimmed the resident's nails. The resident told CP A not to cut his/her fingernails too short because it would hurt. While CP A cut the resident's fingernails, the resident jerked his/her hand back three or four times, telling CP A "that hurt." CP A told the resident he/she was not hurting him/her (the resident), he/she (CP A) was just trying to cut the resident's nails. After CP A finished the resident's nail care, CPA left the resident's room; -He/she (CP B) sat with the resident for around five minutes trying to console him/her. He/she tried to make the resident comfortable, adjusted the thermostat and offered the resident a snack. The resident said his/her fingernails were too short and was upset with CP A; -CP B did not observe any bruising on the resident; -The resident had a right to refuse. CP A forced the resident to take a shower. He/she considered this an abuse of the resident's rights and if the forced shower caused bruising, he/she considered this abuse; He/she did not report this to anyone, because he/she became ill and had to leave the facility after the resident's shower. -He/she did not know why he/she did not report it 	A8022		

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A8022	<p>Continued From page 17</p> <p>when he/she walked into the room and saw the resident resisting. He/she should have stopped the shower and reported it immediately.</p> <p>During an interview on 04/27/23 at 8:40 A.M., LPN F said the following:</p> <ul style="list-style-type: none"> -He/she was the charge nurse on 04/23/23 and started his/her shift at 7:00 P.M. -He/she believed the resident could complete their own shower without assistance; -On 04/23/23, CP A reported to him/her (the nurse) that earlier, he/she (CP A) gave Resident #1 and the resident had behaviors such as hitting, biting and scratching. CP A told the LPN when the resident had the behaviors, he/she asked CP B for assistance; -The LPN did not know if this was normal behavior for the resident; -CP A's report sounded reasonable to him/her and he/she instructed the CP to document the behaviors; -He/she did not assess the resident, but did administer the resident's medication. The resident did not seem upset or hurt in any way; He/she did not notice any injuries on the resident. The bruise on the resident's right wrist was not there at the time. He/she believed he/she would have noticed the bruise, and if he/she saw the bruise, he/she would have contacted the MCD and DOW immediately. -He/she did not ask the resident about his/her behaviors, because he/she did not want to exacerbate the situation; -He/she did not ask CP B any questions related to the resident's behaviors and the CP did not report anything to him/her. CP B did report he/she passed out after leaving the resident's room and left the facility shortly after that; -If he/she would have thought anything was out of the ordinary at that time, he/she would have 	A8022		

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A8022	<p>Continued From page 18</p> <p>notified the MCD or the DOW.</p> <p>During an interview on 04/27/23 at 3:22 P.M., CP C said the following:</p> <ul style="list-style-type: none"> -On 04/24/23, when he/she passed medications, he/she went into the resident's room and found the resident in the bathroom; -The resident said was glad to see the CP and became emotional; -When the CP asked the resident what was wrong, the resident said a mean staff member forced him/her to take a shower last night (4/23/23); -When the CP asked who the staff member was, the resident described the staff member with dark hair with blonde in it (CP A); -The resident grasped CP C's arms and pulled them left to right to demonstrate what the staff member (CP A) did to him/her. The resident said the staff member moved his/her arms all over, pushed and pulled him/her and made him/her take a shower; -The resident then started tapping his/her head with open hands and said water was everywhere; in his/her face, on his/her head, and said he/she screamed for them to stop; -The resident then showed the CP his/her right arm and the CP observed a baseball sized black colored bruise that the CP had not seen before; -The CP asked CP D to sit with the resident while he/she reported this to LPN E; -He/she considered what the staff member did to the resident physical, emotional, and psychological abuse. The incident appeared to be traumatic for the resident psychologically and the bruise indicated physical abuse. <p>During an interview on 04/27/23 at 1:29 P.M., CP D said the following:</p> <ul style="list-style-type: none"> -On 04/24/23 approximately 9:00 P.M., CP C 	A8022		

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A8022	<p>Continued From page 19</p> <p>asked him/her to come to the resident's room;</p> <p>-The resident sat in the bathroom and CP C pointed out the bruises on the resident right wrist and left upper arm;</p> <p>-The bruise on the resident's right wrist was approximately the size of a baseball and dark blackish blue in color and the bruise on the resident's left upper arm was around quarter sized and dark blackish blue in color. Both appeared to be fresh;</p> <p>-He/she knelt down in front of the resident and asked how the resident got the bruises. The resident said on 04/23/23, a staff member forced him/her to take a shower when the resident did not want to. The resident said the staff member twisted, pulled and yanked on him/her. The resident grabbed CP D's wrists and demonstrated how the staff member hurt him/her;</p> <p>-The resident said he/she told the staff member to stop but the staff member told the resident no and that the resident had to take a shower and did not have a choice;</p> <p>-The resident let go of the CP's wrists and patted the CP's head and said this is how the staff member washed my head. The resident said he/she cried and water got in his/her face;</p> <p>-The resident said he/she continued to tell the staff member no and to stop;</p> <p>-The resident cried when telling the details to the CP;</p> <p>-The resident did not know the staff member's name that forced him/her to shower;</p> <p>-He/she and CP C left the resident's room and CP C notified LPN E and the MCD;</p> <p>-LPN E assessed the resident;</p> <p>-He/she considered the incident the resident described was physical, verbal, and emotional abuse;</p> <p>-The resident preferred a bath in the spa room and the resident did not normally resist care.</p>	A8022		

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A8022	<p>Continued From page 20</p> <p>During an interview on 04/27/23, at 8:29 A.M., LPN E said the following:</p> <ul style="list-style-type: none"> -On 04/24/23 at approximately 8:30 P.M., CP C reported the resident told him/her that whoever gave him/her a shower was rough and the resident had bruising; -He/she immediately assessed the resident. The bruise on the resident's right wrist was approximately 5 cm by 3 cm and purplish gray in color. The bruise looked fresh; -The resident told him/her (the LPN) the staff member who gave him/her a shower was rough, throwing and slinging him/her around. The resident did not know the staff member's name but gave a description of the staff member. He/she believed the staff member was CP A from the resident's description; -The resident's description of the incident and the resident's injuries appeared to be physical abuse. He/she made the resident comfortable and reported this to the MCD immediately; -He/she completed a full body assessment at this time and the resident had an older faint, yellowish bruise on his/her left shoulder. The resident confirmed this was old. The resident did not have any skin tears, abrasion or other bruising at this time; -On 04/25/23, he/she assessed the resident's injuries again and the bruising was much worse. The bruises were darker purplish gray and the resident had a quarter sized purplish bruise on the top of the right hand that looked fresh and another quarter sized purplish gray bruise on the left bicep that appeared fresh. <p>During an interview on 04/26/23, at 10:37 A.M., Certified Medication Aide (CMA) G said the following:</p> <ul style="list-style-type: none"> -On 04/25/23, in the morning, the resident 	A8022		

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A8022	<p>Continued From page 21</p> <p>showed him/her the bruise on his/her arm and reported that a staff member held him/her down on the bed because he/she did not want to shower. The resident said the staff member grabbed and twisted his/her arm; -If a resident did not want to take a shower, staff should leave and re-approach later or offer the resident a bed bath. Staff should not force a resident to participate in cares and should not hold a resident down. He/she considered this abuse.</p> <p>During an interview on 04/26/23 at 10:59 A.M. and 2:11 P.M., Licensed Practical Nurse (LPN) I said the following: -He/she was completing follow-up charting on 04/26/23 related to an incident involving Resident #1. The resident had three bruises. He/she was not aware of any bruises on the resident's wrist prior to this incident (4/23/23); -Today (4/26/23) he/she assessed the resident's right wrist. The anterior (front side) and lateral (outside) right arm was reddish purple that measured 3 cm by 2 cm that merged with another bruise on the palm side of the resident's wrist. The bruise on the palm side of his/her wrist was dark purple with reddish shading and measured 7.5 cm in length by 7 cm width. The bruise appeared to be caused by a staff member gripping the resident's wrist or holding his/her wrist down. The Resident had another round dark purple bruise on the underside of his/her right forearm that measured 3 cm by 3 cm. The bruise on the resident's left upper arm measured 2 cm by 2.5 cm and was round and dark purple. -Staff should not hold a resident down or force a resident to do anything. Resident had the right to refuse. If a resident refused a shower, staff should re-approach later and if the resident still refused, have another staff member attempt later.</p>	A8022		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31370	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/27/2023
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NAME OF PROVIDER OR SUPPLIER WILDWOOD SENIOR LIVING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3002 SOUTH JOHN DUFFY DRIVE JOPLIN, MO 64804
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A8022	<p>Continued From page 22</p> <p>If the resident continued to refuse, staff should document the refusal and number of attempts.</p> <p>During interviews on 04/26/23, at 10:16 A.M. and 4:45 P.M., and 04/27/23, at 12:52 P.M., the MCD said the following:</p> <ul style="list-style-type: none"> -On the evening of 04/24/23, the resident reported to CP C and CP D that he/she was glad CP C was caring for him/her that night and not that other staff member. The staff member that walked and talked fast was rough with him/her; -CP C said the resident showed him/her a bruise on his/her wrist. CP C asked the resident if someone did that to him/her and the resident stated yes, the staff member who walked and talked fast. CP C reported this to LPN E who conducted a skin assessment on the resident and notified the MCD; -Based on the resident's description of the CP, the MCD determined the resident was describing CP A; -The resident told the MCD the injury happened on the night of 04/23/23 when CP A tried to get him/her to take a shower and he/she did not want to take a shower. CP B was in the room assisting CP A with the shower and held the resident's hands down in a restraint type manor. -When the MCD asked CP B about the incident, CP B said that the resident yelled for them (CP A and CP B) to stop, but CP B continued to hold the resident's arms down; -When CP A finished the shower, he/she told LPN F that the resident was abusive and hit him/her and CP B. The LPN told CP A to chart thoroughly. The LPN then spoke with the resident, asked if he/she was okay. The nurse did not observe any bruises on the resident at that time. -The MCD observed the bruise on the resident's wrist. It palm-sized as if someone grabbed the resident's wrist or the resident hit it on something; 	A8022		

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A8022	<p>Continued From page 23</p> <ul style="list-style-type: none"> -The MCD suspended CP A and CP B on 04/24/23 pending a complete investigation. -The DOW developed residents' ISPs and CBAs. These included the level of care needed and resident preferences. The staff could view the ISP to see how to care for a resident. -The resident preferred to sponge bathe. He/she did not like to get his/her hair or face wet and had a fear of water. The resident responded better when staff set-up everything before bathing. -Staff should not force a resident to shower. If a resident did not want to shower, staff should chart the refusal and move on to another resident and another staff member would try another day; -If staff held a resident's hands down, he/she considered this a restraint and physical abuse. Staff should not hold a resident's hands down. <p>During interviews on 04/26/23, at 4:29 P.M. and 04/27/23, at 2:04 P.M., the DOW said the following:</p> <ul style="list-style-type: none"> -The resident is afraid of water and did not want to get his/her head wet. The resident's family member brought the resident a shower chair to feel more secure. -On the evening of 04/24/23, he/she, the MCD and Administrator became aware of an incident involving the resident and CP A; -The MCD suspended CP A and CP B pending the investigation. -On 04/24/23, LPN E assessed the resident's bruising he/she sustained from the incident. The DOW assessed the resident on the morning of 04/25/23; -The resident said a staff member was rough with him/her. He/she had a bruise on his/her right wrist that looked like a hand print wrapped around his/her wrist. It was fresh and dark purple; -On the morning of 04/25/23, she (DOW) viewed the facility's camera footage and after reviewing 	A8022		

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A8022	<p>Continued From page 24</p> <p>them, she considered the incident abuse;</p> <p>-She (DOW) called CP B to obtain his/her statement and CP B said he/she held the resident's hands down. He/she (CP B) knew it was wrong and became physically ill after the incident occurred;</p> <p>-She (DOW) called CP A to obtain a statement and his/her story was all over the place. CP A did not know she (DOW) already viewed the camera footage. He/she had to redirect CP A and CP A agreed the resident had a right to refuse and when the DOW asked if the CP felt he/she was wrong to force the resident, the CP asked the DOW what else was he/she (CP A) supposed to do and how many times could the resident refuse a shower;</p> <p>-If a resident refused a shower, she expected staff to figure out why the resident refused, give reassurance, try to make the environment inviting and approach multiple times. If the resident refused three times, the CP should report to the charge nurse or her (DOW). Staff should not force a resident to shower;</p> <p>-She completed the residents' CBAs and ISPs. They showed how much assistance a resident needed and the residents' preferences. Any staff could view these to know how to care for a specific resident.</p> <p>-The resident preferred to bathe independently and preferred to sponge bathe and the ISP should show the resident's preferences for a sponge bath and not a shower.</p> <p>-On 04/26/23 she (the DOW) updated the resident's ISP and CBA to include the resident's bath chair.</p> <p>During an interview on 04/27/23 at 4:19 P.M., the Administrator said the following:</p> <p>-He expected staff to respect the rights of residents including the right to refuse a shower;</p>	A8022		

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A8022	<p>Continued From page 25</p> <p>-He considered CP A and CP B's actions against the resident a violation of the resident's rights, and after hearing the resident's accounts of the incident and viewing the camera footage, also considered it physical abuse.</p> <p>-He suspended CP A on 04/24/23 and CP B on 04/25/23 and neither staff worked since 04/23/23.</p> <p>During an interview on 04/28/23, at 12:59 P.M., the Medical Director said the following:</p> <p>-If a resident did not want to take a shower, staff should not force the resident to do so;</p> <p>-If a staff member forced a resident to shower and bruising occurred on the resident, he/she considered this abuse and violation of the resident's rights.</p> <p>-The facility notified his/her office and nurse practitioner (NP) of the incident and the NP added the information to the resident's medical record;</p> <p>-The resident suffered bruising and based on facility staff's description the resident received the injury from abuse.</p> <p>MO00217502</p> <p>NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger class I level. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had begun implementing corrective action to address the violation. During the onsite visit, the facility suspended CP A and CP B pending the investigation and expanded in-servicing of staff on the types of abuse, techniques for bathing residents with dementia and strategies for residents who refuse care. The facility continued the investigation to include all residents to ensure no other residents had been affected. A final</p>	A8022		

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A8022	Continued From page 26 revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the imminent danger was removed.	A8022		