STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265808	A. BUILDING _____ B. WING _____	C 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW CARE CENTER AT DOUGHERTY FERRY	13612 BIG BEND ROAD VALLEY PARK, MO 63088

(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) COMPLETION DATE
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their abuse policy by not reporting timely after an allegation of sexual abuse was made by one resident (Resident #12) of 12 sampled residents. The census was 82 with 46 in certified beds.	F 609	See attached Plan of Correction	

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

Administrator 7/3/24

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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Review of the facility's Freedom from Abuse, Neglect and Exploitation-Investigation and Reporting policy, revised November 2023, showed:
-Policy Statement: At the facility, all reports of resident abuse shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported;
-Reporting: All alleged violations involving abuse will be reported to the facility Administrator. Or his/her designee, to the following persons or agencies:
-The State licensing/certification agency responsible for surveying/licensing the facility;
-The resident's representative;
-Law enforcement officials;
-The resident's physician;
-The facility medical director;
-Suspected abuse, neglect, exploitation or mistreatment will be reported within two hours;
-Alleged abuse will be reported within two hours if the alleged events have resulted in serious bodily injury;
-If events that cause the allegations do not involve abuse or not resulted in serious bodily injury, the report must be made within 24 hours;
-Verbal/written notices to agencies may be submitted via special carrier, fax, email or by telephone;
-The Administrator, or his/her designee will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five working days of the occurrence of the incident.

Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated

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assessment instrument completed by facility staff, dated 12/26/23, showed:
-Cognitively impaired;
-No behaviors;
-Required no assistance to shower/bathe;
-Diagnoses included dementia, anxiety and depression.

Review of the resident's care plan, revised 1/16/24, showed:
-Focus: The resident has impaired cognitive function related to dementia;
-Goal: The resident will improve current level of cognitive function through the review date;
-Interventions: Administer medications as ordered, discuss concerns about confusion, disease process, nursing home placement with resident/caregiver. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Monitor/document and report any changes in cognitive function.

Review of the resident's progress notes, showed:
-On 1/20/24 at 9:21 A.M., a phone call was transferred to this nurse by the front desk. It was this patient's family member. He/She asked to speak with the resident and he/she had been calling the resident's personal phone, but the resident is not answering. The cordless phone was taken to the resident. The resident took the phone call and spoke with his/her family for about five to seven minutes. While the resident was speaking to his/her family member, this nurse stepped away to speak with another family member. The resident handed the nurse the phone and said, "(He/She) needs to speak with you." Upon answering the phone, the family member said, "Don't tell (him/her) I told you, but

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(he/she) is saying that someone was being sexually inappropriate with (him/her) in the shower and that (he/she) was suicidal and was spitting (his/her) pills out into the toilet". This nurse spoke with the resident. Resident denies suicidal ideation and has no plans for suicide or how he/she would do it. The resident also denies any inappropriate sexual misconduct ever happening. "My family member has lost it and saying that stuff because (he/she) is out of town and worried about me. I never said any of those things to (him/her)". The assistant Director of Nursing (ADON) was notified. Safety checks will be put into place every hour for this patient. Nothing further to report;
-On 1/20/24 at 10:02 A.M., the resident's family member was called and advised that the resident was reported to have made claims of sexually inappropriate interaction, suicidal ideation and spitting up his/her pills. Resident's family member stated, "Well (he/she) does have dementia." Resident's family member also stated that the resident has said some stuff like that when he/she first came to the facility and his/her spouse told the nurse. The family member believes the resident did say those things to the family member but was not concerned at this time. Nothing further to report;
-No further progress notes regarding the incident.

Review of the facility's Summary of Investigation, dated 1/20/24, showed:
-The resident was on the phone with his/her sibling today, while speaking with the sibling, the resident handed the phone to the nurse on duty. The sibling reported to the nurse that the resident was talking about being touched inappropriately in the shower, that she was spitting out his/her medication, and was suicidal. Charge nurse

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immediately notified ADON and Administrator and started investigation interviewing resident and staff;
-The resident denied making these statements and reports his/her "sibling is crazy and making things up." The resident reports that no one ever touched him/her inappropriately, and he/she always takes medication, and he/she has no thoughts of harming him/herself. Statements obtained from staff at time of report. Staff to provide showers in pairs at this time. The resident's responsible party notified, who stated that the resident has dementia and does make unsubstantiated accusations at times;
-The resident does have diagnoses of unspecified dementia, moderate, without behavioral disturbances, psychotic disturbances, mood disturbances and anxiety, other symptoms and signs involving cognitive functions and awareness, major depressive disorder and generalized anxiety disorder;
-The resident was put on frequent checks as a precaution. Upon obtaining staff statements and further investigation, it was determined that these statements are unsubstantiated. Staff will continue to monitor and support resident's psychosocial needs.

Review of Department of Health and Senior Services' (DHSS) system for reporting alleged violations, showed no report from the facility regarding the incident on 1/20/24.

During an interview on 6/11/24 at 8:29 A.M., Certified Nursing Assistant (CNA) A said he/she was accused of touching the resident inappropriately. He/She did provide a shower to the resident on the day in question. The resident can shower on his/her own with supervision.

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CNA A only touched the resident's knees and back. The resident did everything else. He/She wrote a statement after the incident and was not suspended. He/She had continued to work with the resident after the incident.

During an interview on 6/11/24 at 8:37 A.M., the ADON said if there was an allegation of abuse, it should be reported. However, she would go through the chain of command when reporting allegations of abuse. She said it depended on the situation whether or not allegations should be reported. When told about the allegation of sexual abuse made by the resident, the ADON said, "it depends" and could not say if the incident should have been reported to DHSS. She said she reported it to the Director of Nursing (DON) and the Administrator. When the incident was originally reported to her, she did not suspend the staff member in question.

During an interview on 6/12/24 at 10:45 A.M., the DON said she was not aware the incident should have been called in. The investigation was concluded within two hours of the allegations, and they determined the allegation was not substantiated. They initiated 15-minute checks after the resident made the allegations. The resident said the allegation was not true. The resident was very confused, and exit seeking and wanted to leave the facility. The family was not too concerned about the allegations. She said she probably should have reported it at the time but followed the chain of command and reported to the Social Worker and the Administrator.

During an interview on 6/11/24 at 12:11 P.M., the Administrator said the resident was newly admitted when she made the allegations of

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F 609	Continued From page 6 someone touching him/her inappropriately in the shower. The resident's family member also said the resident was suicidal and spitting out his/her pills. The resident was placed on 15-minute checks and the responsible party was contacted. The responsible party said the resident made up allegations and was trying to leave the facility. The allegations were investigated within two hours. They could not determine who the staff member in question was. They decided to provide the resident with showers in pairs. They concluded the alleged abuse did not occur and did not call the allegations in to DHSS.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure they followed their abuse policy	F 610		

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by failing to conduct a thorough investigation into one resident's (Resident #12) allegation of sexual abuse. The resident reported the incident to a family member on 1/20/24. The facility initiated an investigation but failed to interview other residents regarding the incident of abuse. The sample size was 12. The census was 82 with 46 in certified beds.

Review of the facility's Freedom from Abuse, Neglect and Exploitation-Investigation and Reporting policy, revised November 2023, showed:
-Policy Statement: At the facility, all reports of resident abuse shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported;
-Policy Interpretation and Guidance;
-Role of the Administrator:
-If an incident or suspected incident of resident abuse is reported, the Administrator will assign the investigation to the appropriate individual. All the supporting documents relative to the alleged incident shall be provided to the person in charge of the investigation;
-The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation;
-The Administrator will ensure that any further potential abuse is prevented;
-The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident;
-Role of the Investigator:
-The individual conducting the investigation

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will, as a minimum;

-Review the resident's medical record to determine events leading up to the incident;

-Interview any witnesses to the incident;

-Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;

-Interview the resident's roommate, family members and visitors;

-Interview other residents to whom the accused employee provides care or services;

-Review all events leading up to the alleged incident;

-Reporting:

-All alleged violations involving abuse will be reported to the facility Administrator. Or his/her designee, to the following persons or agencies:

-The State licensing/certification agency responsible for surveying/licensing the facility;

-The resident's representative;

-Law enforcement officials;

-The resident's physician;

-The facility medical director;

-Suspected abuse, neglect, exploitation or mistreatment will be reported within two hours;

-Alleged abuse will be reported within two hours if the alleged events have resulted in serious bodily injury;

-If events that cause the allegations do not involve abuse or not resulted in serious bodily injury, the report must be made within 24 hours;

-Verbal/written notices to agencies may be submitted via special carrier, fax, email or by telephone;

-The Administrator, or his/her designee will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five working days of the occurrence of the incident.

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Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/26/23, showed:
-Cognitively impaired;
-No behaviors;
-Required no assistance to shower/bathe;
-Diagnoses included dementia, anxiety and depression.

Review of the resident's care plan, revised 1/16/24, showed:
-Focus: The resident has impaired cognitive function related to dementia;
-Goal: The resident will improve current level of cognitive function through the review date;
-Interventions: Administer medications as ordered, discuss concerns about confusion, disease process, nursing home placement with resident/caregiver. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Monitor/document and report any changes in cognitive function.

Review of the resident's progress notes, showed:
-On 1/20/24 at 9:21 A.M., a phone call was transferred to this nurse by the front desk. It was this patient's family member. He/She asked to speak with the resident and had been calling the resident's personal phone, but the resident is not answering. The cordless phone was taken to the resident. The resident took the phone call and spoke with his/her family for about five to seven minutes. While the resident was speaking to his/her family member, this nurse stepped away to speak with another family member. The resident handed the nurse the phone and said,

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"(he/she) needs to speak with you." Upon answering the phone, the family member said, "don't tell (him/her) I told you, but (he/she) is saying that someone was being sexually inappropriate with (him/her) in the shower and that (he/she) was suicidal and was spitting (his/her) pills out into the toilet". This nurse spoke with the resident. Resident denies suicidal ideation and has no plans for suicide or how he/she would do it. The resident also denies any inappropriate sexual misconduct of ever happening. "My family member has lost it and saying that stuff because (he/she) is out of town and worried about me. I never said any of those things to (him/her)". The assistant Director of Nursing (ADON) was notified. Safety checks will be put into place every hour for this patient. Nothing further to report;
-On 1/20/24 at 10:02 A.M., the resident's family member was called and advised that the resident was reported to have made claims of sexually inappropriate interaction, suicidal ideation and spitting up his/her pills. Resident's family member stated, "Well (he/she) does have dementia." Resident's family member also stated that the resident has said some stuff like that when he/she first came to the facility and his/her spouse told the nurse. The family member believes the resident did say those things to the family member but was not concerned at this time. Nothing further to report;
-No further progress notes regarding the incident.

Review of a handwritten statement by Certified Nursing Assistant (CNA) A, dated 1/20/24, showed: On 1/20/24, I gave the resident a shower. I washed his/her back, hair and feet. He/She did the rest. Nurse told me he/she said someone put their finger in the resident's private

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F 610	Continued From page 11 area. Review of the facility's Summary of Investigation, written by the Administrator, dated 1/20/24, showed: -The resident was on the phone with his/her sibling today, while speaking with the sibling, the resident handed the phone to the nurse on duty. The sibling reported to the nurse that the resident was talking about being touched inappropriately in the shower, that he/she was spitting out his/her medication, and was suicidal. Charge nurse immediately notified ADON and administrator and started investigation interviewing resident and staff; -The resident denied making these statements and reports his/her "sibling is crazy and making things up." The resident reports that no one ever touched him/her inappropriately, and he/she always takes medication, and he/she has no thoughts of harming him/herself. Statements obtained from staff at time of report. Staff to provide showers in pairs at this time. The resident's responsible party notified, who stated that the resident has dementia and does make unsubstantiated accusations at times; -The resident does have diagnoses of unspecified dementia, moderate, without behavioral disturbances, psychotic disturbances, mood disturbances and anxiety, other symptoms and signs involving cognitive functions and awareness, major depressive disorder and generalized anxiety disorder; -The resident was put on frequent checks as a precaution. Upon obtaining staff statements and further investigation, it was determined that these statements are unsubstantiated. Staff will continue to monitor and support resident's psychosocial needs.	F 610		

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Review of the resident's medical record and the facility's investigation, showed
-No documentation to show any other residents were interviewed;
-No documentation to show CNA A was suspended during the facility's investigation.

Review of the facility's handwritten safety checks, showed safety checks conducted on 1/20/24, 1/21/24, 1/22/24 and 1/23/24.

During an interview on 6/11/24 at 8:29 A.M., CNA A said he/she was accused of touching the resident inappropriately. He/She provided a shower to the resident on the day in question. The resident could shower on his/her own with supervision. CNA A only touched the resident's knees and back. The resident did everything else. He/She wrote a statement after the incident and was not suspended. He/She continued to work with the resident after the incident.

During an interview on 6/11/24 at 8:37 A.M., the ADON said if there was an allegation of abuse, it should be reported. However, she would go through the chain of command when reporting allegations of abuse. She said it depended on the situation whether or not allegations should be reported. When told about the allegation of sexual abuse made by the resident, the ADON said, "it depends" and could not say if the incident should have been reported to DHSS. She said she reported it to the Director of Nursing (DON) and the Administrator. When the incident was originally reported to her, she did not suspend the staff member in question.

During an interview on 6/12/24 at 10:45 A.M., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265808	A. BUILDING _____ B. WING _____	C 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW CARE CENTER AT DOUGHERTY FERRY	13612 BIG BEND ROAD VALLEY PARK, MO 63088

(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) COMPLETION DATE
F 610	Continued From page 13	F 610		

DON said the investigation was concluded within two hours of the allegations, and they determined the allegation was not substantiated. They initiated 15-minute checks after the resident made the allegations. The resident said the allegation was not true. The resident was very confused, and exit seeking and wanted to leave the facility. The family was not too concerned about the allegations. They did not interview any other residents after they determined the allegation was unsubstantiated. The investigation was concluded within two hours.

During an interview on 6/11/24 at 12:11 P.M., the Administrator said the resident was newly admitted when he/she made the allegations of someone touching him/her inappropriately in the shower. The resident's family member also said the resident was suicidal and spitting out his/her pills. The resident was placed on 15-minute checks and the responsible party was contacted. The responsible party said the resident made up allegations and was trying to leave the facility. The allegations were investigated within two hours. They could not determine who the staff member in question was. They decided to provide the resident with showers in pairs. They concluded the alleged abuse did not occur and did not call the allegations in to DHSS. No further interviews were conducted because they did not feel the allegation was substantiated.

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23101A	A. BUILDING: _____ B. WING _____	C 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW CARE CENTER AT DOUGHERTY FERI	13612 BIG BEND ROAD VALLEY PARK, MO 63088

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A4065	19 CSR 30-85.042(56) Schedule II Meds-Storage Facilities shall store Schedule II medications, including those in the emergency drug supply, under double lock separately from noncontrolled medication. Schedule II medications may be stored and handled with other noncontrolled medication if the facility has a single unit dose drug distribution system in which the quantity stored is minimal and a missing dose can be readily detected. II This regulation is not met as evidenced by: Based on observation and interview, the facility failed to store controlled substances (a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction) under a double lock for two medication rooms. The census was 82 with 36 in state licensed beds. Review of the facility's Controlled Substance policy, dated November 2023, showed: -Policy statement: the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications; -Policy Interpretation and Implementation: -Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises; -Personnel who are authorized to handle controlled substances are approved by the Director of Nursing (DON) services; -Controlled substances are stored in the medication room in a locked refrigerator; -Keys to controlled substances are kept on a key ring with nursing personnel responsible. During an interview and observation on 6/7/24 at 12:00 P.M., the medication door on the Meadow	A4065	See attached Plan of correction	

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	23101A	A. BUILDING: _____ B. WING _____	C 06/12/2024

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GARDEN VIEW CARE CENTER AT DOUGHERTY FERI	13612 BIG BEND ROAD VALLEY PARK, MO 63088

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A4065	Continued From page 1 Hall was locked. The medication refrigerator was unlocked and inside the refrigerator were five boxes with lorazepam concentrate (a controlled substance used to treat anxiety). Registered Nurse (RN) A said he/she did not know if he/she had a key to the refrigerator. The refrigerator had been unlocked for at least three days. Lorazepam should be stored under two locks and currently it was only stored under one lock. During an interview and observation on 6/7/24 at 12:50 P.M., the DON said lorazepam concentrate should be stored in the refrigerator. The refrigerator should be locked. Only nurses had the key to the lock. The DON said she was not aware the refrigerator was not locked. During an interview and observation on 6/7/24 at 1:00 P.M., the medication door on the Veranda Hall was locked. The medication refrigerator was unlocked and inside were six boxes of lorazepam concentrate. While the surveyor and DON were in the medication room, the nurse opened the door and handed the DON a box of lorazepam concentrate and said he/she had taken the medication out of the refrigerator and administered it to a resident. The DON said she would expect for controlled substances to be under double lock and key. During an interview on 6/11/24 at 6:35 A.M., RN B said lorazepam concentrate should be stored in a locked refrigerator. During an interview on 6/11/24 at 10:32 A.M., Licensed Practical Nurse (LPN) C said lorazepam concentrate should be stored in the refrigerator and the refrigerator should be locked along with the medication room door.	A4065		

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	23101A	A. BUILDING: _____ B. WING _____	C 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW CARE CENTER AT DOUGHERTY FERI	13612 BIG BEND ROAD VALLEY PARK, MO 63088

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A4065	Continued From page 2 During an interview on 6/12/24 at 11:00 A.M., the Administrator said she would expect for controlled substances to be stored under a double lock. The medication room and the medication refrigerator both should be locked. If the nurse took the medication out of the refrigerator to give to a resident, the Administrator would expect for the nurse to lock the refrigerator when they took the medication out of the refrigerator and when the medication was returned. The Administrator would expect for staff to follow the facility's policies and procedures.	A4065		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class III See deficiency cited at F610.	A8023		
A8025	19 CSR 30-88.010(25) Report A/N to DHSS/DMH When Needed If the administrator or other employee of a long-term care facility has reasonable cause to believe that a resident of the facility has been	A8025		

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A8025	Continued From page 3 abused or neglected, the administrator or employee shall immediately report or cause a report to be made to the department. Any administrator or other employee of a long-term care facility having reasonable cause to suspect that a vulnerable person has been subjected to abuse or neglect or observes such a person being subjected to conditions or circumstances that would reasonably result in abuse or neglect shall immediately report or cause a report to be made to the department and to the Department of Mental Health. I/II This regulation is not met as evidenced by: Class II See deficiency cited at F609.	A8025		

PLAN OF CORRECTION

Provider/Supplier Name:	Garden View Care Center at Dougherty Ferry
Street Address, City, Zip:	13612 Big Bend Road, Valley Park, MO 63088
Date of Survey:	6/6/24—6/12/24

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	26-5808

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and Federal law. The submission of this plan of correction does not constitute an admission on the part of Garden View Care Center at Dougherty Ferry or Garden View Care Centers of St. Louis as to the accuracy of the surveyors' findings nor the conclusions drawn there from. The Agencies submission of this Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. This plan of correction is intended to constitute the Facilities credible letter alleging compliance. Substantial compliance has been achieved no later than 7/24/24. Compliance will be maintained as provided in the plan of corrections.	7/24/24
F609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their abuse policy by not reporting timely after an allegation of sexual abuse was made by one resident (Resident #12) of 12 sampled residents. The census was 82 with 46 in certified beds. The alleged deficient practice had the potential to affect any residents residing within the community. The following corrective action has been accomplished for Resident #12: A full investigation was completed at the time of the incident. At that time, Resident #12 denied ever making these allegations to family member and when staff interviewed , insisted did not make these statements. Resident #12 was placed on frequent checks; staff statements were obtained, and staff were educated to provide showers in pairs for Resident #12. No	7/24/24

	F609 Continued employee was suspended at the time of incident as resident did not identify a specific employee and denied ever making these statements to her family member. Therefore, no employee was identified as an alleged perpetrator. Social Services will continue to monitor and support residents' psychosocial needs. The following corrective action will be accomplished: All employees will be in-serviced/educated on investigating and reporting abuse, neglect and exploitation. (See Exhibit 1-Investigating and Reporting Abuse In-Service) New hires will continue to be orientated on abuse, neglect and exploitation as well as reporting and investigating any alleged abuse. The following measures and systemic changes will be taken to ensure the alleged deficient practice does not recur: The facility will continue to ensure the safety and well-being of all residents by ensuring all allegations of abuse or neglect are investigated immediately and in an appropriate manner. The facility will report alleged violations to the Department of Health and Senior Services and/or local law enforcement as deemed appropriate and as per established GVCC policy. Employees will continue to be screened for history of abuse, neglect or mistreatment of residents prior to hire and ongoing thereafter. The Office Manager will keep the results of the background checks, FCSR, and EDL checks in the personnel files of employees. New hires will continue to be orientated on abuse, neglect and exploitation as well as reporting and investigating any alleged abuse. Employees will continue to be educated through in-service training and ongoing education on reporting allegations. The facility plans to monitor its performance and ensure solutions are sustained by: The Director of Nursing and Administrator will monitor any reports of suspected abuse and neglect and will follow the policy of Garden View Care Centers in the investigative process. The Administrator and Director of Nursing will report in quarterly QAPI meetings the results of any investigations that were completed during the quarter and any investigations requiring a report to DHSS.	
F610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure they followed their abuse policy by failing to conduct a thorough investigation into one resident's (Resident #12) allegation of sexual abuse. The resident reported the incident to	7/24/24

F610 Continued
a family member on 1/20/24. The facility initiated an investigation but failed to interview other residents regarding the incident of abuse. The sample size was 12. The census was 82 with 46 in certified beds.

The alleged deficient practice had the potential to affect any residents residing within the community.

The following corrective action has been accomplished for Resident #12:
A full investigation was completed at the time of the incident. At that time, Resident #12 denied ever making these allegations to family member and when staff interviewed , insisted did not make these statements. Resident #12 was placed on frequent checks; staff statements were obtained, and staff were educated to provide showers in pairs for Resident #12. No employee was suspended at the time of incident as resident did not identify a specific employee and denied ever making these statements to family member. Therefore, no employee was identified as an alleged perpetrator. Social Services will continue to monitor and support residents' psychosocial needs.

The following corrective action will be accomplished:
Social Services interviewed a random sample of residents to identify comfort at GVCC and potential for alleged violations. (See Exhibit 2- Resident Interviews)
All employees will be in-serviced/educated on investigating and reporting abuse, neglect and exploitation. (See Exhibit 1- Investigating and Reporting Abuse In-Service)
New hires will continue to be orientated on abuse, neglect and exploitation as well as reporting and investigating any alleged abuse.

The following measures and systemic changes will be taken to ensure the alleged deficient practice does not recur:
The facility will continue to ensure the safety and well-being of all residents by ensuring all allegations of abuse or neglect are investigated immediately and in an appropriate manner.

The facility will report alleged violations to the Department of Health and Senior Services and/or local law enforcement as deemed appropriate and as per established GVCC policy.

Employees will continue to be screened for history of abuse, neglect or mistreatment of residents prior to hire and ongoing thereafter. The Office Manager will keep the results of the background checks, FCSR, and EDL checks in the personnel files of employees.

New hires will continue to be orientated on abuse, neglect and exploitation as well as reporting and investigating any alleged abuse. Employees will continue to be educated through in-service training and ongoing education on reporting allegations.

	F610 Continued The facility plans to monitor its performance and ensure solutions are sustained by: The Director of Nursing and Administrator will monitor any reports of suspected abuse and neglect and will follow the policy of Garden View Care Centers in the investigative process. The Administrator and Director of Nursing will report in quarterly QAPI meetings the results of any investigations that were completed during the quarter and any investigations requiring a report to DHSS.	
A4065	19 CSR 30-85.042(56) Schedule II Meds-Storage This regulation is not met as evidenced by: Based on observation and interview, the facility failed to store controlled substances (a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction) under a double lock for two medication rooms. The census was 82 with 36 in state licensed beds. No resident was found to have been affected by the alleged deficient practice. The alleged deficient practice had the potential to affect all residents within the community. The following corrective actions will be accomplished: All nursing staff will be educated on the proper storage of controlled substances and remaining under a double lock. (See Exhibit 3- Schedule II Medication Storage In-Service) The following measures and systemic changes will be taken to ensure the alleged deficient practice does not recur: Director of Nursing and/or designee will perform weekly audits of Medication Rooms to ensure both locking mechanisms are in place and secure. (See Exhibit - Schedule II Medication Storage Audit) The facility plans to monitor its performance and ensure solutions are sustained by completing weekly medication storage audits and reporting the results in quarterly QAPI meetings.	7/24/24
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies See POC for F610	7/24/24
A8025	19 CSR 30-88.010(25) Report A/N to DHSS/DMH When Needed See POC for F609.	7/24/24

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.