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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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. 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 (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurrence of the incident. 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 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 (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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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 someone touching him/her inappropriately in the shower. The (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 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 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 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: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, (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 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; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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 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 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.