STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265159	A. Building B. Wing	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary, Queen and Mother Center	7601 Watson Road Shrewsbury, MO 63119

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29948 Based on interview and record review, the facility failed to ensure one resident was free from employee to resident abuse in which a resident's spouse restrained the resident while an agency nurse forced a syringe of medication into the resident's closed mouth, despite his/her verbal protests and physical resistance, for one of three sampled residents (Resident #4). The census was 121. The administrator was informed on 11/28/22 of an Immediate Jeopardy (IJ), which began on 10/16/22. The IJ was removed on 12/6/22 as confirmed by surveyor on-site verification. Review of the facility's policy titled, Freedom from Abuse, Neglect and Exploitation Policy and Procedure, developed 11/27/17, showed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse included but was not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraints not required to treat the resident's medical symptoms. An owner, licensee, administrator, licensed nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. All new employees or volunteers were to receive training on the abuse, neglect and exploitation policy prior to direct or indirect resident contact. The facility was to provide identification, ongoing assessment, and care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect. Employees must always report any abuse or suspicion of abuse immediately to the administrator. If a family member, resident representative or resident was possibly contributing to the potential abuse and the resident could be at risk, then the situation was to be evaluated and options identified and put into place for resident protection. The facility was to take all necessary actions as a result of an abuse investigation, including analyzing the occurrence to determine the reason that the abuse occurred and what changes needed to be made to prevent further occurrences: defining how care systems and processes would be changed to protect residents, training staff about the changes made as a result of the investigation and reporting, corrective action for staff involved in the incident, identifying the staff responsible, monitoring the implementation of the changes made to the abuse prevention plan. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated resident rights policy, showed residents of nursing homes had rights which were guaranteed to them under Federal and State laws. The laws required nursing homes to treat each resident with dignity and respect and care for each resident in an environment which promoted and protected their rights. Residents had the right to a dignified existence: to be treated with consideration, respect and dignity, as well as having their individuality, wishes and preferences recognized. They were to be free from abuse, neglect, exploitation and misappropriation of property. The right to a dignified existence also included exercising their rights without interference, coercion, discrimination or reprisal. Review of Resident #4's undated face sheet, showed an admitted [DATE] and his/her spouse listed as durable power of attorney (DPOA) for health care and finances (allows an individual/agent to make decisions regarding the resident's health care and finances, if the resident is unable to make decisions or communicate due to severe illness or injury). The facesheet lists malignant neoplasm of brain unspecified (brain cancer), encephalopathy unspecified (admission), headache unspecified, essential (primary) hypertension (high blood pressure), anxiety disorder unspecified and other seizures. Review of the record, showed no DPOA on file, nor was there documentation by a physician of the DPOA enacted due to incompetency by the resident. Review of the resident's care plan, updated 10/14/22, showed the following: -Potential for pain due to diagnosis of cancer; -Reposition for comfort. If this is not effective, then the resident has as needed (PRN) medication; -Caregiver role strain with the resident's terminal cancer; -Encourage communication between caregiver and staff. Review of the resident's October 2022, physician's orders, showed the following: -10/14/22, Lorazepam Intensol (sedative used to treat anxiety) Schedule IV concentrate 2 milligrams (mg)/millimeters (mL), amount: 0.25 mL. Special instructions: for comfort; -10/15/22, haloperidol lactate concentrate (high-potency antipsychotic used to treat mental/mood disorders) 2 mg/mL, amount: 0.5 mL oral. Special instructions: give with scheduled Lorazepam every 4 hours; -Morphine concentrate (treats moderate to severe pain) Schedule II solution 100 mg/5 mL (20 mg/mL) amount: 0.5 mL every 4 hours; -Morphine concentrate Schedule II solution 100 mg/5 mL (20 mg/mL) amount: 0.5 mL every 2 hours PRN for pain/shortness of breath. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's progress notes, showed on 10/15/22 at 2:37 P.M., the resident's spouse approached an unspecified nurse and requested the resident receive morphine every two hours. The nurse explained he/she could make hospice aware of the request. The spouse told the nurse when the resident was asleep, they needed to administer the medication to the resident and they did not have to ask the resident if they could give it to the resident. The nurse explained the nurse could not force it into the resident's mouth, when the resident pursed his/her lips tightly and turned his/her head. At 8:36 P.M., the resident's spouse approached another nurse and said the resident needed PRN morphine. When the nurse asked the resident if he/she was in pain, his/her spouse answered for him/her. The spouse also told the nurse if the resident refused his/her pain medications, the nurse was to give them to the spouse so the spouse could administer them. The spouse wanted staff to administer the resident's routine and PRN medications around the clock, regardless of how the resident was feeling. The spouse said the resident did not know what he/she was talking about. The nurse said he/she could not give the spouse the resident's medications to administer, the spouse said, yes you can. The nurse spoke with the Director of Nursing (DON) to make her aware of the spouse's behaviors. Review of Certified Nurse's Aide (CNA) B's written statement, dated 10/16/22, showed on 10/16/22, the resident's spouse activated the resident's call light and requested ice water. As CNA B was leaving, the spouse came out of the room and also asked the nurse to give the resident some medications for pain. As CNA B was coming back to the room, the spouse asked the nurse (Nurse A) to put the medications into the resident's mouth. The resident said no. So, the resident's spouse started holding the resident's arms and legs and told the nurse to go ahead and do it. The spouse said to put it into the resident's mouth, because the resident had brain cancer and did not know if he/she was in pain. CNA B said to the nurse, you can't do that. The nurse and spouse said that Nurse could, that it was in the resident's chart. So, the nurse put the medications in the resident's mouth. The resident started spitting it out, angering the spouse. So, CNA B and the nurse walked out of the room. CNA B asked the nurse, are you sure about what you just did? The nurse said, yes that he/she was going by what was in the resident's chart. However, it did not look right to CNA B. The nurse said that everything was in the computer regarding the resident's medications and what was going on with his/her brain cancer. CNA B said,okay, I was just asking because I don't have all that information. But, it just don't look good, that's all and I'm sorry if that's what it says and I know that you're the charge nurse. But, I was just asking. The nurse said it was okay, that everything is in here, that the resident was okay and would be fine. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Nurse A's statement, dated 10/19/22 at 1:18 P.M., showed at 2:00 P.M., the resident's spouse came out of the door (to his/her room) and signaled for Nurse A and the CNA to come in. The spouse told them the resident had to go to the bathroom. When they entered the room, the resident was trying to get out of the bed. Nurse A and the CNA held the resident to the side, to make it seem like he/she was peeing into a urinal. The resident kept trying to stand, saying he/she needed to get up. The spouse came back in and was by the resident's legs, rubbing them. The resident laid there for a minute, looking confused and rubbing his/her head with both hands. The spouse then said, ok, it's time to take your medicine. Nurse A put the first syringe by the resident's mouth and tried to administer the medication. Half of it got into the resident's mouth, before his/her hand came up and pushed the nurse's hand. The resident moved his/her head. Nurse A tried to go back towards the resident's mouth with a syringe and he/she moved his/her head again. The spouse was trying to soothe the resident to take it, but he/she was very agitated. He/she started kicking and swinging his/her hands. The spouse asked if Nurse A could give the next medication, so Nurse A tried to put the syringe of medication by the resident's mouth again. The resident was moving his/her head and spitting. He/she was kicking hard and the spouse was trying to hold the resident's legs down. Nurse A told the spouse that the medication was not getting into the resident's mouth. The spouse asked if Nurse A could return at 4:00 P.M. and administer a PRN dose. Review of the resident's progress notes, showed no entry on 10/16/22, involving medication administration by Nurse A. Review of the facility's self-report cover sheet, e-mailed on 10/19/22, showed the alleged incident involving the resident, Nurse A and the resident's spouse showed since the resident's admission on 10/13/22, the resident's spouse continued to ask for increases in pain and agitation medications without the consent of the resident. The resident's spouse was insisting that the nurses administer medications to the resident which were not warranted, based on pain observations and resident consent. The resident could voice pain levels and refuse medications, but the spouse was insisting that the staff follow the spouse's instructions on providing pain and agitation medications. The administrator and DON spoke with the resident's hospice company, in order to ask for additional assistance on communication to the spouse of the protocols the facility must follow when administering routine and PRN medications. During an interview on 11/11/22 at 4:04 P.M., Nurse C said the resident was alert enough to open his/her mouth, but would clench his/her teeth or turn his/her head away when he/she attempted to administer medications. The resident's spouse attempted to get Nurse C to forcefully administer the resident's medications, instructing him/her to push it through the resident's lips and towards the inside of the cheek. Nurse C told the resident's spouse that was against the law. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/8/22 at 3:00 P.M., the resident said on the day in question, Nurse A brought in three syringes of medication and did not identify what medications the syringes contained or ask the resident if he/she wanted to take the medications. The resident verbally declined them. His/her spouse said he/she was going to get them anyway. Without saying anything, Nurse A attempted to administer the first syringe. The resident was pushing it away. He/she fought to keep the syringe away from his/her mouth, so his/her spouse held him/her down. The resident said, no, I don't want it. Nurse A pushed another syringe into the resident's mouth. CNA B said, what are you doing? You ain't supposed to be doing that. Nurse A pushed the third syringe into the resident's mouth. The liquid medication was going into his/her mouth so fast, he/she was forced to swallow some of it. The resident resisted with all of his/her strength, but he/she was weak and helpless. All he/she could do was turn his/her head away. Some of the medication went up his/her nose, and some went all over his/her face and dried there. The medications the resident was forced to swallow drugged him/her to the point that he/she could not move or think clearly that night. All he/she could do was lie there with tears streaming out of his/her eyes. He/she found the incident very distressing and felt that it was physical and mental abuse. Afterwards, the resident was so fearful of staff, he/she did not want to be touched or drink any water (believing his/her spouse was adding the liquid morphine to it). The resident began declining all medications, as well as food and water fearing they contained medication. Without the pain medication in his/her system, the resident could think clearly and regained the ability to walk unassisted. The resident got him/herself off of hospice and discharged from the facility. After leaving the facility, he/she did not sleep through the night. Every time he/she heard a noise, he/she woke up afraid, thinking that someone was coming to administer medication. During an interview on 11/4/22 2:50 P.M., the resident's spouse said he/she urged staff to administer the resident's medications, based on the hours (the scheduled times) ordered by hospice of morphine for pain, Lorazepam for anxiety and haldol which was a mood stabilizer. On the day in question, the resident did knock Nurse A's hand away and turn his/her head as Nurse A administered the first syringe of medication. He/she tended to resist all medications, because he/she did not believe in them. The spouse said, [NAME], we need to take this for your anxiety. The spouse did not recall the resident swinging his/her hand or kicking or crying out. The spouse did not hold down the resident's arms or legs. The spouse just rubbed the resident's stomach and chest, in order to calm him/her down. The resident was not agitated and shouting. He/she did say he/she did not want to do the medications anymore. The spouse could not recall whether or not the resident was calling out for his/her daughter that day, or if that had occurred on a different day. Nurse A could not get the next syringe past the resident's lips. The spouse could not recall how many syringes of medication Nurse A attempted to administer, but recalled that the resident would not take any more medication. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 10/28/22 at 2:30 P.M. and 11/8/22 at 3:00 P.M., Nurse A said on 10/16/22, he/she was providing care to the resident for the first time. During the change of shift report, the outgoing nurse reported the resident had been at the facility for two days and received routine Ativan, haldol and morphine every four hours as well as PRN Ativan and morphine in between those doses every two hours. The outgoing nurse also said the resident's spouse was adamant about the resident receiving medications on time. At times, the spouse was also adamant about the resident receiving his/her PRN medications, regardless of whether or not the resident requested it. The outgoing nurse went on to report the resident had brain cancer, was not eating a lot and sometimes would hit the nurses' hand or move his/her head or spit out medications, while they were being administered. Nurse A did not receive any instructions on what to do, when any of those things occurred. At 2:00 P.M. that day, Nurse A went to the resident's room, accompanied by CNA B, to administer scheduled medications. The resident's spouse and children were present. The spouse had the children leave the room. The resident's spouse started rubbing the resident's legs and saying, it's time for your meds. Nurse A administered the first syringe of medications via the corner of the resident's closed mouth. Half of it went in, before the resident moved his/her head to the side. Nurse A tried again, attempting to stick a second syringe of medications in through the corner of the resident's mouth, so the resident would not choke. The resident started kicking and swinging his/her arms. His/her spouse pushed the resident's legs back down and held them. When the resident swung at the spouse, he/she grabbed his/her arms and held them down. The spouse said, can we try to give the next medication? The resident moved his/her head. Nurse A attempted to administer a total of two vials of medication. The resident did not receive any of the second vial. Nurse A had tried to push the syringe into the resident's mouth, but the resident resisted and had his/her mouth locked. The resident was not crying, but he/she was shouting (he/she's) trying to kill me. His/her spouse told Nurse A to administer the resident's PRN medication in two hours. Nurse A agreed to do so, because the resident was agitated and Nurse A felt Ativan might help. At 4:00 P.M., Nurse A went back. At that time, a family member calmed and soothed the resident, who had no problem taking the PRN medication. A week after the incident occurred, the DON called Nurse A, informed him/her the facility was conducting an investigation, requested a written statement and told Nurse A he/she should have stopped when the resident refused the medications and told the resident that Nurse A would return later to attempt the medication pass. Nurse A last worked at the facility a year ago. Prior to the incident, Nurse A had not received any education on the facility policies and no one informed him/her there was a binder at the nurse's station containing facility policies. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 10/28/22 at 2:30 P.M. and 11/8/22 at 3:00 P.M., CNA B said on 10/16/22, the resident was fairly new to the facility, appeared to be alert enough to know what was going on and was not normally combative. When CNA B saw him/her, the resident was lying in bed, waiting for water. While CNA B was present, the spouse said it was time for the resident's medications. The resident said, No, I don't need anything. Nurse A entered the room, introduced him/herself and told the resident he/she had the resident's medications. The resident said, I told you I don't want it. The spouse became annoyed and said, well you're gonna get it. The spouse told Nurse A to put the medications into the resident's mouth anyway, because the resident was confused. Nurse A pushed one of the syringes of medication into the resident's mouth. The resident turned his/her head away and spit out some of the medications. Nurse A attempted to administer a second syringe of medications. The resident tried to block it with his/her hand and the resident's spouse held down his/her arms. The resident started kicking, trying to get away and crying out for his/her daughter. The spouse held down his/her legs. The resident clamped his/her mouth shut and Nurse A pushed the syringe of medications past his/her lips through the side of his/her mouth. The resident started crying and saying, I told you I don't want it. CNA B spoke up and said, hey, you can't do that. The spouse turned and looked at CNA B, saying it was all in the resident's chart that he/she had brain cancer, was confused, did not know what was going on or what he/she was doing. Nurse A attempted to administer a total of three syringes of medication. When the resident's daughter entered the room, he/she told the daughter his/her spouse held him/her down and a nurse squirted the medications into his/her mouth. The resident said, (he/she's) trying to kill me. I told you, (he/she's) trying to kill me. Afterwards, CNA B reminded Nurse A the resident had the right to refuse medications. Nurse A said it was all in the resident's chart he/she had brain cancer, the resident was confused and did not know what he/she was saying or what he/she was doing. The resident had only been in the facility for a few days and CNAs did not have access to a resident's entire chart. However, CNA B believed what he/she had witnessed was abuse, due to the resident having been held down while Nurse A administered medications even though the resident's teeth were clenched together and the resident was crying out for his/her daughter. CNA B was also aware he/she was supposed to report any observed or suspected abuse within two hours. However, when the resident's spouse and Nurse A both said the resident's confusion was documented in the resident's chart, CNA B felt continuing to question their actions may have been overstepping CNA B's bounds. He/she started thinking that perhaps, the resident did not know what he/she was doing in refusing the medications and fighting during medication administration. His/her spouse said the resident needed the medication. The incident occurred during the day shift on Sunday (10/16/22). The incident continued to bother CNA B, because it just didn't look right. So, CNA B reported it the next time he/she worked, which was Tuesday (10/18/22). He/she went to Social Worker D and started asking questions. During interviews on 11/7/22 at 4:06 P.M. and 11/8/22 at 3:22 P.M., Social Worker D said CNA B reported the allegation of the resident's spouse holding the resident down while the nurse administered medications against the resident's wishes to Social Worker D on Tuesday (10/18/22). Social Worker D was on his/her way to a care planning meeting at the time and instructed CNA B to go and tell the administrator. After learning of the incident, Social Worker D spoke to the resident who said he/she recalled being held down, after saying he/she did not want the medications and the nurse gave it to him/her anyway. The resident said Nurse A was trying to put it into the resident's mouth while the resident's teeth were gritted. Social Worker D asked about the spouse being continued to allow to visit and the resident did not say that he/she did not want his/her spouse to visit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 10/21/22 at 10:10 A.M. and 11/4/22 at 1:29 P.M., the DON said on the resident's first day, his/her spouse came in demanding a larger amount of pain medication than was typically given. The spouse was upset the resident's physician had declined a request for higher doses. When staff attempted to administer the resident's medications, the resident would clench his/her teeth, shake his/her head and voice concerns about the medications. The resident said he/she did not want any more pain medication, because it made him/her loopy. The resident's level of alertness went back and forth, when he/she received the medications. The DON had not observed any indications the resident needed pain medication or haldol to keep him/her calm. As the days progressed, the resident increasingly clenched his/her teeth during med pass. The nurses were verbally instructed, shift by shift, via the outgoing nurse during the change of shift report, to inform the resident whenever they were about to administer morphine. They were told not to administer it, if the resident declined it. The spouse wanted them to force the medications into the resident's mouth. The DON expected the nurses to know if a resident declined medications, then they were not to administer it. Based on nursing judgement, nurses should know that a line was crossed, if a family member held down a resident. They should go and get a nursing supervisor. The facility did not provide training or orientation to temporary staff regarding facility policies. However, agency staff were informed there was a resource binder at each nurses station, to which they could refer for facility policies as guidance on how to handle difficult situations. Based on the facility's resident rights policy, a resident had the right to refuse medications. A nurse forcing a resident to take medications against their will was a form of abuse. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/7/22 at 2:37 P.M., the administrator said the incident occurred on 10/16/22, but CNA B reported the incident and actually wrote his/her witness statement on 10/18/22, which was the next day he/she worked. Social Worker D said CNA B reported the incident to Social Worker D on Tuesday (10/18/22). The facility reported the allegations to DHSS the same day, via the self-report cover sheet and the written statements of Nurse A and CNA B, because they realized Nurse A and the resident's spouse physically and mentally abused the resident. The administrator expected staff to report abuse allegations immediately to the charge nurse. CNA B had undergone training on the abuse and neglect policy in the past. During those sessions, other employees in the chain of command were identified to whom he/she could report abuse allegations. CNA B also received a list of contact phone numbers for those individuals. The DON said after the incident, she informed CNA B the abuse allegations should have been reported immediately. The DON said she informed CNA B that CNA B should have immediately reported the abuse allegations to a supervisory staff person someone in management. According to the administrator, she and the DON met with the resident's spouse after the incident and asked what happened. The spouse said he/she had to hold the resident down, due to the resident kicking his/her legs, swinging his/her arms and refusing medications. The spouse claimed that he/she rubbed or held the resident's legs in order to calm the resident. They did not discuss with the resident's spouse the inappropriateness of the spouse's actions in violating the facility resident rights and abuse prohibition policies. The resident was able to make his/her needs known, even though the resident's spouse said the resident was confused. The administrator felt Nurse A and the resident's spouse engaged in mental and physical abuse of the resident on 10/16/22. Individuals from temporary agencies working in the facility were considered contracted employees. Initially, staff were going by what the spouse said about the resident scratching his/her head as an indication he/she was in pain. Then, the resident started coming to and refusing his/her medications. In the midst of refusing his/her medications, the resident said they made him/her loopy and very tired. As the resident took less medication, due to declining them, the resident was able to express the medications made him/her feel loopy and tired. Not taking the medications allowed the resident to formulate his/her thoughts. The resident improved to the point he/she got off of hospice and was ambulating, when he/she was discharged from the facility. Note: At the time of the complaint investigation, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review, it was determined the facility had implemented corrective action to address and lower the violation at that time. A revisit/final revisit will be conducted to determine if the facility is in substantial compliance with the participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State Law (Section 198.0261 RSMo) requiring that prompt remedial action be taken to address Class I violation(s). MO00208742

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	265159	A. Building B. Wing	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary, Queen and Mother Center	7601 Watson Road Shrewsbury, MO 63119

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29948 Based on interview and record review, the facility staff did not follow their Abuse Prohibition policy and immediately report an incident of employee to resident abuse. A certified nurse aide (CNA) witnessed an agency nurse forcing a syringe of medications into a resident's closed mouth, while the resident protested and was restrained by his/her spouse. This affected one of three sampled residents (Resident #4). The census was 121. Review of the facility's policy titled, Freedom from Abuse, Neglect and Exploitation Policy and Procedure, developed 11/27/17, showed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse included but was not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraints not required to treat the resident's medical symptoms. An owner, licensee, administrator, licensed nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. All new employees or volunteers were to receive training on the abuse, neglect and exploitation policy prior to direct or indirect resident contact. The facility was to provide identification, ongoing assessment, and care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect. Employees must always report any abuse or suspicion of abuse immediately to the administrator. If a family member, resident representative or resident was possibly contributing to the potential abuse and the resident could be at risk, then the situation was to be evaluated and options identified and put into place for resident protection. The facility will ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, that may constitute a reasonable suspicion of a crime are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including 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. Review of Resident #4's undated face sheet, showed his/her spouse listed as durable power of attorney (DPOA) for health care and finances (allows an individual/agent to make decisions regarding the resident's health care and finances, if the resident is unable to make decisions or communicate due to severe illness or injury). Review of the record, showed no DPOA on file, nor was there documentation by a physician of the DPOA enacted due to incompetency by the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA B's written statement, dated 10/16/22, showed on 10/16/22 the resident's spouse activated the resident's call light and requested ice water. As CNA B was leaving, the spouse came out of the room and also asked the nurse (Nurse A) to give the resident some medications for pain. As CNA B was coming back to the room, the spouse asked the nurse to put the medications into the resident's mouth. The resident said no. So, the resident's spouse started holding the resident's arms and legs and told the nurse to go ahead and do it. The spouse said to put it into the resident's mouth, because the resident had brain cancer and did not know if he/she was in pain. CNA B said to the nurse, you can't do that. The nurse and spouse said that the nurse could, that it was in the resident's chart. So, the nurse put the medications in the resident's mouth. The resident started spitting it out, angering the spouse. CNA B and the nurse walked out of the room. CNA B asked the nurse, are you sure about what you just did? The nurse said yes, that he/she was going by what was in the resident's chart. However, it did not look right to CNA B. The nurse said that everything was in the computer regarding the resident's medications and what was going on with his/her brain cancer. CNA B said,okay, I was just asking because I don't have all that information. But, it just don't look good, that's all and I'm sorry if that's what it says and I know that you're the charge nurse. But, I was just asking. The nurse said it was okay, that everything is in here, that the resident was okay and would be fine. Review of the resident's progress notes, showed no entry on 10/16/22 involving medication administration by Nurse A. Review of Nurse A's statement, dated 10/19/22 at 1:18 P.M., showed the resident's spouse came out of the door (to his/her room) and signaled for Nurse A and the CNA to come in. After the spouse said it was time for the resident's medicine, Nurse A put the first syringe by the resident's mouth and tried to administer the medication. Half of it got into the resident's mouth, before his/her hand came up and pushed the nurse's hand. The resident moved his/her head. Nurse A tried to go back towards the resident's mouth with a syringe and he/she moved his/her head again. The spouse was trying to soothe the resident to take it, but he/she was very agitated. He/she started kicking and swinging his/her hands. The spouse asked if Nurse A could give the next medication, so Nurse A tried to put the syringe of medication by the resident's mouth again. The resident was moving his/her head and spitting. He/she was kicking hard and the spouse was trying to hold the resident's legs down. Nurse A told the spouse that the medication was not getting into the resident's mouth. Review of the facility's self-report cover sheet, e-mailed on 10/19/22, showed the alleged incident involving the resident, Nurse A and the resident's spouse showed since the resident's admission on 10/13/22, the resident's spouse continued to ask for increases in pain and agitation medications without the consent of the resident. The resident's spouse was insisting that the nurses administer medications to the resident which were not warranted based on pain observations and resident consent. The resident could voice pain levels and refuse medications, but the spouse was insisting that the staff follow the spouse's instructions on providing pain and agitation medications. The administrator and Director of Nursing (DON) spoke with the resident's hospice company, in order to ask for additional assistance on communication to the spouse of the protocols the facility must follow when administering routine and PRN medications. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/8/22 at 3:00 P.M., the resident said on the day in question, Nurse A brought in three syringes of medication and did not identify what medications the syringes contained or ask the resident if he/she wanted to take the medications. The resident verbally declined them. His/her spouse said he/she was going to get them anyway. Without saying anything, Nurse A attempted to administer the first syringe. The resident was pushing it away. He/she fought to keep the syringe away from his/her mouth, so his/her spouse held him/her down. The resident said, no, I don't want it. Nurse A pushed another syringe into the resident's mouth. CNA B said, what are you doing? You ain't supposed to be doing that. Nurse A pushed the third syringe into the resident's mouth. The liquid medication was going into his/her mouth so fast, he/she was forced to swallow some of it. The resident resisted with all of his/her strength, but he/she was weak and helpless. All he/she could do was turn his/her head away. Some of the medication went up his/her nose, and some went all over his/her face and dried there. The medications the resident was forced to swallow drugged him/her to the point that he/she could not move or think clearly that night. All he/she could do was lie there with tears streaming out of his/her eyes. He/she found the incident very distressing and felt that it was physical and mental abuse. Afterwards, the resident was so fearful of staff, he/she did not want to be touched or drink any water (believing his/her spouse was adding the liquid morphine to it). The resident began declining all medications, as well as food and water fearing they contained medication. Without the pain medication in his/her system, the resident said he/she could think clearly and regained the ability to walk unassisted. The resident got him/herself off of hospice and discharged from the facility. After leaving the facility, he/she did not sleep through the night. Every time he/she heard a noise, he/she woke up afraid, thinking that someone was coming to administer medication. During an interview on 11/4/22 2:50 P.M., the resident's spouse said on the day in question, the resident did knock Nurse A's hand away and turn his/her head as Nurse A administered the first syringe of medication. He/she tended to resist all medications, because he/she did not believe in them. The spouse said, [NAME], we need to take this for your anxiety. The spouse did not recall the resident swinging his/her hand or kicking or crying out. The spouse did not hold down the resident's arms or legs. The spouse just rubbed the resident's stomach and chest, in order to calm him/her down. The resident was not agitated and shouting. He/she did say he/she did not want to do the medications anymore. Nurse A could not get the next syringe past the resident's lips. The spouse could not recall how many syringes of medication Nurse A attempted to administer, but recalled that the resident would not take any more medication. During interviews on 10/28/22 at 2:30 P.M. and 11/8/22 at 3:00 P.M., Nurse A said on 10/16/22 at 2:00 P.M., Nurse A administered one syringe of medications via the corner of the resident's closed mouth. Half of it went in, before the resident moved his/her head to the side. Nurse A tried again, attempting to stick a second syringe of medications in through the corner of the resident's mouth. The resident started kicking and swinging his/her arms. His/her spouse pushed the resident's legs back down and held them. When the resident swung at the spouse, he/she grabbed his/her arms and held them down. Nurse A had tried to push the syringe into the resident's mouth, but the resident resisted and had his/her mouth locked. A week after the incident occurred, the DON called Nurse A, informed him/her the facility was conducting an investigation, requested a written statement and told Nurse A he/she should have stopped when the resident refused the medications and told the resident that Nurse A would return later to attempt the medication pass. Nurse A last worked at the facility a year ago. Prior to the incident, Nurse A had not received any education on the facility policies and no one informed him/her there was a binder at the nurse's station containing facility policies. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 10/28/22 at 2:30 P.M. and 11/8/22 at 3:00 P.M., CNA B said on 10/16/22, CNA B believed what he/she had witnessed was abuse, due to the resident having been held down while Nurse B administered medications even though the resident's teeth were clenched together and the resident was crying out for his/her daughter. CNA B was also aware he/she was supposed to report any observed or suspected abuse within two hours. However, when the resident's spouse and Nurse A both said the resident's confusion was documented in the resident's chart, CNA B felt continuing to question their actions may have been overstepping CNA B's bounds. He/she started thinking that perhaps, the resident did not know what he/she was doing in refusing the medications and fighting during medication administration. His/her spouse said the resident needed the medication. The incident occurred during the day shift on Sunday (10/16/22). The incident continued to bother CNA B, because it just didn't look right. So, CNA B reported it the next time he/she worked, which was Tuesday (10/18/22). He/she went to Social Worker D and started asking questions.On 11/8/22, the DON spoke with CNA B about the requirement to report abuse within two hours of suspecting, observing or learning of it. There was now a paper at the nurse's station listing phone numbers for the DON, administrator and management. It was the first time, since the incident, that anyone had spoken to CNA B about his/her delay in reporting the incident. During interviews on 11/7/22 at 4:06 P.M. and 11/8/22 at 3:22 P.M., Social Worker D said CNA B reported the allegation of the resident's spouse holding the resident down while the nurse administered medications against the resident's wishes to Social Worker D on Tuesday (10/18/22). Social Worker D was on his/her way to a care planning meeting at the time and instructed CNA B to go and tell the administrator. After learning of the incident, Social Worker D spoke to the resident who said he/she recalled being held down, after saying he/she did not want the medications and the nurse gave it to him/her anyway. The resident said Nurse A was trying to put it into the resident's mouth while the resident's teeth were gritted. During interviews on 10/21/22 at 10:10 A.M. and 11/4/22 at 1:29 P.M., the DON said she had not observed any indications the resident needed pain medication or haldol to keep him/her calm. As the days progressed, the resident increasingly clenched his/her teeth during med pass. The nurses were verbally instructed, shift by shift, via the outgoing nurse during the change of shift report, to inform the resident whenever they were about to administer morphine. They were told not to administer it, if the resident declined it. The spouse wanted them to force the medications into the resident's mouth. The DON expected the nurses to know if a resident declined medications, then they were not to administer it. Based on nursing judgment, nurses should know that a line was crossed, if a family member held down a resident. They should go and get a nursing supervisor. The facility did not provide training or orientation to temporary staff regarding facility policies. However, agency staff were informed there was a resource binder at each nurses station, to which they could refer for facility policies as guidance on how to handle difficult situations. Based on the facility's resident rights policy, a resident had the right to refuse medications. A nurse forcing a resident to take medications against their will was a form of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/22 at 2:37 P.M., the Administrator said the incident occurred on 10/16/22, but CNA B reported the incident and actually wrote his/her witness statement on 10/18/22, which was the next day he/she worked. Social Worker D said CNA B reported the incident to Social Worker D on Tuesday (10/18/22). The facility reported the allegations to DHSS the same day, via the self-report cover sheet and the written statements of Nurse A and CNA B, because they realized Nurse A and the resident's spouse physically and mentally abused the resident. The Administrator expected staff to report abuse allegations immediately to the charge nurse. CNA B had undergone training on the abuse and neglect policy in the past. During those sessions, other employees in the chain of command were identified to whom he/she could report abuse allegations. CNA B also received a list of contact phone numbers for those individuals. The DON said after the incident, she informed CNA B the abuse allegations should have been reported immediately. The Administrator felt Nurse A and the resident's spouse engaged in mental and physical abuse of the resident on 10/16/22. Individuals from temporary agencies working in the facility were considered contracted employees. MO00208742