STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265669	A. Building B. Wing	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warrensburg Manor Care Center	400 Care Center Drive Warrensburg, MO 64093

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 33409 Based on interview and record review, the facility failed to ensure two sampled residents (Resident #1 and #18) were treated with dignity and respect. Agency Licensed Practical Nurse (LPN) A was inconsiderate and raised his/her voice when speaking to a cognitively impaired sampled resident (Resident #1); and became argumentative and raised his/her voice to one sampled resident (Resident #18) on 1/21/23, out of 13 sampled residents. The facility census was 53 residents. 1. Record review of Resident #1's Face sheet showed he/she had diagnoses of: -Schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others). -Alzheimer's disease (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). -Anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus). -Borderline Personality (BPD-a mental illness marked by an ongoing pattern of varying moods, self-image, and behavior). Record review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 1/20/23, showed: -The Brief Interview for Mental Status (BIMS) should be conducted. -Had a BIMS score of 3 out of 15 which indicated severe cognitive impairment. -Was able to understand others and was able to make his/her needs known. -Was independent with ambulation and transfers. Record review of the resident's nursing note dated 1/21/23 at 11:35 A.M. by Agency LPN A showed: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During the morning medication pass Resident #1 came up to this nurse and told him/her that someone needed to do something with his/her bed. The bed sheets were slick. -Agency LPN A said he/she would have to go to laundry and get linens that would fit the bed, Resident #1 said yeah OK. -Resident #1 immediately got upset and walked away from the nurses cart. -Resident #1 came back while Agency LPN A's back was turned and tried to get close to the nurse to hit him/her. -Agency LPN A moved out of the way. -The second time Resident #1 came up to the cart, he/she took the box of Kleenex saying they were his/hers Kleenex and that the nurse had taken them. -NOTE: There was no documentation related to the resident actually hitting Agency LPN A. Record review of the resident's medical record showed there was no additional documentation related to Agency LPN A being allegedly inconsiderate and having a disagreement with residents on 1/21/23. Record review of the resident's Care Plan for Impaired Coping dated 1/23/23 showed: -He/she was at risk for harm directed toward to others and or himself/herself. -The resident would be free of verbally aggressive behaviors. -Interventions included: --Administer medications as prescribed. --Encourage the resident to verbalize cause for aggression. --If the resident posed a potential threat to injure himself/herself or others staff were to notify the physician. --If safe, allow the resident personal space. --Monitor for cognitive, emotional or environmental factors that may contribute to violent behaviors. --Monitor for signs/symptoms of agitation. --Provide clear, simple instructions, provide reorientation to the situation. --Provide verbal feedback to the resident regarding his/her behavior and utilize diversion techniques as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the resident's medical record with the MDS Coordinator on 2/9/23 showed no additional documentation found related to the incident with the Agency LPN A. During an interview on 2/8/23 at 10:17 A.M., Resident #1 said: -Sometimes staff members have good and bad days. (related to moods) -He/she could kind of remember Agency LPN A being rude to him/her. -He/she was not fearful, and he/she loved being at the facility. Observation on 2/8/23 at 10:17 A.M. showed the resident was able to make his/her basic care needs known. 2. Record Review of Resident #18's Admission face sheet showed he/she had a diagnosis of Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Was his/her own responsible person. During an interview on 2/10/23 at 10:23 A.M., the resident said: -Resident #1 came up to Agency LPN A and was requesting items from him/her. -Resident #1 was following Agency LPN A around and he/she finally got agitated with Resident #1 and told him/her to get out of his/her space. -He/she tried to explain to Agency LPN A that Resident #1 was forgetful, he/she did not remember asking for items or assistance. -Agency LPN A got upset with him/her also. -Agency LPN A was agitated and short and spoke to him/her and other residents on the unit with a loud voice. 3. Record review the facility staffing sheet for January 2023 showed: -On 1/21/23 during the day shift Agency LPN A was scheduled to work the back hallway on the day shift. -Had LE by his/her name which indicated he/she left early. Record review of a witness statement by Certified Nurses Aide (CNA) B dated 1/21/23 showed: -Agency LPN A seemed very frustrated that morning. -He/she saw Resident #1 go over to Agency LPN A. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Agency LPN A said you better get out of my space. I will call the doctor to evaluate you. -Resident #1 flipped Agency LPN A off and walked away. That was around breakfast time, maybe 8:30 A.M., he/she really did not remember. -Around 10:00 A.M. he/she heard Agency LPN A yelling at Resident #18 during the activity saying; you all are rude and I do not even care anymore. I am trying to do my job. During an interview on 2/8/23 at 9:30 A.M., the Housekeeping Supervisor said: -On 1/21/23 Resident #1 was coming down the hall and seemed upset. -He/she asked Resident #1 what was wrong and he/she had pointed back to Agency LPN A and said that thing back there. -Resident #1 said he/she was told by Agency LPN A don't ever touch me and don't get in my bubble. -Resident #1 said he/she was only wanting his/her sheets changed. -Resident #1 said he/she had tapped Agency LPN A on the shoulder. -He/she was informed that was three or four CNA's who had witnessed Agency LPN A yelling, belittling Resident #1 and residents who were playing bingo saying they were to loud. -He/she called the Administrator, who came to the facility and started a full investigation. -Agency LPN A was asked to leave the facility. -Administration had obtained witness statements from facility staff. -He/she was unaware that he/she was able to ask the Agency LPN A to leave the building. During an interview on 2/8/23 at 11:15 A.M., Certified Medication Technician (CMT) B said: -On 1/21/23, he/she was coming off the south back hallway, when he/she heard and saw Agency LPN A and Resident #1 exchanging words. -Agency LPN A said that Resident #1 had struck him/her in the neck. -The resident was wanting a box of tissues. -Agency LPN A was trying to pass medication while Resident #1 was around the medication cart. -Resident #1 was agitated, so he/she escorted Resident #1 to get a soda and back to his/her bedroom to change the linens on his/her bed. -He/she could hear Agency LPN A arguing with another resident who was trying to explain that Resident #1 had dementia and forgot easily. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Another staff member had already contacted and reported Agency LPN A's behaviors to the charge nurse and the Administrator. -The facility HR staffing coordinator and Administrator arrived at the facility and started the investigation which included obtaining witness statements. -The Administrator asked Agency LPN A to leave the facility. During an interview on 2/8/23 at 11:55 A.M. Agency Human Resources (HR) said; -He/she had verified the information reported to them by the facility Administrator on 1/21/23. -Agency LPN A had been placed on leave of absence until the investigation was completed. -The agency provided training to agency staff related to resident rights and respect. During an interview on 2/10/23 at 9:30 A.M., CMT D said Resident #1 could be cranky at times, he/she did not like crowds or noise. During an interview on 2/10/23 at 11:43 A.M., the Administrator said: -The Housekeeping Supervisor called late morning on 1/21/23 said Agency LPN A was not acting right toward the residents. -A resident was upset and facility staff felt uncomfortable with Agency LPN A in the building. -He/she called and talked with the agency HR to have them remove Agency LPN A from the building. -When he/she called back to the building Agency LPN A was still in the building. --He/she called the agency again. -He/she arrived at the building with the facility Human Resource Director, and went to the back hallway to find Agency LPN A. -He/she asked Agency LPN A to leave the building and Agency LPN A became argumentative. -He/she asked the facility Human Resource Director to call the police to escort Agency LPN A out of the building. Agency LPN A then left the building. -He/she called and gave more details of the incident to the agency supervisor and placed Agency LPN A on the no call back list. During an interview on 2/10/23 at 12:40 P.M. Director of Nursing (DON) said: -He/she thought the disagreement happened during the evening shift. -He/she would expect the notifications to be documented in the residents nursing notes. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #1 could be grouchy at times and difficult to care for. -He/she would expect nursing staff to document any behavior in the resident nursing notes. -He/she expected agency staff to complete a facility orientation related to the facility policy and the care of the resident. -He/she would expect agency staff to ask questions of facility staff on how to handle difficult resident behaviors. During a phone interview on 2/15/23 at 10:17 A.M., Agency LPN A said on 1/21/23 during morning medication pass: -Resident #1 came to the medication cart and requested his/her bed be made. -He/she informed the resident that he/she would have to check the laundry to get the right sheet. -The resident had walked away upset and said ok. -Resident #1 was pacing the floor walking back and forth in front of the medication cart and Agency LPN A. -Resident #1 had Dementia and Schizophrenia and could get upset easily. -He/she was getting medications and Resident #1 was passing by, he/she asked Resident #1 if he/she would like his/her medications. -The resident was given his/he medications. -He/she was getting tissues for another resident to administer eye drops. -Resident #1 snatched the box of tissues and hit Agency LPN A in the throat with the box and then called Agency LPN A a bad name. -He/she informed Resident #1, he/she was not to hit him/her again. -Resident #1 was cursing and yelling derogatory racial slurs toward him/her. -He/she told Resident #1 that's okay (related to slurs), but if he/she hit him/her again he/she would call 911. -Resident #1 started going toward him/her. -CMT B intervened and took Resident #1 to the front of the building for about 15-20 minutes. -When Resident #1 returned to the unit, he/she was pacing back in forth in front of him/her while cursing and was attempting come toward him/her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she stepped back away from Resident #1. -Residents were getting upset about not getting their medication due to Resident #1's behaviors of attempting to hit and get into his/her personal space. -He/she informed his/her co-worker if Resident #1 did not stay out of his/her space, he/she would have to to call the doctor to have Resident #1 evaluated for his/her out of control behaviors toward him/her. -Resident #1 was showing signs of aggressive behaviors toward him/her and Resident #1's behavior had the potential of affecting other residents and other staff members. -He/she said another resident (Resident #18) who was playing bingo informed him/her that Resident #1 had Dementia. -He/she informed Resident #18, that Resident #1 still did not have the right to be up in his/her personal space or to hit him/her. -He/she had raised his/her voice after Resident #1 had hit him/her in the throat and did inform Resident #1 do not get into his/her personal space and not to hit him/her again. -He/she did not call the resident any names. -He/she tried to redirect and inform Resident #1 several times that morning that his/her behaviors and actions were not appropriate. -He/she went on break around 11:00 A.M. and noticed that he/she had missed calls from his/her agency supervisor. -When he/she called the agency supervisor back, he/she was informed to leave the facility immediately. -He/she felt these were false allegations against him/her. -He/she completed the documentation in Resident #1's nursing notes related to the resident's behavior and then left the facility.