STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175323	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nortonville Health Care Center	412 E Walnut St Nortonville, KS 66060

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** The facility identified a census of 38 residents. The sample included three residents for abuse. Based on record review, observations, and interviews, the facility failed to prevent an incident of resident-to-resident abuse and protect one resident, Resident (R) 2, from abuse. On 11/19/25 at 01:53 PM R1, a cognitively impaired resident with known aggressive behavior, entered the dining area and, without provocation, forcefully punched (with a closed fist) R2. There were approximately seven to eight additional residents in the dining area at the time of the altercation. R1 punched R2 two to three times in the left shoulder while R2 and others began shouting. R2 tried to block R1's punches, and both residents fell from their wheelchairs to the floor. Activity Staff Z, who was present in the dining area, was approximately ten feet from R1 and R2. Activity Staff Z ran toward the residents, yelled for help, and multiple staff members arrived to separate R1 and R2. The facility's failure to continuously monitor R1, as care-planned, placed R2 and other residents at risk for serious and potentially life-threatening injury, which resulted in immediate jeopardy.Findings included: - R1's Electronic Medical Record (EMR) documented R1 admitted [DATE], with diagnoses of Traumatic Brain Injury (TBI) with loss of consciousness (an injury to the brain caused by trauma, resulting in a loss of consciousness), major depressive disorder (known also as clinical depression, a mental health condition characterized by low mood, and a loss of interest in activities once enjoyed), anxiety disorder (a mental health condition that causes fear, dread and other symptoms that are out of proportion to the situation), and generalized anxiety disorder (a more severe form of anxiety disorder characterized by persistent excessive worry that interferes with daily functioning). R1's admission Minimum Data Set (MDS) dated [DATE] recorded R1 was unable to complete a Brief Interview for Mental Status (BIMS), and indicated R1 had severely impaired cognition. The MDS documented R1 had no behaviors during the seven-day assessment period, but indicated a mood score of 15, which indicated severe depression (feelings of sadness, despondency, dejection, severe enough to interfere with daily activities). The MDS assessment recorded that R1 received anti-psychotic (medication used to treat mental illness by altering neurotransmitters in the brain), anti-anxiety (medication used to treat worry, nervousness, uneasiness), anti-depression (medication to relieve feelings of sadness), and seizure control (medication ot control abnormal electrical activity in the brain which causes change in awareness and muscle control) medications.The Physician Order Sheet (POS) dated November 2025 recorded that R1 received the following psychoactive medications: quetiapine (an atypical antipsychotic used to treat schizophrenia, bipolar disorder, and major depressive disorder), Lorazepam (a benzodiazepine medication used to treat anxiety disorders), and Duloxetine (an antidepressant used to treat major depression). R1's Care Plan initiated on 08/20/25, recorded on 08/31/25, R1 was aggressive with another resident; R1 threw water on her and punched her. The updated 08/31/25 care plan recorded: One-on-one monitoring was initiated for R1 (no end/stop date for the one-on-one monitoring was noted), and staff were directed to monitor R1 when he was in the facility's common areas. R1's revised Care Plan dated 09/18/25, recorded R1's potential for aggression and directed staff to monitor behavior episodes and attempt to determine the underlying (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175323	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nortonville Health Care Center	412 E Walnut St Nortonville, KS 66060

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	cause, consider location, time of day, person(s) involved, and situations. The plan of care directed staff to document behavior and potential causes. The care plan lacked further interventions related to R1's documented aggressive behaviors.Review of R1's Nurses Progress Notes revealed the following entries: On 09/01/25 at 10:39 AM the facility placed the resident on a one-on-one observation for an incident 08/31/25. At times, R1 would get restless and verbally aggressive. On 09/03/25 at 08:39 AM R1 was non-redirectable. R1 believed he was still in prison. R1 attempted to crawl onto the ground, and staff assisted R1 down to the floor, so he did not injure himself. R1 was fed, provided water, and toileted, but the behaviors continued. R1 became verbally aggressive with staff when staff attempted to redirect. Staff remained with R1 one-on-one for safety. On 09/06/25 at 06:51 PM R1 was verbally and physically aggressive. R1 ran into doors with his wheelchair. On 09/08/25 at 10:48 AM staff spoke to R1's Power of Attorney (POA) regarding finding placement elsewhere, due to the inability to meet R1's needs at the facility. R1 could become very restless due to his cognitive issues resulting from his TBI. The facility sent referrals out for alternative placement. On 09/14/25 at 03:17 PM R1 was chronically repetitive, disorganized, and became violent with staff members and other residents when agitated. R1 fixated on cigarette breaks, the topic of detectives, and correctional officers. R1 had a history of calling EMS/police and was resistant to reorientation. The resident was anxious, wandered the halls, and he knocked on/attempts to enter other residents' rooms disturbing them and/or frightening them. On 09/16/25 at 10:57 AM staff reported to the nurse that R1 touched her breast. The nurse educated R1 that it was inappropriate to touch staff or anyone else. R1 stated he was trying to touch her nipples. The nurse again educated R1 that it was an inappropriate action. On 09/23/25 at 12:56 PM staff heard another resident yelling for R1 to stop. Staff went toward the yelling and found R1 unplugging items and yelling at another resident. Staff tried to redirect R1, and he grabbed at the staff member and hit the staff member in several areas. R1 grabbed the staff members shirt as staff tried to back R1 up in his wheelchair to the hallway. R1 continued to hit staff. Other staff members came and assisted with R1, and they redirected R1 by asking him if he wanted to smoke. R1 allowed staff to push him down the hallway. On 10/17/25 at 11:42 AM R1 entered Administrative Staff A's office in his wheelchair, and demanded he go out to smoke. R1 started backing into shelves, knocking things over, and cursing. Two Certified Nurse's Aides (CNA) were able to get the resident out of the Administrative Staff A's office and take him to his room.Observation on 11/19/25 at 01:53 PM revealed R2 sat calmly, in the back of the dining room, facing forward toward the television. R1 wheeled directly toward R2's back left side and delivered two to three swift and forceful blows to R2's left shoulder. R2 turned left toward R1, blocking punches with his left arm, and while trying to push R1 away, both residents ended up on the floor. Other residents present in the dining room appeared with heightened emotions and yelled, Stop! Oh my! What happened? Staff responded and removed R1 and R2 to their rooms. On 11/19/25 at 02:55 PM, R2 was seated in his room, watching television with one-on-one supervision. R2 stated he just came in and hit me. R2 stated, I don't know why some people around here have issues.On 11/19/25 at 03:00 PM, R1 was observed in his room with one-on-one supervision. R1 was noted to have an abrasion over his right eye. R1 was alert but with a blank stare and/or flat affect. During an attempted interview at this time, R1 stated he did not know what happened (in the dining room) and began calling out for an unknown person. During an interview on 11/19/25 at 03:20 PM, Activity Staff Z stated she was in the dining room helping a resident with lunch and did not see what happened, but heard R2 state, Do not hit me. Activity Staff Z looked up and saw the fight and responded. Activity Staff Z stated she had not known R1 to be aggressive like that and noted he had been doing really well.During an interview on 11/19/25 at 03:30 PM, Licensed Nurse (LN) G stated R1 could understand direction at times and other times had a volatile mood. LN G stated R1 would yell at staff and sometimes call out for the CO (corrections officer). LN G believed R1 was in prison previously for a short time. LN G asked R1 why he did that, and he said he did not know. LN G asked Activity Staff Z and R2 if anything provoked R1, and they said no. Activity Staff Z said R1 just wheeled himself into the dining room, thought he was going to sit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175323	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nortonville Health Care Center	412 E Walnut St Nortonville, KS 66060

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	where he usually sat, and then he hit R2. During an interview on 11/19/25 at 04:00 PM, Administrative Nurse D stated R2 said he was just sitting there, and R1 rolled right in and hit him twice, and R2 swung back and brought R1 to the ground so he could end the fight. Administrative Nurse D indicated staff responded appropriately to the event, the physician was notified at 02:06 PM, and both residents were placed on one-on-one supervision. Both residents had a full-body skin assessment, and no injuries to R2 were noted. R1 had an abrasion or scratch-like mark over his left eye. Administrative Nurse D acknowledged the incident on 08/31/25, where R1 threw water on another resident, and stated R1 was placed on one-on-one supervision at that time, but had been doing well, since that time. Administrative Nurse D noted that R1 was no longer with one-on-one monitoring, as noted in R1's care plan, but could not provide a date when the one-on-one monitoring stopped. Administrative Nurse D stated that although staff were not trained particularly in dealing with residents with head injuries, evidence of all staff abuse, neglect, and exploitation training was provided on 10/07/25 and 10/13/25.During an interview on 11/19/25 at 04:00 PM, Administrative Staff A stated the incident on 08/31/25 was not reported to the State agency, as there was no intent and no harm, noted. Administrative Staff A acknowledged reporting today's incident to the State agency and was initiating an investigation and collecting witness statements.The facility's Abuse and Neglect Policy revised on 06/12/2024 documented various types, i.e., verbal, physical, sexual, mental, etc., and defined Abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff-to-resident and certain resident-to-resident altercations.The policy documented under Guidelines for identification: The facility will identify event occurrences, patterns, and trends that may constitute mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property as defined above.On 11/19/25 at 05:50 PM, Administrative Staff A was provided a copy of the IJ Template and notified that beginning on 11/19/25 at 01:53 PM, the facility's failure to prevent and protect a resident (R2) from an incident of abuse placed the resident(s) in Immediate Jeopardy. All residents have the potential to be affected by the deficient practice.1. Education will be completed by the Administrator and/or Designee before the start of the shift on care plan review. Monitoring of residents, abuse and neglect, and appropriate intervention and protection of trainers to remain free from abuse and neglect, starting on 11/19/25 at 02:30 PM and ongoing. No employee will be permitted to work until education has been completed prior to starting their next shift. 2. R1 was placed on 1:1 at 02:01 pm on 11/19/2025, to remain 1:1 for 24 hours and be reevaluated for further intervention. 3. R1's care plan was reviewed and updated to reflect the current resident status as of 11/19/25.4. Notification to R1's Responsible Party completed 11/19/25.5. Notification to physician for R2 completed 11/19/25.6. Notification to R2's Responsible Party completed 11/19/25.7. A full investigation was initiated on 11/19/25.8. R2 had a skin assessment completed on 11/19/25.9. R1 had a skin assessment completed on 11/19/25.10. The facility will validate competency with 3-5 employees per day of education provided. This will be done 2-3 times per week x2, weekly x2, and ongoing to validate compliance. The facility presented an acceptable plan for removal of the immediate jeopardy on 11/19/25 at 07:41 PM, which was verified by the surveyor on site. The deficient practice was lowered to a scope and severity of G for isolated harm following the removal of the immediate jeopardy.