STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 - Minimal harm or potential for actual harm 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** Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of seven sampled residents, was free from physical abuse by Resident #2 when Resident #2 hit Resident #1 in the face with a fist multiple times. The facility census was 91. Review of the facility's Abuse and Neglect Policy, revised 6/12/24, showed the following: -Abuse is the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations; -Physical abuse is the purposeful beating, striking, wounding, or injury of any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes, hitting, slapping, punching, biting, and kicking; -The facility will identify and correct by providing interventions in which abuse is more likely to occur, such as more secluded areas in the facility and ensuring the staff are knowledgeable of resident care needs. Prevention will also include assessment, care planning and monitoring of residents with needs or behaviors which may lead to conflict; -As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of mistreatment for these residents. 1. Review of Resident #1's undated face sheet showed the following: -The resident admitted on [DATE]; -Diagnoses included encephalopathy (any disorder or disease of the brain, especially chronic degenerative conditions), bipolar II disorder (condition that causes unusual shifts in mood, energy, activity levels and the ability to carry out day-to-day tasks), schizoaffective disorder (chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors), and anxiety disorder (mental health condition characterized by excessive and persistent fear or anxiety that interferes with daily life, causing significant distress). (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Care Plan, dated 5/28/24, showed the following: -The resident was at risk for aggression and other personality change related to diagnosis of traumatic brain injury; -Avoid confrontation; -Do not argue or get defensive with the resident; -The resident had behavioral symptoms related to his/her mental illness, wandered around the facility at times and was easily anxious; -Intervene as necessary to protect the rights and safety of others, remove from situation and take to alternate location as needed. Review of the resident's Care Plan, updated 6/21/24, showed the following: -The resident could be verbally aggressive and intrusive related to ineffective coping skills, mental/emotional illness, poor impulse control; -When the resident became agitated, intervene before agitation escalated, guide away from source of distress, engage calmly in conversation. Review of the resident's significant change MDS, dated [DATE], showed the following: -The resident had mild cognitive impairment; -He/She experienced verbal behaviors towards others and other behavioral symptoms not directed towards others that occurred 1-3 days out of seven days of the assessment; -The behaviors put the resident at significant risk for physical illness or injury; -He/She wandered 1-3 days out of seven days of the assessment; -He/She needed supervision with ambulation. Review of the resident's nurse note, dated 5/16/25 at 5:14 P.M., showed the following: -Peers of the resident came to tell staff that another peer was hitting the resident; -Peers said the resident walked down the sidewalk toward the carport and the other peer started yelling at the resident to get back over to the supervised smoking area; -The other peer went over to the resident and punched him/her multiple times in the face; -The staff sent the resident to the emergency department via ambulance for evaluation; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The psych physician, primary care physician, guardian, administrator, and management were notified. During an interview on 5/23/25 at 1:30 P.M., Resident #1 said the following: -Resident #2 hit him/her on the chin; -The altercation made him/her mad; -He/She felt safe now because Resident #2 was gone. 2. Review of Resident #2's undated face sheet showed the following: -The resident admitted on [DATE]; -Diagnoses included generalized anxiety disorder, major depressive disorder (mental health condition characterized by persistent feelings of sadness, emptiness, and a loss of interest or pleasure in daily activities), and dementia (general term for a group of symptoms that affect memory, thinking, and other cognitive abilities). Review of the resident's admission MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She required supervision for ambulation. Review of the resident's care plan, dated 2/21/25, showed the resident had impaired thought processes related to dementia and often had mood disturbances with agitation. Review of the resident's care plan, updated on 4/16/25, showed the following: -Begin behavior monitoring; -Skilled nursing to increase frequency of assessment of behavior monitoring (aggressive/hostile behavior). Behavior monitoring will increase with frequency during the skilled timeframe; -Increase detection and assessment of triggers and identify alternate approaches. Review of the resident's nurse note, dated 4/18/25 at 11:58 A.M., showed the following: -The resident sat in the town square of the facility with peers on couches and the nurse overheard the resident yell loudly and scream profanity; -The resident was upset about another resident that wanted to sit on the couch and he/she did not want the peer to sit on the couch; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse explained to the resident, screaming foul words in front of other residents and staff who may find this offensive, the area he/she displayed behavior was not appropriate as it was a community environment, and if the resident wanted to continue discussing things in that manner, he/she could go to a private area; -The resident declined and continued to raise his/her voice and said more profanities. The resident said he/she would continue to act this way and the nurse could try and put his/her hands on the resident and see what happens; -Staff present during behavior crisis with no redirection effective; -The nurse contacted the police. Review of the resident's nurse note, dated 5/16/25 at 4:24 P.M., showed the following: -The resident's peer went inside the facility to tell staff that there was a resident altercation; -The staff went outside to separate the residents and bring them back inside the facility; -The resident said, he/she hit Resident #1; -The Administrator advised the resident, his/her actions were not appropriate; -The resident said Resident #1 should have stayed away from him/her; -A police officer responded to the facility and spoke with the resident, who admitted he/she hit Resident #1. During an interview on 5/23/25 at 11:53 A.M., Resident #2 said the following: -The staff changed his/her status from supervised smoker to unsupervised smoker to get Resident #1 away from him/her; -On the day of the altercation, Resident #1 went over to the unsupervised smoking area; -He/She told Resident #1 to go back to the other area; -Resident #1 started in on him/her and he/she hit Resident #1. 3. During an interview on 5/23/25 at 10:45 A.M., Resident #4 said the following: -Resident #2 was a bully that didn't like weak residents with mental illness; -He/She witnessed the resident yell at other residents and threatened to kick their ass; -Resident #1 went out the supervised smoking area door early to wait to smoke; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #2 went out the unsupervised smoking area door and saw Resident #1, then told Resident #1 to go back to the other area; -Resident #1 did not comply, Resident #2 started hitting Resident #1 in the face; -The altercation occurred on the sidewalk between the supervised and unsupervised smoking area. During an interview on 5/23/25 at 1:15 P.M., Licensed Practical Nurse (LPN) A said the following: -Resident #2 had a temper; -Resident #1 was annoying at times to the other residents and Resident #2 did not like it; -There was an incident that occurred prior to this altercation where Resident #1 pushed another resident in a wheelchair down the 100 Hall. Resident #2 saw it from the common area and yelled at Resident #1 to stop pushing the other resident, Resident #1 yelled back, he/she was not doing anything wrong. Resident #2 charged down the 100 Hall towards Resident #1, and the staff intervened before anything happened; -Resident #2 had a target on Resident #1. During an interview on 5/23/25 at 2:01 P.M., and 5/28/25 at 3:42 P,M. the Administrator said the following: -Resident #2 did not have any issues with other residents prior to the altercation; -The resident never mentioned to the DON or herself that he/she had any issues with Resident #1 and the Administrator never expected the altercation to happen; -She did not consider the altercation as being abuse, nor preventable. MO254376

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to meet residents' needs for three residents (Resident #6, #7 and #8), in a review of eight sampled residents, when staff failed to answer the resident's call light in a timely manner, resulting in the residents' toileting needs not being met, episodes of bladder incontinence (loss of bladder control), and prolonged time the resident remained in a soiled incontinence brief. The facility census was 86.Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to meet residents' needs for three residents (Resident #6, #7 and #8), in a review of eight sampled residents, when staff failed to call lights in a timely manner, resulting in the residents' toileting needs not being met, episodes of bladder incontinence (loss of bladder control), and prolonged time the resident remained in a soiled incontinence brief. The facility census was 86. 1. Review of the Facility Assessment, dated 03/03/25, showed the following:-The facility assessment will be used to inform staffing decisions to ensure a sufficient number of staff with the appropriate competencies and skill sets necessary to care for residents' needs as identified through resident assessments and plans of care; -Consider specific staffing needs for each shift, such as day, evening, night and adjust as necessary based on any changes to its resident population; -The average daily census was 93 residents; -The residents were either disabled or incapacitated; -This staffing plan is based on the facility assessment, along with facility-based and community-based risk assessments to inform staffing decisions to ensure that there are a sufficient number of staff to care for the residents' needs;-This document is updated and adjusted as necessary based on changes to the resident population;-Staffing needs as per resident unit included four to six Certified Nurse Assistants (CNAs) for day shift, and three to four CNAs for night shift. 2. Review of the facility's staffing sheets, of the staff who worked, showed the following: -06/11/25: three CNAs scheduled for the day shift (which is less than the four to six CNAs needed for day shift as indicated by the facility staffing assessment); -06/12/25: three CNAs scheduled for the day shift (which is less than the four to six CNAs needed for day shift as indicated by the facility staffing assessment); -06/17/25: three CNAs scheduled for the day shift (which is less than the four to six CNAs needed for day shift as indicated by the facility staffing assessment);-06/24/25: three CNAs scheduled for the day shift (which is less than the four to six CNAs needed for day shift as indicated by the facility staffing assessment); -06/27/25: three CNAs scheduled for the day shift (which is less than the four to six CNAs needed for day shift as indicated by the facility staffing assessment);-07/07/25: three CNAs scheduled for the day shift (which is less than the four to six CNAs needed for day shift as indicated by the facility staffing assessment). 3. Review of Resident #6's care plan, last revised 05/08/24, showed the following: -Resident had an Activity of Daily Living (ADL) self-care performance deficit related to activity intolerance and impaired balance; -Resident required extensive assistance by one staff for toileting. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff on 05/15/25, showed the following: -Makes self understood; -Understands others; -Cognitively intact; -No rejection of cares; -Dependent for toileting;-Had a colostomy and was always incontinent of bladder. During an interview on 07/09/25 at 1:40 P. M., the resident said the following: -The facility did not have enough staff; there were four halls and when there were only three CNAs, it made it rough for staff to help everyone; -He/She required a mechanical lift for transfers and that took two staff to operate; sometimes he/she would have to wait for a while until staff could help him/her; -A couple of weeks ago, he/she had to wait over 30 minutes for his/her call light to be answered; he/she had wet (had been incontinent of urine) the bed; -He/She was uncomfortable in the wet bed and embarrassed. 4. Review of Resident #7's care plan, last revised 06/09/22, showed the following: -Resident had bladder incontinence related to limited range of motion (ROM), and gait imbalance; -Resident used disposable (incontinence) briefs, check and change every two hours and as needed, change clothing as needed after incontinence episodes. Review of the resident's annual MDS, dated [DATE], showed the following: -Makes self understood; -Understands others; -No rejection of cares; -Partial to moderate assistance for toileting;-Always incontinent of bowel and bladder. During an interview on 07/09/25 at 10:27 A. M., the resident said the following: -He/She needed help to go to the bathroom; -He/She wore incontinence briefs; -His/Her incontinence brief was currently wet; -Sometimes staff did not answer the call light right away and he/she would urinate in the brief. Observation on 07/09/25 at 10:27 A.M. showed the following: -The resident sat in a wheelchair in his/her room; -There was a strong smell of urine in the resident's room; -The

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide a full time Director of Nursing (DON), who did not serve as a charge nurse, when the facility had a census over 60. The facility census was 86.Based on interview and record review, the facility failed to provide a full time Director of Nursing (DON), who did not serve as a charge nurse, when the facility had a census over 60. The facility census was 86. Review of the facility Registered Nurse (RN) Policy, revised 04/30/24, showed the facility will designate a Registered Nurse to serve as the Director of Nursing on a full-time basis. Review of the facility's staffing sheets showed the facility did not have DON coverage on the following dates: -06/16/25, facility census 86;-06/17/25, facility census 86; -06/19/25, facility census 86; -06/23/25, facility census 86;-06/24/25, facility census 86;-06/25/25, facility census 86;-06/27/25, facility census 87. During an interview on 07/09/25 at 4:15 P.M., the DON said the following:-She had previously served as the DON, but during the month of May and June 2025, worked as a charge nurse because the facility was short-staffed; -The current (interim) administrator had been the DON during this time, but had been pulled to other facilities for a couple of weeks in June, so there were several days when there was no DON in the facility; -She reassumed the DON position full-time on or about 07/02/25. During an interview on 07/10/25 at 2:00 P.M., the administrator said the following: -She was previously the acting DON for the facility, as the former DON was pulled back to a charge nurse position due to staffing issues; -There were several days in June that she was away from the facility, so there was no DON coverage on those dates. 1539073