STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265247	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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. (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	Based on interview and record review, the facility failed to protect one resident (Resident #1) from physical and verbal abuse. Certified Nurse Assistant (CNA) A slapped the resident with an open hand and referred to the resident as a pedophile in the presence of the resident. The facility census was 48.On 06/30/25, the administrator was notified of the past noncompliance which occurred on 6/13/25. On 6/21/25, the administrator became aware of the staff to resident abuse allegation involving Certified Nurse Assistant (CNA) A and Resident #1. Upon discovery, the facility suspended CNA A, conducted an investigation, and notified the appropriate parties. All facility staff were educated on the facility abuse policy related to physical and verbal abuse and on the expectations for monitoring for abuse and reporting abuse. The deficiency was corrected on 6/21/25. Review of the facility's abuse policy, last reviewed on 01/31/24, showed the following:-It was the facility's policy to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse;-Abuse meant the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse. It includes verbal abuse and physical abuse;-Physical abuse included but not limited to hitting, slapping, punching, biting, and kicking;-Verbal abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging the derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability 1. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 06/12/25, showed the following:-His/Her cognition was moderately impaired;-He/She was dependent on staff for assistance with all activities of daily living (ADL);-He/She was always incontinent of bowel and bladder;-He/She had physical behaviors directed toward others one to three days out of the previous seven day look back period. Review of the resident's face sheet, dated 06/24/25, showed the resident's diagnoses included anxiety disorder, hemiplegia/hemiparesis (paralysis of one side of the body), and nontraumatic intracerebral hemorrhage (bleeding in the brain). Review of the resident's care plan, last reviewed on 06/24/25, showed the following:-He/She required extensive assistance from two staff for all activities of daily living (ADL) tasks;-He/She had a feeding tube in his/her abdomen;-He/She had the potential for increased behavioral symptoms due to diagnoses of dementia, stroke, depression, and history of sexual verbal/physical behaviors with staff;-He/She made staff uncomfortable with sexual and verbal behaviors. Staff were to remind and educate the resident this was inappropriate;-He/She required cues, reminders, and education to not touch staff in a sexual or physical way or ask for sexual favors. Review of facility's online report, dated 06/21/25, showed an allegation of abuse that occurred on 6/13/25 as Certified Nursing Assistant (CNA) B assisted CNA A change the resident. After the staff cleaned the resident, the resident's feeding tube opened. CNA A smacked the resident on the thigh below his/her buttock because CNA A thought the resident opened the feeding tube on purpose and soiled himself/herself and the bed again. Review of the facility's investigation report, dated 06/21/25, showed the following:-Nurse Aide (NA) F reported to Licensed Practical Nurse (LPN) C that CNA B told NA F that CNA B and CNA A went into the resident's room to get up the resident. The resident had soiled himself/herself and the bed. Once staff (CNA A and CNA B) changed the bed, they rolled the resident, and the resident's feeding tube opened and spilled the contents out onto the resident and the bed, which required another bed/clothing change. At that time, CNA A smacked the resident on the thigh below the buttock because he/she (CNA A) thought the resident disconnected the feeding tube on purpose;-The resident was unable to answer questions due to his/her cognitive impairment;-Staff interviews showed CNA A was more agitated with the resident due to the resident's increased sexual behaviors;-CNA B reported that CNA A referred to the resident as a pedophile;-CNA E said CNA A referred to the resident as a pedophile while rounding on the hall;-CNA A was suspended until further notice.-In conclusion, per interviews with the resident and other residents and staff, there was no evidence to substantiate the allegation of abuse. Review of a CNA B's written statement/interview, provided by the facility, dated 06/25/25 at 11:10 A.M., showed CNA B witnessed CNA A smack the resident's posterior left thigh because the resident's feeding tube top kept popping open. During an interview on 06/30/25 at 12:00 P.M., NA F said CNA B reported to him/her he/she witnessed CNA A smack the resident on the leg when CNA A and CNA B provided care on 06/13/25. Review of LPN C's written statement/interview, provided by the facility, dated 06/21/25 at 3:15 P.M., showed the following:-NA F reported to him/her CNA B witnessed CNA A strike the