STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265253	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Healthcare & Rehabilitation Center	206 West First Street Lamar, MO 64759

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. Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required two-hour time frame when staff failed to report an allegation of employee to resident abuse when visitor reported one staff (Certified Nursing Assistant (CNA) B) yelled and cussed at one resident (Resident #1). The facility census was 100.Review of the facility's policy titled, Abuse Prevention Program, not dated, showed the following:-Zero tolerance of verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property, by employees, family members, visitors, or other residents;-Verbal abuse is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to a resident or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that she will never see her family again;-Mental abuse includes, but is not limited to, humiliation, harassment, and threat of punishment or deprivation;-New employees will be instructed on reporting any indications of abuse, neglect, mistreatment, or misappropriation of resident property immediately upon discovery to their supervisor;-If an alleged or suspected incident of abuse, neglect, mistreatment, or misappropriation of resident property occurs, the Administrator, or designee, will report to the following: the information is to be completed by each facility in accordance with Federal, State, and Local Laws: Missouri requires a call be made to the Elderly Abuse and Neglect Hotline, etc.1.Review of Resident #1's face sheet (a brief summary of the resident's medical and admission history) showed the following: -admission date of 02/25/26;-Diagnoses included Alzheimer's disease, dementia with other behavioral disturbance (a general term for a number of neurological conditions that cause a decline in cognitive abilities), and high blood pressure.Review of the resident's care plan, initiated on 02/27/26, showed the following:-Staff should monitor the resident for cognitive factors, emotional factors, and environmental factors that may contribute to new behaviors;-The resident has the potential to be physically aggressive related to Alzheimer's disease;-When the resident becomes agitated intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; and if response is aggressive, staff to walk calmly away, and approach later;-The resident has potential to be verbally aggressive related to Alzheimer's disease;-The resident has impaired cognitive function/dementia or impaired thought processes related to Alzheimer's.Review of the resident's discharge Minimum Data Set (MDS - a federally required assessment tool completed by facility staff), dated 04/10/26, showed the following: -Severe cognitive impairment;-The resident exhibited physical behavioral symptoms directed towards others, verbal behavioral symptoms directed toward others, and/or other behavioral symptoms not directed toward others.Review of the resident's medical record showed staff documented a late entry on 04/09/26, at 1:44 P.M., the resident had gotten aggressive with multiple staff when he had been redirected. He has cornered a certified medical technician (CMT) and grabbed him/her by the wrists. Resident wandered in and out of other residents' rooms and was not able to stay seated for longer than about a minute. The resident was not easily redirected. (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
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident had stern an angry demeanor. Staff will continue to monitor and support.During an interview on 04/14/26, at 2:41 P.M., Registered Nurse (RN) C said the following:-An altercation occurred between Certified Nurse Aide (CAN) B and the resident 04/09/26, at approximately 12:50 P.M.;-RN C did not witness the altercation between the resident and CNA B;-A family member visiting another resident reported to RN C that CNA B had been inappropriate with Resident #1;-The visitor said CNA B yelled and cussed at Resident #1 saying he/she wanted Resident #1 taken out in f***** handcuffs and I'll knock you on your ass;-RN C spoke with CNA B about the situation and CNA B denied saying that to the resident;-CNA B left the office, then returned, taking her belongings and left the building;-The Director of Nursing (DON) was present when CNA B came to the office and took her belongings and left;-RN C said that he/she reported the incident to the Administrator the day it occurred;-RN C said he/she felt the incident was abuse and told the DON that it should be reported to the state. During an interview on 04/23/26, at 12:28 P.M., CNA B said the following:-CNA B told the resident to quit fucking hitting me;-CNA B also told the resident he/she is lucky that he/she doesn't go out of there in handcuffs;-CNA B said neither the Director of Nursing (DON) or the Administrator reached out to her for a statement about the incident;-There is never an appropriate time to yell or cuss at a resident;-The words she used towards Resident #1 could be considered abuse. Review of DHSS records showed the home did not self-report the allegation of employee to resident abuse reported by a visitor to RN C. During an interview on 04/14/26, at 2:22 P.M., Certified Nursing Assistant (CNA A) said the following:-Staff yelling/cussing at a resident was considered abuse;-If CNA A heard a staff member yelling/cussing at a resident he/she would immediately report it to the charge nurse;-All allegations of abuse, neglect, and misappropriation were reported to the state in two hours;-CNA A did not see the altercation between CNA B and the resident;-CNA A was assisting another resident when he/she heard yelling by Resident #1 and CNA B;-CNA A saw CNA B walk out of the unit following the screaming;-CNA A did not hear what CNA B said to the resident. During an interview on 04/14/26, at 3:13 P.M., Certified Medical Technician (CMT) D said the following:-CMT D did not witness the incident between CNA B and Resident #1;-A family member visiting another resident reported to CMT D that they heard CNA B say to the resident if you hit me I will f****** hit you back;-CMT D said staff cannot tell a resident that they will hit them back, that would be considered abuse;-The state required all allegations of abuse and neglect to be reported within two hours.During an interview on 04/14/26, at 3:28 P.M., the Director of Nursing (DON) said the following:-The DON went to the unit after hearing that CNA B had been yelling;-Family members visiting another resident heard CNA B yelling at Resident #1;-Staff told the DON that Resident #1 had his/her arm around CNA B's neck;-The DON did not hear what CNA B had yelled at the resident;-The DON did not speak with CNA B regarding the incident;-Some things that probably should not have been said, were said by CNA B while trying to get away from the resident;-The DON did not feel that CNA B yelling at Resident #1 was abuse;-There was no appropriate time or situation for a staff member to yell or cuss at a resident.During an interview on 04/17/26, at 1:59 P.M., the Staff Coordinator (SC) said the following:-He/she reported all allegations of abuse and neglect to the DON immediately;-Staff were required to report abuse and neglect allegations to the state within two hours;-Staff told him/her a family member reported hearing CNA B yelling at Resident #1;-Staff had reported the incident to the Administrator and the DON;-SC reached out to CNA B regarding the incident.During an interview on 04/17/26, at 3:52 P.M., the Administrator said the following:-Staff reported to the Administrator that CNA B became upset with Resident #1 when the resident grabbed CNA B's wrist;-Staff reported that CNA B told Resident #1 that he/she was not putting up with this shit;-CNA B attempted to remove the resident's hand from his/her wrist when the resident said, I'm going to take you f****** down;-CNA B said to the resident, you need to be in handcuffs;-It was not appropriate for staff to tell a resident they needed to be in handcuffs;-The altercation did not rise to abuse because CNA B was trying to get out of the situation;-Staff had not reported hearing CNA B cussing or threatening Resident #1;-The Administrator was not told that visitors had heard CNA B (continued on next page)

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	265253	A. Building B. Wing	04/17/2026

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Truman Healthcare & Rehabilitation Center	206 West First Street Lamar, MO 64759

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cussing or yelling at the resident;-The Administrator or charge nurse on call were responsible for reporting abuse and neglect allegations.Complaint #2979068

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all allegation of possible abuse were thoroughly investigate when staff failed to complete a timely written investigation of an allegation of employee to resident abuse when a visitor reported one staff (Certified Nursing Assistant (CNA) B) cussed and threatened one resident (Resident #1). The facility census was 100.Review of the facility's policy titled, Abuse Prevention Program not dated, showed the following:-If an incident occurs, or there is any allegation that an incident might have occurred, of abuse, neglect, mistreatment, or misappropriation of resident property, the Administrator, or designee, will investigate;-The person doing the investigation will complete a resident abuse/neglect investigation report;-The administrator will sign and maintain all completed resident abuse/neglect investigation reports and all investigations will remain confidential, except that the findings and actions shall be reported according to state requirements;-All individuals participating in the investigation shall report their findings to the Administrator and complete the information in writing on the Resident Abuse/Neglect Investigation Report form;-The administrator will involve the Social Service Designee in the investigative process to provide the necessary medically related social services appropriate for the resident.1.Review of Resident #1's face sheet (a brief summary of the resident's medical and admission history) showed the following: -admitted on [DATE];-Diagnoses included Alzheimer's disease, dementia with other behavioral disturbance (a general term for a number of neurological conditions that cause a decline in cognitive abilities), and high blood pressure.Review of the resident's care plan, initiated on 02/27/26, showed the following:-Staff should monitor the resident for cognitive factors, emotional factors, and environmental factors that may contribute to new behaviors;-The resident had the potential to be physically aggressive related to Alzheimer's disease;-When the resident became agitated intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; and if response is aggressive, staff to walk calmly away, and approach later;-The resident had potential to be verbally aggressive related to Alzheimer's disease;-The resident had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's.Review of the resident's discharge Minimum Data Set (MDS - a federally required assessment tool completed by facility staff), dated 04/10/26, showed the following: -Severe cognitive impairment;-The resident exhibited physical behavioral symptoms directed towards others, verbal behavioral symptoms directed toward others, and/or other behavioral symptoms not directed toward others.Review of the resident's medical record showed staff documented a late entry on 04/09/26, at 1:44 P.M., the resident had gotten aggressive with multiple staff when he had been redirected. He has cornered a certified medical technician (CMT) and grabbed him/her by the wrists. Resident wandered in and out of other residents' rooms and was not able to stay seated for longer than about a minute. The resident was not easily redirected. Resident had stern an angry demeanor. Staff will continue to monitor and support.During an interview on 04/14/26, at 2:41 P.M., Registered Nurse (RN) C said the following:-An altercation occurred between Certified Nurse Aide (CAN) B and the resident 04/09/26, at approximately 12:50 P.M.;-RN C did not witness the altercation between the resident and CNA B;-A family member visiting another resident reported to RN C that CNA B had been inappropriate with Resident #1;-The visitor said CNA B yelled and cussed at Resident #1 saying he/she wanted Resident #1 taken out in f***** handcuffs and I'll knock you on your ass;-RN C spoke with CNA B about the situation and CNA B denied saying that to the resident;-CNA B left the office, then returned, taking her belongings and left the building;-The Director of Nursing (DON) was present when CNA B came to the office and took her belongings and left;-RN C said that he/she reported the incident to the Administrator the day it occurred;-No staff were asked to write a statement regarding the incident;-Administration did not start an investigation of the incident;-RN C he/she felt the incident was abuse.During an interview on 04/23/26, at 12:28 P.M., CNA B said the following:-CNA B (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told the resident to quit fucking hitting me;-CNA B also told the resident he/she is lucky that he/she doesn't go out of there in handcuffs;-CNA B said neither the Director of Nursing (DON) or the Administrator reached out to her for a statement about the incident;-There is never an appropriate time to yell or cuss at a resident;-The words she used towards Resident #1 could be considered abuse. Review of the resident's medical record showed staff did not document investigating the allegation of abuse. Review of DHSS records showed the home did not investigate the allegation of employee to resident abuse.During an interview on 04/14/26, at 3:13 P.M., Certified Medical Technician (CMT) D said the following:-A family member visiting another resident reported to CMT D that they heard CNA B say to the resident if you hit me I will f****** hit you back;-CMT D said staff cannot tell a resident that they will hit them back, that would be considered abuse;-He/she was not aware of administration investigating the incident between CNA B and Resident #1.During an interview on 04/17/26, at 1:59 P.M., the Staff Coordinator (SC) said the following:-Staff reported the incident to the Administrator and the Director of Nursing (DON);-He/she did not ask CNA B to provide a written statement of the incident.During an interview on 04/14/26, at 3:28 P.M., the DON said the following:-The DON did not speak with CNA B regarding the incident;-The DON did not feel that CNA B yelling at Resident #1 was abuse;-The DON did not obtain a written statement of the incident from CNA B or any other staff;-The DON did not know if an investigation had been opened regarding the incident between CNA B and Resident #1.During an interview on 04/17/26, at 3:52 P.M., the Administrator said the following:-She did not speak with CNA B about the incident prior to or after CNA B quitting;-CNA B attempted to remove the resident's hand from his/her wrist when the resident said, I'm going to take you fucking down;-CNA B said to the resident, you need to be in handcuffs;-It was not appropriate for staff to tell a resident they needed to be in handcuffs;-The Administrator asked staff if they heard or saw the altercation between Resident #1 and CNA B and all reported not hearing or seeing anything;-The Administrator was not told that visitors had heard CNA B cussing or yelling at the resident;-The Administrator or charge nurse on call were responsible for completing investigations alleging abuse and neglect.Complaint #2979068

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to maintain an environment as free of accidents as possible when staff failed to provide standby and/or supervision assistance for one resident (Resident #2) resulting in the resident falling. The facility census was 100. Review of the facility policy titled, Accidents and Incidents - Investigating and Reporting, dated 2001, showed the following:-All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator;-The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident;-The following data, as applicable, shall be included on the Report of Incident/Accident form: the date/time the accident/incident took place; the nature of the injury/illness (fall); the circumstances surrounding the accident or incident; where the accident or incident took place; the names of witness and their accounts of the accident or incident; the injured person's account of the accident or incident; the time the injured person's attending physician was notified, as well as the time the physician responded and his/her instructions; the date/time the injured person's family was notified and by whom; the condition of the injured person, including his/her vital signs; the disposition of the injured (transferred to hospital, put to bed, sent home, returned to work, etc); any corrective action taken, follow-up information; and the signature and title of the person completing the report;-The nurse supervisor/charge nurse and/or the department director or supervisor shall complete an incident report in the electronic record. 1.Review of Resident #2's face sheet (a brief summary of the resident's medical and admission history) showed the following: -admission date of 03/24/26;-Diagnoses included coronary artery disease (CAD - a narrowing or blockage of the arteries and vessels that provide oxygen and nutrients to the heart), Parkinson's disease (brain disorder causing unintended or uncontrolled movements), and neuropathy (abnormality of the nervous system).Review of the resident's entry Minimum Data Set (MDS - a federally required assessment tool completed by facility staff), dated 03/28/26, showed the resident was cognitively intact.Review of the resident's care plan, initiated 03/25/26, showed the following: -The resident had impaired physical mobility R/T loss of extremity and post operation discomfort;-The resident received antidepressant meds, anticonvulsant meds, and opioid pain meds which could increase risk for falls;-The resident required assistance with transfers.Review of the resident's Physical Therapy (PT) Evaluation and Plan of Treatment, dated 03/27/26, showed the following:-Acquired absence of right leg below knee, unsteadiness on feet, and muscle weakness (generalized);-Resident referred to PT due to new onset of compromised physical exertion level during activity, decrease in functional mobility, decrease in strength, decreased coordination, falls/fall risk, functional limitation with ambulation, increased need for assistance from others, pain, reduced dynamic balance, reduced static balance, and vertigo;-Fall risk;-Resident feels unsteady when standing and when walking;-Sit to stand with supervision or touching assistance; -Toilet transfer with supervision or touching assistance.Review of the resident's Occupational Therapy (OT) Evaluation and Plan of Treatment, dated 03/27/26, showed the following:-Needed for assistance with personal care and muscle weakness (generalized);-Resident presents with decreased strength, balance, and activity tolerance resulting in decreased independence and increased risk for falls and functional completion;-Fall risk and vertigo;-Toileting hygiene with partial/moderate assistance; -Shower/bathe self with partial/moderate assistance; -Tub/shower transfer with supervision or touching assistance; -Toilet transfer with supervision or touching assistance.Review of the resident's medical record showed staff documented the following: -On 03/28/26, at 10:05 A.M., the skilled evaluation showed no impairment using upper extremities. The resident had impairment on both sides of lower extremities. The resident's gait was unsteady. The resident had poor balance when standing;-On 04/03/26, at 2:23 P.M., Registered Nurse (RN) H documented the resident had been in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the shower room at 1:45 P.M, and fell to buttocks during transfer, resulting in busting open his amputation site. Staff called 911, hospital contacted, Director of Nursing (DON), and Administrator. Resident left by ambulance at 2:15 P.M.During an interview on 04/14/26, at 4:23 P.M., the resident said the following: -The resident came to the facility for rehabilitation after a recent below the knee amputation;-On 04/03/26, staff assisted the resident to the shower room;-Once at the shower room door the aide that had been assisting the resident was told by a nurse that the resident did not need assistance with showering;-The resident said that he/she did need assistance because of his/her instability and the aide agreed with the resident;-The nurse told the aide according to the resident's plan of care, it said the resident was independent with showers;-The resident told the aide that he/she did not want to get them in trouble, and he/she would shower on his/her own;-After showering the resident had transferred him/herself to the toilet to get dressed;-The resident lost his/her balance, falling against the toilet.During an interview on 04/17/26, at 9:20 A.M., Therapy Tech (TT) E said the following:-The resident required assistance with shower transfers due to the wet floor;-Staff should provide stand-by assistance for the resident during transfers.During an interview on 04/17/26, at 9:44 A.M., the Director of Rehab (DOR) said the following;-The resident required assistance with activities of daily living and transfers due to a recent amputation;-Staff should assist the resident with showers and transfers;-The DOR shared resident evaluations/recommendations with department heads during weekly meetings;-Any resident receiving therapy should have stand by assistance while showering.During an interview on 04/17/26, at 11:46 A.M., Certified Nurse Aide (CNA) F said the following: -The resident required transfer assistance with toileting and showers;-He/she helped the resident after his/her fall by holding towels and pressure on the resident's stump;-He/she did not know why the resident was in the shower room alone.During an interview on 04/17/26, at 12:38 P.M., Nursing Assistant (NA) G said the following:-The resident required supervision for transfers;-The resident asked for assistance with transfers in the shower.During an interview on 04/17/26, at 12:54 P.M., Licensed Practical Nurse (LPN) H said the following:-The resident required one person assistance with everything including showers;-LPN H did not know if the resident required a sit-to-stand or Hoyer lift to transfer.During an interview on 04/17/26, at 1:08 P.M., NA I said the resident required supervision when showering.During an interview on 04/17/26, at 3:03 P.M., the Director of Nursing (DON) said the following: -Staff reported to the DON that the resident had fallen while transferring off the toilet;-The resident lost his/her balance causing him/her to fall;-The resident required transfer assistance to the bed and toilet;-The DON did not know if staff provided standby assistance while the resident was in the bathroom.During an interview on 04/17/26, at 3:17 P.M., the MDS Coordinator said the following:-Staff came to the MDS Coordinator's office to let her know the resident had fallen;-The MDS Coordinator had pressure on the resident's leg until EMS arrived;-The resident fell after using the restroom;-The resident was alone when the resident fell;-The resident did not like anyone in the restroom while he/she was using it;-The MDS Coordinator did not know what type of assistance the resident required;-The MDS Coordinator relayed the fall information to the nurse on duty.During an interview on 04/22/26, at 1:10 P.M., the Facility Physician said the expectation would be for the resident to have standby or supervision assistance due to the residents recent below the knee amputation.During an interview on 04/17/26, at 3:52 P.M., the Administrator said the following: -Staff reported that the resident had fallen while pulling up his/her clothing after using the bathroom;-She did not know if the resident's plan of care showed the resident needed stand by assistance or if he/she was independent while using the restroom.Complaint #2982358

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and record review, the facility failed to provide meals in a timely manner in accordance with each residents' preferences when staff failed to provide a meal tray to one resident (Resident #2) during scheduled mealtimes. The facility census was 100.Review of the facility's policy titled, Frequency of Meals, dated 2001, showed the following: -Each resident shall receive at least three meals daily, at times comparable to typical mealtimes in the community, or in accordance with resident needs, preferences, requests and the plan of care;-The facility will serve at least three meals or their equivalent daily at schedule times. There will not be more than a fourteen-hour span between the evening meal and breakfast.1.Review of Resident #2's face sheet (a brief summary of the resident's medical and admission history) showed the following: -admission date of 03/24/26;-readmission date of 04/09/26;-Diagnoses included coronary artery disease (CAD - a narrowing or blockage of the arteries and vessels that provide oxygen and nutrients to the heart), Parkinson's disease (brain disorder causing unintended or uncontrolled movements), and neuropathy (abnormality of the nervous system).Review of the resident's entry Minimum Data Set (MDS - a federally required assessment tool completed by facility staff), dated 03/28/26, showed the resident was cognitively intact.Review of the resident's care plan, initiated 03/25/26, showed the following: -The physician has prescribed a carb consistent diet for the resident;-The resident will maintain a stable weight and be free of nutritional deficit;-The resident will consume 75% of ordered diet each day;-The resident had the potential for weight loss/gain;-Staff should minimize risk for significant weight loss/gain through the next review date.During an interview on 04/14/26, at 4:23 P.M., the resident said the following: -The resident came to the facility for rehabilitation after a recent below the knee amputation;-The resident ate his/her meals in his/her room due to his/her diagnosis, which caused his/her hands to shake;-On 04/11/26, at 7:30 A.M., staff came to the resident's room to pick up the resident's dinner tray;-The resident did not receive a dinner tray on 04/11/26;-On 04/12/26, at 9:30 A.M., the resident had to chase down his/her breakfast tray after not receiving one.During an interview on 04/17/26, at 9:20 A.M., Therapy Tech (TT) E said the resident reported not getting a dinner tray on 04/11/26.During an interview on 04/17/26, at 9:44 A.M., the Director of Rehab (DOR) said the resident reported to the DOR that he/she did not receive a dinner tray on 04/11/26.During an interview on 04/17/26, at 11:46 A.M., Certified Nurse Aide (CNA) F said the following: -CNA's are responsible for taking meal orders for residents that eat in their rooms;-The meal orders are given to kitchen staff who prepare the trays;-CNA's deliver the hall trays to the residents and collect the trays when the residents are finished;-CNA's are responsible for making sure each resident gets a meal.During an interview on 04/17/26, at 5:03 P.M., [NAME] J said the following: -Nurse aides take meal orders from residents eating in their rooms and return them to the kitchen staff;-Kitchen staff place the resident's meal card with the resident's menu;-The cook reviews the orders and marks the residents who receive hall trays off the facility roster before the meals are served;-For residents eating in the dining room, resident meal cards are left in the kitchen and are marked off the rooster after their meal has been served;-If a name is not marked off the roster the cook checks with the charge nurse as to why the resident did not eat.During an interview on 04/17/26, at 12:17 P.M., the Dietary Manager (DM) said the following: -CNA's are responsible for taking meal orders from the residents who eat in their rooms;-The orders are given to kitchen staff who prepare the trays and take them down the hall for CNA's to pass to residents;-When the kitchen staff do not receive a menu from a resident, kitchen staff are to go to the resident's hall and speak with nursing staff about why the resident did not eat;-The resident reported that he/she did not receive dinner on 04/11/26;-The resident also reported he/she had to come to the dining room on 04/12/26, to get breakfast because staff did not take his/her order or deliver a tray to his/her room;-Kitchen staff are to speak with the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265253	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Healthcare & Rehabilitation Center	206 West First Street Lamar, MO 64759

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	charge nurse when a resident does not get a meal.During an interview on 04/17/26, at 12:38 P.M., Nursing Aide (NA) G said the following:-Nursing staff were responsible for taking residents meal orders and providing them to the kitchen staff;-Kitchen staff prepare the trays and bring them to the halls;-CNA's and NA's passed out meal trays to the residents;-NA G goes to each room to make sure all residents receive a tray or are in the dining room for meals.During an interview on 04/17/26, at 12:54 P.M., Licensed Practical Nurse (LPN) H said the following:-Staff ask residents who want to eat in their rooms and report that to the kitchen staff;-The kitchen staff keep track of who eats and who doesn't.During an interview on 04/17/26, at 1:08 P.M., NA I said the resident had missed two meals, one lunch and one dinner. NA I could not recall what days this occurred.During an interview on 04/17/26, at 3:44 P.M., the Social Service Staff (SS) said the following:-The resident came to the SS office and reported on 04/11/26, at 7:30 P.M., an aide came to his/her room to get his/her meal tray;-The resident said he never received a dinner tray.During an interview on 04/17/26, at 3:03 P.M., the Director of Nursing (DON) said the following: -Aides were responsible for letting kitchen staff know which residents were eating in their rooms;-Staff had not reported to the DON that the resident had not received two meals after returning to the facility;-Staff were responsible for making sure residents are served all meals.During an interview on 04/17/26, at 3:52 P.M., the Administrator said kitchen staff were responsible for making sure all residents receive their meals.Complaint #2982358