

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER Wellsville Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 E Locust Wellsville, MO 63384	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interviews and record review, facility staff failed to report an allegation of sexual abuse between two residents (Resident #1 and Resident #2) to the Department of Health and Senior Services (DHSS) within the two hour timeframe. The facility census was 57.</p> <p>1. Review of the facility's Abuse and Neglect policy, revised 6/12/24, showed an alleged violation of abuse, neglect, exploitation, or mistreatment, including injuries of an unknown origin and misappropriation of resident property will be reported immediately, but no later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury and twenty four hours is the alleged violation does not involve abuse and has not resulted in serious bodily injury.</p> <p>Review of the DHSS complaint/facility self-report database showed facility staff did not report the resident's allegation of sexual abuse to DHSS after the resident reported his/her allegation to facility staff.</p> <p>During an interview on 3/18/25 at 12:00 P.M., the Director of Nursing (DON) said the incident was reported to the state agency when the allegation was Resident #2 went in Resident #1's room while he/she slept and rubbed lotion on his/her legs and abdomen. He/She said he/she did not report to DHSS when Resident #1 changed his/her story to the peri area because he/she did not believe the allegations.</p> <p>During an interview on 3/18/25 at 1:10 P.M., the administrator in training said he/she was not here when the allegations were made but was told it was reported. He/She said Resident #1 changed his/her story after the original allegation, to sexual assault, the facility policy was not followed to report to DHSS and he/she does not know why.</p> <p>During an interview on 3/18/25 at 1:41 P.M., the regional nurse said the incident should have been reported when Resident #1 changed the allegations from rubbing soap on his/her legs to sexual assault and he/she does not know why it was not done.</p> <p>During an interview on 3/18/25 at 1:47 P.M., the interim administrator said the original allegations of Resident #2 rubbing lotion on Resident #1's legs and abdomen were reported because state agency was on site but once the allegations changed to sexual assault it should have been reported to DHSS within two hours. He/She said he/she expects the designee to follow the policy at all times and does not know why it was not done.</p> <p>MO00251208</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to follow their Abuse and Neglect Policy when staff failed to investigate an allegation of resident to resident sexual abuse. The facility census was 57.</p> <p>1. Review of the facility's Abuse and Neglect policy, revised 6/12/24, showed an alleged violation of abuse, neglect, exploitation, or mistreatment, including injuries of an unknown origin and misappropriation of resident property will be reported immediately, but no later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury and twenty four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. It directs the Administrator or designee will at a minimum:</p> <ul style="list-style-type: none"> -Investigate all allegations and types of incidents; -Call 911; -Notify the attending physician, resident's family/legal representative, and medical director; -Monitor and document the resident's condition, including response to medical treatment or nursing interventions; -Document actions taken in the medical record; -Revise the resident's care plan; -Personal statements from staff and residents; <p>Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;</p> <ul style="list-style-type: none"> -Review root cause of the incident; -Each interview and the investigation will be handled privately as possible. <p>2. Review of Resident #1's Annual Minimum Data Set, dated [DATE], showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> -Cognitively intact; -Diagnosis of Depression. <p>Review of the residents medical record did not contain documentaion of an allegation of sexual assault or action taken by the facility.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/18/25 at 12:23 P.M., the resident said almost two weeks ago in the middle of the night Resident #2 came in to his/her room while he/she was sleeping and started to rub soap all over him/her. He/She said he/she thought the aides were coming to clean him/her up in the middle of the night until he/she felt rubbing in between his/her thighs and fingers inside. He/She said he/she has never felt so violated in his/her whole life. He/She said he/she felt like staff was not taking it seriously because they never did anything about it, he/she said he/she talked to staff multiple times after the allegation and they made it seem like it was ok because Resident #2 has dementia. He/She said they never called his/her family or his/her doctor. He/She said he/she called the cops because the facility never did anything and he/she feels unsafe at the facility.</p> <p>3. Review of Resident #2's admission MDS, dated [DATE], showed staff assessed the resident as follows:</p> <p>-Moderately cognitively impaired;</p> <p>-Alzheimer's (progressive disease that destroys memory and other important mental functions), Traumatic brain injury, Anxiety, and Depression.</p> <p>Review of the residents medical record did not contain documentaion of an allegation of sexual assault or action taken by the staff.</p> <p>4. During an interview on 3/18/25 at 12:00 P.M., the Director of Nursing (DON) said he/she said he/she did not investigate when the resident changed his/her story to the peri area because he/she did not believe the allegations.</p> <p>During an interview on 3/18/25 at 1:10 P.M., the administrator in training said he/she was not here when the allegations were made but was told it was investigated. He/She said when the resident changed his/her story after the original allegation of just lotion being applied to sexual assault, the facility policy was not followed in regard to investigating and he/she does not know why.</p> <p>During an interview on 3/18/25 at 1:41 P.M., the regional nurse said the incident should have been investigated when he/she changed the allegations from rubbing soap on his/her legs to sexual assault and he/she does not know why it was not done.</p> <p>During an interview on 3/18/25 at 1:47 P.M., the interim administrator said once the allegations changed to sexual assault there was nothing done. He/She said the DON was in charge of the investigations and documenting in the medical records and he/she does not know why that was not done. He/She said he/she expects the designee to follow the policy at all times and does not know why it was not done.</p> <p>MO00251208</p>		