

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  07/24/2025
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)
F 0600  Level of Harm - 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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, facility staff failed to ensure three residents' (Resident #3, #4, and #5) out of nine sampled residents remained free from physical abuse when Resident #2 who had a history of physical aggression physically assaulted the residents. The facility census was 65.1. Review of the facility's Abuse and Neglect policy, revised 06/12/24, showed staff are directed as follows:-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish which can include residents and staff;-Physical abuse is purposefully beating, striking, wounding, or injuring which includes but not limited to hitting, slapping, punching, biting, and kicking;-Facility will develop a policy for screening and training of employees, protection of residents, prevention of incidents, identification, and reporting of abuse. Facility will identify, correct, and intervene in abuse situations, protect resident from harm, identify and correct by providing interventions, and will take steps to prevent mistreatment. 2. Review Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/13/25, showed staff assessed the resident as admitted on [DATE], had moderate cognitive impairment, exhibits physical and verbal behaviors which interfere with care and put others at risk of physical injury. Review of the resident's care plan, revised 07/24/25, assessed the resident with exhibits emotional distress, impaired coping skills, exhibits behaviors that may create disturbances for other residents, exhibits agitation. Review of the resident's nurse's notes showed staff documented:-On 04/09/25 at 7:43 A.M., resident yelled and became agitated with staff during care and the resident's roommate stated he/she did not feel safe in the room with the resident;-On 04/14/25 at 8:50 A.M., resident had a verbal altercation with another resident at breakfast;-On 04/24/25 at 2:53 A.M., resident verbally aggressive, disrespectful to peers, and got into other people's personal space to intimidate;-On 04/24/25 at 3:35 P.M., resident had a physical altercation with Resident #5 and kicked him/her;-On 06/17/25 at 2:29 A.M., physical altercation occurred on 06/16/25 at 10:40 P.M., between Resident #2 and Resident #4. Staff came to him/her LPN B and stated Resident #2 had beat the shit out of Resident #4. Resident #4 told him/her Resident #2 hit him/her and he/she complained of blurred vision and a headache. Resident #4 sent by ambulance to the hospital for evaluation and Resident #2 sent to the hospital for a psychiatric evaluation.-On 07/23/25 at 10:25 A.M., physical altercation occurred on 07/22/25 at 7:40 P.M. with Resident #3. Resident #2 punched Resident #3 in his/her left side of face causing him/her to fall to the wall behind him/her and hit his/her face on it. Resident #2 punched Resident #3. Staff one to one direct care with the resident until both residents were sent to the hospital for evaluation. During an interview on 07/24/25 at 10:00 A.M., Resident #7 said he/she has lived at the facility for a long time with no concerns until the past several months. The resident said he/she does not feel safe at the facility due to the physical altercations Resident #2 has caused. The resident said he/she is in fear of her safety and is thinking about moving from the facility. 3. Review Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's care plan, revised 7/22/25, showed staff assessed the resident as high risk for falls, and required assistance due to confusion. Review of the resident's nurse's notes, dated 07/23/25, showed staff documented a physical altercation occurred on 07/22/25 at 7:40 P.M., between Resident #2 and Resident #3. Resident #2 punched Resident #3 in his/her left side of face causing Resident #3 to spin, fall, and hit his/her face on the wall behind him/her. Staff documented the incident unprovoked. Staff took Resident #2 from the incident and stayed one on one direct care with Resident #2 until both residents were sent to the hospital for evaluation. Review of the resident's hospital discharge report, dated 07/22/25, showed the hospital performed a Computed Tomography (CT) (a non-invasive imaging procedure) of cervical spine, CT of head and brain, X-ray of pelvis, X-ray of right knee. Resident sustained a concussion. During an interview on 07/25/25 at 9:00 A.M., LPN B said he/she was the charge nurse on duty when the incident between Resident #2 and Resident #3 occurred. LPN B said he/she witnessed Resident #2 punch Resident #3 in his/her left face and the incident was unprovoked. LPN B said he/she thinks Resident #2 should have been placed on one-on-one direct care upon his/her readmission to the facility, but he/she was not working that day and does not know why he/she wasn't. 4. Review OF Resident #4's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's care plan, revised 06/22/25, showed staff assessed the resident feels unsafe in the facility due to a physical altercation with another resident, staff were directed to educate resident to notify staff of any inappropriate behavior from other resident and at risk for falls. Review of the resident's nurse's notes</p>		