

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/01/2026
NAME OF PROVIDER OR SUPPLIER Lake Stockton Healthcare Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1523 3rd Road Stockton, MO 65785	

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. (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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report all allegations of possible abuse within two hours of the allegation being made to the State Survey Agency (SSA) when the facility did not report an allegation of physical abuse between to residents (Resident #1 and #2) to the Department of Health and Senior Services (DHSS). A sample of five residents were sampled. The facility census was 85. Review of the facility's policy titled Patient Abuse/Neglect, Elder Abuse, and Persons with Disability Abuse, revised 08/2021, showed the following: -Facility staff, employees, and physicians will follow regulations and standards in the identification of and procedures for handling alleged victims of abuse; -Facility purpose is to guide staff, employees, physicians, and any mandated reporter within the facility in identifying victims of abuse and provide a reporting mechanism in accordance with all local, state, and federal laws; -In the event a staff member with responsibility for the care of a person [AGE] years of age or older or adults with disabilities ages 18 to [AGE] years of age has reasonable cause to suspect that an individual has been subjected to abuse or neglect, receives an allegation of abuse or neglect, or observes this individual being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that individual shall immediately make a report to the DHSS or the appropriate facility designee; -The facility designee will report or assist the person with direct knowledge of the concern to report immediately, within two hours of the allegation is for mental, physical, verbal, or sexual abuse or there has been bodily injury related to abuse. If not abuse and there is no injury, the designee should report within 24 hours of the observation or allegation; -The report is made to the DHSS at the hotline, or in cases involving long-term care (LTC), the report shall be made first to the Regional DHSS office (if during regular business hours) or the hotline if after hours; -A fax notice or email to the regional DHSS during hours the hotline is closed (midnight to 7 A.M.) is acceptable for the two hour notice but a follow up call is required; -The DHSS website can also be utilized to report concerns, complaints, or allegations of patient/resident abuse/neglect (sexual, physical, or verbal) by another patient, resident, employee, vendor, or visitor; -Hotline information may also be reported to law enforcement, but all suspected cases and/or allegations of elder abuse or abuse of persons with disability must be reported to DHSS; -This policy does not preclude others from reporting suspected abuse or neglect, including other staff members and physicians directly involved with the patient; -In LTC, the facility designee, which is the facility administrator, administrator on-call, director of nursing (DON), or registered nurse (RN) on-call, shall be responsible for reporting suspected abuse or neglect. 1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance) showed the following: -admission date of 03/15/24; -Diagnoses included Alzheimer's disease (a progressive brain disorder, the most common cause of dementia, characterized by gradual memory loss, impaired thinking, and changes in behavior, impacting daily function over time). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/15/25, showed the following: -The resident had severe cognitive impairment; -The resident had no behaviors. Review of the resident's care plan, revised 01/01/26, showed the staff did not care plan any prior resident-to-resident altercations. following: -Resident was independent with ambulation and did not use an assistive device; -Resident had memory loss due to Alzheimer's dementia; -Resident may have times where he/she gets disoriented about where he/she is or why; -Please allow the resident extra time to process information; -Resident may need reassurance that he/she was safe; -Staff to avoid changes in the resident's environment; -Resident was sometimes resistant to cares and could get aggressive at times; -Staff to reinforce positive behavior; -If agitated staff to leave and reapproach later; -Staff to reduce excessive stimuli; -Staff to use a calm reassuring approach; -Staff to maintain a non-defensive stance; -Staff to assess for trigger situations such as pain, personal loss, relocation, conflict or prior history. (Staff did not care plan any prior history of resident-to-resident altercations.) Review of the resident's progress note dated 10/17/25, at 1:22 P.M., showed the following: -A Fall Communication Form dated 10/17/25, at 12:45 P.M., for an unwitnessed fight and fall; -Resident #1 was finishing eating lunch. A family member of another resident visiting at lunch stated Resident #1 threw his/her spoon at Resident #2. Resident #1 then got up from his/her chair and went at Resident #2 and pushed Resident #2 over while seated in the dining room chair; -Both residents went down with Resident #2 still in the chair and Resident #1 on top of Resident #2; -Resident #1 hit his/her head on the office chair located near the lantern station the certified nurse aides (CNAs) use for</p>		