

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Prairie Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  631 West Main Street Buffalo, MO 65622	

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 interview and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to facility management and within two hours to the state licensing agency (Department of Health and Senior Services-DHSS) when staff failed to report an allegation of employee to resident abuse until the following day for one resident (Resident #1). The facility census was 46.</p> <p>Review of the facility policy titled, Abuse Prevention, dated 10/21/22, showed the following:</p> <ul style="list-style-type: none"> <li>-The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitor, or any other individual;</li> <li>-Abuse is any willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish, or emotional distress. This includes the deprivation by any individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident;</li> <li>-Physical abuse is an employee purposefully beating, striking, wounding, or injuring any consumer. In any manner whatsoever, an employee mistreating or maltreating a consumer in a brutal or inhumane manner. An employee handling a consumer with any more force than is reasonable for a consumer's proper control, treatment, or management;</li> <li>-The Administrator and Director of Nursing (DON) must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator or DON must be called at home or must be paged and informed of such incident;</li> <li>-The Administrator or designee shall report any allegations of abuse, neglect, or misappropriation of resident property as well as report any reasonable suspicion of a crime in accordance with Section 1150B of the Social Security Act of the Department of Health as required;</li> <li>-Alleged violations abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of resident property are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury;</li> </ul> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265471
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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>-Report the results of all investigations to the Administrator or designee and other officials in accordance with state law including State Survey Agency within five working day of the incident.</p> <p>1. Review of Resident #1's face sheet (a brief resident profile) showed the following:</p> <ul style="list-style-type: none"> <li>-admission date of 06/20/22;</li> <li>-Diagnoses included vascular dementia (brain damage caused by multiple strokes), polyneuropathy (a nervous system disorder that impacts nerve function in multiple areas of the body), dependence on wheelchair, and need for assistance with personal cares.</li> </ul> <p>Review of the resident's care plan, revised on 01/24/25, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident has behavioral symptoms related to diagnosis of dementia;</li> <li>-Staff should approach calmly and unhurried, introduce self and explain all procedures;</li> <li>-Staff should attempt to refocus behaviors to something positive;</li> <li>-Staff should reduce stimulations and keep conversation short/simple;</li> <li>-Staff should speak in a reassuring voice and be supportive of their feelings;</li> <li>-Resident screams out daughter's name and demands from staff, physically abusive to staff, refuses showers, incontinent care, and activities of daily living (ADLs) from staff often.</li> </ul> <p>Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool administered by staff), dated 05/09/25, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had severe cognitive impairment;</li> <li>-The resident required partial/moderate assistance of staff for toileting, transfers, and mobility.</li> </ul> <p>Review of Nurse Aide (NA) C's written statement, dated 05/26/25, showed the following:</p> <ul style="list-style-type: none"> <li>-On Sunday morning (05/25/25) at 3:00 A.M., NA C was doing checks with NA D and went into the resident's room to get him/her changed;</li> <li>-The resident was hitting NA D and NA D hit the resident back;</li> <li>-NA C waited until the following day to report it.</li> </ul> <p>During an interview on 06/03/25, at 11:27 A.M., NA C said the following:</p> <ul style="list-style-type: none"> <li>-Staff should report any abuse allegation immediately to the charge nurse;</li> </ul> <p>(continued on next page)</p>

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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>-On 05/25/25, at approximately 3:00 A.M., she was making rounds on the memory care unit with NA D when they stopped to check on the resident. They told the resident they needed to check to see if he/she was wet. The resident began to yell and curse at them and began hitting NA D. NA D slapped back at the resident. He/she did not report the incident until the following day of 05/26/25. He/she did not want to report NA D while he/she was still on shift with him/her.</p> <p>Review of DHSS records showed facility staff made a self-report regarding an allegation of possible abuse on the afternoon of 05/26/26 (the day following the alleged abuse incident). The self report showed the following:</p> <p>-It was reported to the Administrator 05/26/25, at 12:11 P.M., that two nurse aides were the resident's room doing cares on 05/25/25 at 3:00 A.M. The resident was hitting and scratching NA D. NA D slapped the resident in the face.</p> <p>During an interview on 06/03/25, at 10:16 A.M., Certified Nursing Assistant (CNA) A said the following:</p> <p>-He/she would report any abuse allegation to the charge nurse immediately after ensuring safety of the resident;</p> <p>-The facility has two hours to report any abuse allegation to the state agency;</p> <p>-Slapping a resident would be an allegation of abuse and should be reported immediately.</p> <p>During an interview on 06/03/25, at 10:21 A.M., CNA B said the following:</p> <p>-He/she would ensure safety of a resident first and report immediately to charge nurse following an allegation of abuse;</p> <p>-The facility should report any abuse allegation to the state agency within 24 to 48 hours;</p> <p>-Slapping a resident would be an allegation of abuse and should be reported immediately.</p> <p>During an interview on 06/03/25, at 11:49 A.M., CNA E said the following:</p> <p>-He/she would ensure safety of a resident first and report immediately to charge nurse following an allegation of abuse;</p> <p>-The facility has two hours to report any abuse allegation to the state agency.</p> <p>During an interview on 06/03/25, at 11:55 A.M., Registered Nurse (RN) F said the following:</p> <p>-He/she would ensure safety of the resident and assess the resident following any abuse allegation and then report immediately to the Director of Nursing (DON);</p> <p>-The facility has two hours to report any abuse allegation to the state agency;</p> <p>-Slapping a resident would be an allegation of abuse.</p> <p>(continued on next page)</p>		

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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>During an interview on 06/03/25, at 12:37 P.M., RN G said the following:</p> <ul style="list-style-type: none"> <li>-Staff report any abuse to him/her immediately, and he/she would ensure resident safety, complete an assessment for injuries, and then report up the chain of command;</li> <li>-The facility has two hours to report any abuse allegation to the state agency;</li> <li>-Slapping a resident would be an allegation of abuse.</li> </ul> <p>During an interview on 06/03/25, at 1:08 P.M., the Social Services Director (SSD) said the following:</p> <ul style="list-style-type: none"> <li>-She would report any abuse allegation immediately to the Administrator;</li> <li>-The facility has two hours to report any abuse allegation to the state agency.</li> </ul> <p>During an interview on 06/03/25, at 1:21 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-Staff should ensure resident safety and then report any abuse allegation immediately to charge nurse, DON, or Administrator;</li> <li>-The facility has two hours to report any abuse allegation to the state agency.</li> </ul> <p>During an interview on 06/03/25, at 1:38 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> <li>-Staff should ensure the safety of a resident first then report any abuse of allegation immediately to the charge nurse, DON, or Administrator;</li> <li>-The facility has two hours to report any abuse allegation to the state agency.</li> </ul> <p>MO00254817</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>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to document a timely and thorough investigation, to include interviews with multiple staff and other residents, and immediate steps taken to protect all residents during the investigation for an allegation of possible physical abuse involving one resident (Resident #1). The facility census was 46.</p> <p>Review of the facility policy titled, Abuse Prevention, dated 10/21/22, showed the following:</p> <ul style="list-style-type: none"> <li>-The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitor, or any other individual;</li> <li>-Abuse is any willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish, or emotional distress. This includes the deprivation by any individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident;</li> <li>-Physical abuse is an employee purposefully beating, striking, wounding, or injuring any consumer. In any manner whatsoever, an employee mistreating or maltreating a consumer in a brutal or inhumane manner. An employee handling a consumer with any more force than is reasonable for a consumer's proper control, treatment, or management;</li> <li>-The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation;</li> <li>-Any allegation of abuses, or neglect, misappropriation or exploitation against any employee must result in his/her immediate suspension to protect the resident;</li> <li>-Report the results of all investigations to the Administrator or designee and other officials in accordance with state law including State Survey Agency within five working day of the incident.</li> </ul> <p>1. Review of Resident #1's face sheet (a brief resident profile) showed the following:</p> <ul style="list-style-type: none"> <li>-admission date of 06/20/22;</li> <li>-Diagnoses included vascular dementia (brain damage caused by multiple strokes), polyneuropathy (a nervous system disorder that impacts nerve function in multiple areas of the body), dependence on wheelchair, and need for assistance with personal cares.</li> </ul> <p>Review of the resident's care plan, revised 01/24/25, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident had behavioral symptoms related to diagnosis of dementia;</li> <li>-Staff should approach calmly and unhurried, introduce self and explain all procedures;</li> </ul> <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>-This was a he-said she-said alleged abuse investigation since the resident's cognition was impaired and there were no other witnesses;</p> <p>-The investigation included written statements by Nursing Assistant (NA) C and NA D.</p> <p>(The investigation did not show documented interviews with other staff or residents.)</p> <p>During an interview on 06/03/25, at 10:16 A.M., Certified Nursing Assistant (CNA) A said the following:</p> <p>-He/she would report any abuse allegation to the charge nurse immediately following ensuring safety of the resident;</p> <p>-Slapping a resident would be considered abuse.</p> <p>During an interview on 06/03/25, at 10:21 A.M., CNA B said the following:</p> <p>-He/she would ensure safety of a resident first and report immediately to charge nurse following an allegation of abuse;</p> <p>-Slapping a resident would be considered abuse.</p> <p>During an interview on 06/03/25, at 11:49 A.M., CNA E said he/she would ensure safety of a resident first and report immediately to charge nurse following an allegation of abuse.</p> <p>During an interview on 06/03/25, at 11:55 A.M., Registered Nurse (RN) F said the following:</p> <p>-He/she would ensure safety of the resident and assess the resident following any abuse allegation and then report immediately to the DON;</p> <p>-Slapping a resident would be considered abuse.</p> <p>-He/she does not participate in investigations of abuse allegations;</p> <p>During an interview on 06/03/25, at 12:37 P.M., RN G said the following:</p> <p>-Staff report any abuse to him/her immediately, and he/she would ensure resident safety, complete an assessment for injuries, and then report up the chain of command;</p> <p>-Slapping a resident would be considered abuse.</p> <p>During an interview on 06/03/25, at 1:08 P.M., the Social Services Director (SSD) said the following:</p> <p>-She has not been informed if she has a role in abuse investigations with the new Administrator, but did interview residents on previous abuse allegations;</p> <p>-She did not conduct any interviews for this investigation.</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 06/03/25, at 1:21 P.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> <li>-Staff should ensure resident safety and then report any abuse allegation immediately to charge nurse, DON, or Administrator;</li> <li>-A full body skin assessment is completed on the resident and 15-minute checks are initiated;</li> <li>-Any staff member accused of abuse is immediately suspended pending an investigation.</li> </ul> <p>During an interview on 06/03/25, at 1:38 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> <li>-Staff should ensure the safety of a resident first then report any abuse of allegation immediately to the charge nurse, DON, or Administrator;</li> <li>-The nurse should assess the resident and notify the physician and family;</li> <li>-The alleged staff member should be suspended immediately pending an investigation;</li> <li>-An abuse allegation investigation should include obtaining witness statements, conducting assessments of the resident, interviewing residents, and completing in-services. She did not interview any residents or other staff members.</li> </ul> <p>MO00254817</p>