STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand River Health Care	118 Trenton Road Chillicothe, MO 64601

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. 44939 Based on interview and record review, the facility failed to ensure one resident, (Resident #1) was free from verbal and physical abuse when Certified Nursing Assistant (CNA) A grabbed the resident's arm, jerking him/her back into the wheelchair, while yelling and cursing at the resident. The facility census was 27. Review of the facility's Abuse Prohibition policy, dated November 2017, showed: -It is the policy of this facility that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment, or involuntary seclusion. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties; -Any owner, licensee, administrator, licensed nurse, employee or volunteer of a nursing home shall not physically, mentally, or emotionally abuse, mistreat or neglect a resident. Review of Resident #1's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 11/12/24 showed: -He/She has the diagnoses of mood disorder due to known physiological condition (a mental health condition characterized by persistent and pervasive change in a person's emotional state), violent behaviors, depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Parkinsonism (a disorder of the central nervous system that affects movement, often including tremors), Diabetes Mellitus type 2 (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), heart failure, generalized anxiety disorder (a mental health disorder characterized by severe, ongoing anxiety that interferes with daily activities); - The resident has minimal difficulty hearing, unclear speech, usually makes self understood and usually understands others; (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She refused to participate in a Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). He/She does have short and long term memory problems; -He/She displays verbal behaviors, physical behaviors, and rejection of care almost daily; -He/She requires moderate to substantial assistance with Activities of Daily Living (ADL's), including dressing, bathing, toileting and personal hygiene. Review of the Resident's comprehensive care plan, dated 11/12/24, showed the following interventions: -He/She has impaired decision making due to cognitive loss; -He/She has difficulty making self understood due to impaired cognition and unclear speech. Staff are to approach him/her calmly and allow him/her time to speak. Observe the resident for signs of distress, including guarding, restlessness and increased breathing; -He/She prefers low-noise environments and solitary activities. Maintain a calm, slow approach with the resident. -He/She has socially inappropriate/disruptive behavioral symptoms as evidenced by fluctuations in mood, and non-compliance with taking medications. Allow resident to have control over situations, if possible. Avoid over-stimulation. Assess if the resident' behavior is dangerous to self, other residents and/or staff. Review of the resident's progress note, dated 12/8/24 at 11:40 A.M., said: -Staff heard the resident yelling from his/her room. Nurses Aide (NA) A went into the room to see why the resident was yelling. The resident was observed on the fall mat and had been incontinent of urine. The resident was yelling and combative with staff as they assisted him/her up from the floor. The resident agreed to allow NA A to assist him/her to the restroom. While in the restroom, the resident became angry and combative, as the resident thought the NA was going to close the restroom door. The resident began to yell that he/she wanted out of the restroom. The NA got out of the resident's way and the resident began making his/her way to the nurses' station. Once at the nurses' station, the resident tried to go behind the desk, saying he/she wanted to use the phone. Staff advised the resident that he/she could use the phone in the resident phone room. The resident stated the phone in the phone room did not work and he/she wanted to use the one at the nurses' station. Staff attempted to pull the resident's wheelchair back from the nurses' station. At this time, two laundry staff members, Laundry Aide A and Laundry Aide B, heard commotion by the nurses station. The resident was having behaviors, yelling, and trying to strike staff. Laundry Aide A said that CNA A, grabbed the resident's arm and said You're not going to fucking hit me! and pulled him/her around. CNA A was kicking at the resident's wheelchair. Activity Director was called and he/she came to the nurses' station, took the resident to a quiet area, and asked him/her what happened. He/She said the aides were hurting him/her by not letting him/her use the phone and one, CNA A, pinched his/her arm and kicked him/her. The Activity Director noticed a red mark on the resident's inner elbow. The Administrator was called and spoke to resident and Activity Director about the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/16/24 at 12:23 P.M., Resident #1 said: -He/She had fallen on the mat next to the bed and yelled for staff to come help him/her. NA A and CNA A came into the room and helped him/her back up into the wheelchair. NA A then assisted him/her to the restroom. NA A went to leave the restroom and the resident became upset because he/she thought NA A was going to close the restroom door. He/She left the restroom and went down to the nurses's station to use the phone to call his/her sister. CNA A and NA A followed him/her to the nurses' station and told him/her to use the phone in the resident phone room. That phone does not work and he/she wanted to use the phone at the nurses' station. CNA A began yelling and cursing at the resident. The resident became upset at CNA A for yelling at him/her and attempted to hit CNA A. CNA A grabbed the resident by the right arm and jerked him/her around in the wheelchair while cursing at him/her. CNA A was also kicking at the wheelchair, trying to get the resident to back up from the nurses' station. The resident felt scared when CNA A grabbed his/her arm, jerked him/her around and cursed at him/her. During an interview on 12/16/24 at 1:10 P.M., Laundry Aide A said: -He/She heard yelling at the nurses station and Laundry Aides A and B went to the desk to see what was going on. Resident #1 was trying to get behind the desk. He/She was yelling that he/she wanted to use the phone. CNA A and NA A were attempting to keep the resident from going behind the desk. The resident was swinging his/her arm at CNA A. CNA A was yelling and cursing at the resident and kicking at his/her wheelchair, trying to get the resident to back up. CNA A then grabbed the resident by the right arm and jerked him/her back in the wheelchair. The Activity Director came to the desk at this time, took the resident to the front of the building to calm down and calm the Administrator. During an interview on 12/16/24 at 1:15 P.M., the Activity Director said: -Laundry Aides A and B witnessed CNA A yelling at Resident #1, grab his/her right arm and jerk him/her back in the wheelchair. The Laundry Aides called the Activity Director on his/her cell phone and told him/her to come to the nurses desk. The Activity Director heard yelling as he/she came down the hall towards the nurses desk. When he/she got to the desk, he/she witnessed the resident yelling at CNA A and NA A. The Activity Director accompanied the resident to the front of the building to calm down and to call the Administrator. The Activity Director noted a red mark to the inside of the resident's right arm. The Administrator told the Activity Director to instruct CNA A to leave the facility and the Administrator was on the way to the facility. The Activity Director told CNA A to leave the facility. CNA A became upset, began yelling at the Activity Director and refusing to leave. The Activity Director informed CNA A he/she would have to call law enforcement if he/she did not leave the facility. At this time, CNA A left. During an interview on 12/16/24 at 2:00 P.M., the Administrator said: -It is his/her expectation that staff treat residents with respect. -Residents have the right to be free from abuse. -It is his/her expectation that the staff should have allowed the resident to use the phone at the nurses desk and notify the charge nurse that the resident was agitated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	MO246288