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	11/21/2025

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 - Minimal harm or potential for 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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one residents (Resident #2) right to be free from physical abuse when Resident #1 hit Resident #2 on the arm on two separate occasions. The facility census was 28.Review of the facility Abuse Policy, undated, showed:- It is the policy of the 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;- The resident will be protected from abuse, neglect, and harm while they are residing at the facility;- Abuse is the willful infliction of injury, unreasonable restriction, threat or punishment with resulting physical harm or pain, or mental pain or deprivation by an individual; - Abuse is any intentional act that causes harm or potential harm to a resident. It can be physical, emotional, sexual, verbal, or financial. Abuse can occur as a single incident or a repeated pattern of behavior;- Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.1. Review of Resident #1's admission MDS (Minimum Data Set), a federally mandated assessment tool completed by facility staff, dated 8/31/25., showed:- Severe cognitive impairment;- Diagnoses included: psychotic disorder (disorder involving a disconnection with reality), obsessive compulsive disorder (a mental condition in which a person experiences persistent, intrusive thoughts that cause distress and performs repetitive physical or mental acts in order to prevent or counteract the thoughts and relieve the distress), and dementia;- Required substantial assistance from staff for activities of daily living (ADL's) to include showering, toileting, and transfers. Review of the resident's care plan, dated 11/10/25, showed:- The resident had the tendency to yell out or hit his/herself or others when he/she got frustrated or angry;- The resident resisted care related to behaviors toward self and others and the resident was often uncooperative with staff;- The resident had a care plan goal of no more than one episode of aggressive behavior per day toward self or others;- The resident required nursing staff to encourage the resident to voice feeling or redirection or to have alone time away from other residents and noisy environments. Review of the resident's nursing progress notes for the month of October 2025 showed:- On 10/24/25 at 8:47 A.M., Resident #1 witnessed in the hallway yelling. The resident usually is kind and affectionate with staff. This morning the resident seems agitated and irritable. The resident apologizes after yelling and can't fully control the impulse of yelling;- On 10/27/25 at 7:25 A.M., Resident #1 had hit Resident #2 in the dining hall. Resident #1 came to Resident #2's table and hit the resident in the left shoulder. The Administrator, the guardian, and the provider were notified.- No further charting noted related to this incident. Review of the resident's nursing progress notes for the month of November 2025 showed:- On 11/9/25 at 12:30 P.M., Resident #1 began to hit Resident #2 in the arm while in the dining hall. Staff tried to remove Resident #1 from the dining hall and he/she resisted by planting feet on the floor, hit self on the head repeatedly, flipped off staff and called staff names. Resident #1 continued to resist staff, began to flip off other residents and called them names until he/she calmed down and was put to bed. The Administrator, guardian, and provider were notified; - On 11/9/25 at 7:20 P.M., Resident #1 went to the dining room for supper and became agitated and began yelling and cursing at other residents. Resident #1 was brought to the dayroom where he/she continued to yell and curse but did not hit anyone;- No further charting noted related to this incident.2. Review of Resident #2's Quarterly MDS, dated [DATE], showed;- Mild cognitive impairment;- Diagnoses included: stroke, hypertension, and anxiety;- Required substantial assistance from staff for activities of daily living (ADL's) to include showering, toileting, and lower body dressing.Review of the resident's care plan, dated 10/21/25, showed:- The resident was at risk for fall related to generalized weakness;- At times the resident refuses or resisted personal cares and staff would maintain a pleasant friendly demeanor when approaching the resident.Review of the resident's nursing progress notes for the month of October 2025, showed:- On 10/27/25 at 7:25 A.M., Resident #2 said he/she was hit by Resident #1 in the left shoulder, in the dining room. Resident #2 was checked, denied pain, and no injury was noted. The Administrator, guardian and provider were notified;- On 10/27/25 at 11:20 A.M., Resident #2 said Resident #1 was next to him/her and bumped into his/her chair then tapped his/her arm;- No further charting noted related to this incident.Review of the resident's nursing progress notes for the month of November 2025, showed:- On 11/9/25 at 12:30 P.M., Resident #2 was eating lunch in the dining room when Resident #1 began hitting him/her on the arm. Staff removed Resident #1 from vicinity of Resident #2, assessed Resident #2, and notified the guardian and provider;- On 11/9/25 at 11:46 P.M., 72-hour observation for an incident