

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/15/2025
NAME OF PROVIDER OR SUPPLIER  Rocky Ridge Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  3111 Highway A Mansfield, MO 65704	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to protect all residents right to be free from sexual abuse by other residents when staff failed to care plan and implement new interventions when one resident (Resident #1) exhibited sexually abusive behaviors towards two residents (Resident #2, Resident #3) and sexually verbal behaviors toward one resident (Resident #4). The facility census was 49.</p> <p>Review of the facility policy, titled Abuse Prohibition Protocol Manual, revised 11/28/2016, showed the following:</p> <ul style="list-style-type: none"> <li>-All residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation;</li> <li>-The facility must thoroughly investigate the alleged violation, prevent further abuse while the investigation is in progress, and take appropriate corrective action;</li> <li>-Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents regardless of their age, ability to comprehend, or disability;</li> <li>-Sexual abuse is defined as non-consensual sexual contact of any type with a resident that includes all unwanted intimate touching of any kind especially of breasts or perineal area and nudity.</li> </ul> <p>1. Review of Resident #1's face sheet (brief resident profile sheet) showed the following information:</p> <ul style="list-style-type: none"> <li>-admission date of 08/01/24;</li> <li>-Diagnoses included schizoaffective disorder (mental health condition including delusions and hallucinations), anxiety, and bipolar disorder (mood swings ranging from depressive lows to manic highs), alcohol abuse and pyelonephritis (chronic kidney infections).</li> </ul> <p>Review of the resident's progress note dated 09/11/24, at 4:04 P.M., showed the following information:</p> <ul style="list-style-type: none"> <li>-The Director of Nursing (DON) documented the resident had been sexually inappropriate several times since admission;</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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident was treated for a urinary tract infection (UTI) the previous month;</p> <p>-The the resident's family wished for the resident to be moved closer to them. Referrals had been sent to multiple homes and none [NAME] accepted the resident.</p> <p>Review of the resident's progress note dated 10/18/24, at 3:17 P.M., showed the Social Services Director (SSD) documented the resident had behaviors of exposing himself/herself to other residents.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/08/24, showed the following information:</p> <p>-Cognitively intact;</p> <p>-Independent with bed mobility, transfer, dressing, toilet use, and personal hygiene;</p> <p>-Used walker or wheelchair for ambulation;</p> <p>-Physical behavioral symptoms directed at others exhibited.</p> <p>Review of the resident's care plan, revised 11/14/24, showed the following information:</p> <p>-The resident had a history of being sexually inappropriate with peers;</p> <p>-Staff will accompany the resident when going outside;</p> <p>-The resident may need additional monitoring at times;</p> <p>-The resident may become sexually inappropriate at times;</p> <p>-Remove the resident from public area when behavior is unacceptable.</p> <p>Review of the resident's progress note dated 11/18/24, at 8:46 A.M., showed the following information:</p> <p>-Staff observed Resident #1 grabbing Resident #3's genitals;</p> <p>-Resident #3 said this has happened four times this weekend;</p> <p>-The Resident #1 had been redirected multiple times since admission for inappropriate behaviors with staff and residents. The resident did not respond or even act like he/she had been told not to do this;</p> <p>-The resident has had UTI's with behaviors which exacerbate the sexual behaviors, however, the behaviors are ongoing.</p> <p>(Staff did not document any new interventions to address the resident's sexual behaviors and abuse of other residents.)</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's current care plan showed staff did not care plan the reported behaviors/resident abuse and did not care plan any new interventions to prevent future episodes.</p> <p>Review of the resident's progress note dated 11/20/24, at 1:21 P.M., showed the following information:</p> <ul style="list-style-type: none"> <li>-The nurse documented that Resident #3 reported that Resident #1 propelled his/her wheelchair up to Resident #3 and asked him/her if he/she could touch his/her private area;</li> <li>-Resident #3 reported this immediately to staff and appeared to be upset by the behavior;</li> <li>-The nurse spoke with Resident #1 asking him/her if this happened. Resident #1 said yes it did, I'm horny. The resident was educated not to speak to other residents in that manner.</li> </ul> <p>(Staff did not document any new interventions to address the resident's sexual behaviors and abuse of other residents.)</p> <p>Review of the resident's current care plan showed staff did not care plan the reported behaviors/resident abuse and did not care plan any new interventions to prevent future episodes.</p> <p>Review of the resident's progress note dated 12/01/24, at 7:40 P.M., showed the following information:</p> <ul style="list-style-type: none"> <li>-The nurse documented that Resident #1 was observed standing in Resident #2's room, naked from the waist down;</li> <li>-The nurse redirected Resident #1 back to his/her room and reeducated the resident not to go in other residents' rooms and not to leave his/her room without clothing;</li> <li>-Resident #1 denied the behavior;</li> <li>-Staff notified the DON;</li> <li>-Staff notified the physician and orders received to send to hospital for psych evaluation and possible UTI;</li> <li>-Staff notified family;</li> <li>-The resident was transported to hospital for evaluation.</li> </ul> <p>Review of the resident's medical record showed the resident tested negative for a UTI.</p> <p>Review of the resident's current care plan showed staff did not care plan the reported behaviors/resident abuse and did not care plan any new interventions to prevent future episodes.</p> <p>Review of the resident's progress note dated 12/09/24, at 4:45 P.M., showed the following information:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The nurse documented that another resident (Resident # 3) reported that while at supper in the dining room, Resident #1 propelled his/her wheelchair up to his/her table and asked Resident #3 if he would fuck him/her. Resident #3 told him/her no and Resident #1 went on his/her way;</p> <p>-The nurse spoke to Resident #1 who admitted to saying the above statement and didn't care or see why it was inappropriate;</p> <p>-Resident #1 ate his/her supper then stayed the remainder of the evening in his/her room.</p> <p>(Staff did not document any new interventions to address the resident's sexual behaviors and abuse of other residents.)</p> <p>Review of the resident's current care plan showed staff did not care plan the reported behaviors/resident abuse and did not care plan any new interventions to prevent future episodes.</p> <p>Review of the resident's progress note dated 12/15/24, at 2:47 A.M., showed the following information:</p> <p>-The nurse documented that a guest of another resident reported that the resident had been inappropriate and grabbed his/her groin;</p> <p>-The nurse spoke with the resident who denied the incident.</p> <p>Review of the resident's current care plan showed staff did not care plan the reported behaviors/resident abuse and did not care plan any new interventions to prevent future episodes.</p> <p>Review of the resident's progress note dated 12/17/24, at 4:42 P.M., showed the following information:</p> <p>-The resident propelled his/her wheelchair up to Resident #3, reached out and grabbed his/her genitals;</p> <p>-Resident #3 began to scold Resident #1, until staff removed Resident #1;</p> <p>-Resident #3 was very upset and requested anxiety medication.</p> <p>(Staff did not document any new interventions to address the resident's sexual behaviors and abuse of other residents.)</p> <p>Review of the resident's current care plan showed staff did not care plan the reported behaviors/resident abuse and did not care plan any new interventions to prevent future episodes.</p> <p>Review of the resident's progress note dated 01/06/25, at 6:10 A.M., showed the following information:</p> <p>-Staff observed Resident #1 in Resident #2's room, sitting on top of Resident #2 with his/her pants down and his/her hands down Resident #2's pants;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff immediately went in the room and removed Resident #1 off Resident #2;</p> <p>-The nurse assisted with pulling up Resident #1's pants and walked the resident back to his/her room;</p> <p>-The resident was redirected and educated that he/she should not be in other residents' rooms;</p> <p>-The resident was placed on 15-minute checks;</p> <p>-The DON and the Administrator was notified.</p> <p>Review of the facility's follow-up investigation report, dated 01/08/25, showed the following information:</p> <p>-The victim was Resident #2, and the alleged aggressor was Resident #1;</p> <p>-Resident #1 was found on top of Resident # 2, in Resident #2's room;</p> <p>-Resident #1 had his/her pants pulled down with his/her hands down Resident #2's pants;</p> <p>-Resident #2 was not able to give consent;</p> <p>-Resident #1 was taken back to his/her room;</p> <p>-Resident #1 was currently on 15-minute checks;</p> <p>-Resident #2 continued to yell out;</p> <p>-Resident #1 sat in his/her doorway and said I want to come to you, but they won't let me;</p> <p>-Resident #1 was moved to another hall further away from Resident #2;</p> <p>-The DON, Administrator, physician and guardians were notified,</p> <p>2. Review of Resident #2's face sheet showed the following information:</p> <p>-admission date of 05/14/24;</p> <p>-Diagnoses included schizophrenia (a disorder that affects the ability to think, feel and behave clearly), anoxic brain damage (occurs when the brain is deprived of oxygen, resulting in brain cell death and impairment), metabolic encephalopathy (brain dysfunction caused by chemicals in the blood) and dysphagia (difficulty speaking).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/21/24, showed the following information:</p> <p>-Severe cognitive impairment;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene;</p> <p>-Unclear speech with slurred or mumbled words;</p> <p>-Physical behavioral symptoms directed at others exhibited.</p> <p>Review of the resident's care plan, revised 11/20/24, showed the following information:</p> <p>-Provide resident with supportive care and services;</p> <p>-Provide resident with a safe and secure environment on an ongoing basis.</p> <p>Review of the resident's progress note dated 01/06/25, at 08:26 A.M., showed the following information:</p> <p>-Resident had been laying on his floor mat per his request;</p> <p>-Staff observed Resident #1 in Resident #2's room, sitting on top of Resident #2 with his/her pants down and his/her hands down Resident #2's pants;</p> <p>-Staff immediately went in the room and removed Resident #1 off Resident #2;</p> <p>-Staff notified the nurse, who assisted with pulling up Resident #1's pants and walked the resident back to his/her room;</p> <p>-Resident #1 was redirected and placed on 15-minute checks;</p> <p>-Resident #2 was assessed and no injuries noted;</p> <p>-Resident #2 had been previously medicated with Zyprexa (antipsychotic) and oxycodone (opioid pan medication), therefore, no additional medications were administered;</p> <p>-Staff notified the DON and the Administrator.</p> <p>3. Review of Resident #3's face sheet showed the following information:</p> <p>-admission date of 11/01/24;</p> <p>-Diagnoses included bladder cancer, brain cancer, prostate cancer, heart failure, and anxiety.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following information;</p> <p>-Cognitively intact;</p> <p>-Independent with bed mobility, transfer, mobility/walking, dressing, toilet use, and personal hygiene;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Verbal behavioral symptoms directed at others exhibited;</p> <p>-Daily wandering exhibited.</p> <p>Review of the resident's care plan, revised 10/24/24, showed the following information:</p> <p>-Provide resident with supportive care and services;</p> <p>-Provide resident with a safe and secure environment on an ongoing basis;</p> <p>-Redirect resident when possible.</p> <p>Review of the resident's progress note dated 11/18/24, at 8:46 A.M., showed the following information:</p> <p>-Staff observed Resident #1 grabbing Resident #3's genitals;</p> <p>-Resident #3 said this has happened four times this weekend;</p> <p>-Resident #1 has been redirected multiple times since admission for inappropriate behaviors with staff and residents.</p> <p>Review of the resident's progress note dated 11/20/24, at 1:21 P.M., showed the following information:</p> <p>-The nurse documented that Resident #3 reported that Resident #1 propelled his/her wheelchair up to Resident #3 and asked him/her if he/she could touch his/her private area;</p> <p>-Resident #3 reported this immediately to staff and appeared to be upset by the behavior;</p> <p>-The nurse spoke with Resident #1 asking him/her if this happened. Resident #1 said yes it did, I'm horny. The resident was educated not to speak to other residents in that manner.</p> <p>During an interview on 01/15/25, at 11:10 A.M., Resident #3 said that Resident #1 has been sexually inappropriate and liked to grab his/her groin as he/she walked by. Resident #1 grabbed Resident #3's groin one time when outside on smoke break and one time while at the nurses' station. Both times Resident #3 said he/she pushed Resident #1's hand away and told him/her to stop and then reported it to the nurse. They punish him/her Resident #1 by taking away his/her smoke breaks or send him/her out (to the hospital), but he/she always comes back. Resident #3 said that Resident #1 touches other residents too, not just me. Resident #3 said that he/she doesn't like Resident #1 touching him/her and doesn't want Resident #1 touching him/her. Resident #3 said that he/she has told staff to keep him/her away from me.</p> <p>4. Review of Resident #4's face sheet showed the following information:</p> <p>-admission date of 08/05/24;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included schizoaffective disorder (mental health condition including delusions and hallucinations), bipolar (mood swings ranging from depressive lows to manic highs), anxiety.</p> <p>Review of the resident's quarterly MDS, dated [DATE] showed the following information:</p> <p>-Cognitively intact;</p> <p>-Independent with bed mobility, transfer, mobility/walking, dressing, toilet use, and personal hygiene;</p> <p>-No behaviors exhibited.</p> <p>Review of the resident's care plan, revised 10/23/24, showed staff to provide resident with a safe and secure environment on an ongoing basis.</p> <p>Review of the resident's progress note dated 12/09/24, at 4:45 P.M., showed the following information:</p> <p>-The nurse documented that Resident # 3 reported that while at supper in the dining room, Resident #1 propelled his/her wheelchair up to his/her table and asked Resident #3 if he would fuck him/her. Resident #3 told him/her no and Resident #1 went on his/her way;</p> <p>-The nurse spoke to Resident #1 who admitted to saying the above statement and didn't care or see why it was inappropriate.</p> <p>During an interview on 01/15/25, at 11:50 A.M., Resident #4 said that Resident #1 would tell him/her that he/she wanted to fuck him/her. The resident said he/she would demand it. He/she would say it a lot, too many times to count. The resident said he/she would always tell him/her no and report it to the nurse. The resident said it has been happening for months (not sure how many months). The resident said that it made him/her feel uncomfortable and did not like to hear those words. The resident said that he/she would try to keep his/her distance from Resident #1 because she would tell him/her that she wanted to fuck him/her every time he/she would see him/her.</p> <p>5. During an interview on 01/15/25, at 9:51 A.M., Certified Nurse Aide (CNA) H said that he/she had witnessed Resident #1 being sexually inappropriate with staff. The resident had tried to grab his/her groin on multiple occasions. CNA H reported this to his/her charge nurse and the DON. He/she also witnessed Resident #1 on top of Resident #2. Resident #1 had a brief on and had his/her hands down Resident #2's pants. Resident #2's eyes were big and he/she was yelling when CNA H went into the room and pulled Resident #1 off Resident #2. He/she notified the nurse immediately. Resident #1 was on 15-minute checks and staff know to watch him/her when he/she leaves his/her room.</p> <p>During an interview on 01/15/25, at 10:15 A.M., CNA F said Resident #1 was on 15-minute checks and can only go outside to smoke with staff because he/she was known to be sexually inappropriate.</p> <p>During an interview on 01/15/25, at 10:00 A.M. CNA E said the resident was on 15-minute checks because of inappropriate sexual behaviors. The resident was known to be inappropriate towards staff and residents. The resident liked to grab groins and butts.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/15/25, at 9:44 A.M., Certified Mediation Tech (CMT) D said the following:</p> <ul style="list-style-type: none"> <li>-Abuse and neglect (A/N) is any kind of hitting or yelling at residents. Inappropriate touching and verbal comments are also considered sexual abuse;</li> <li>-He/she would report any abuse immediately to the charge nurse;</li> <li>-He/she had witnessed Resident #1 grab Resident #3's crotch area and reported it to the DON immediately. Resident #3 was upset and began yelling at Resident #1.</li> </ul> <p>During an interview on 01/09/25, at 9:50 A.M., Registered Nurse (RN) A said the following:</p> <ul style="list-style-type: none"> <li>-Resident #1 normally only comes out of his/her room to smoke or eat;</li> <li>-The resident had chronic UTI's and is on antibiotics daily because his/her family member claims that he/she only has behaviors when he/she has a UTI;</li> <li>-Staff must watch the resident every time he/she comes out of his/her room because he/she has had so many behaviors;</li> <li>-The resident often grabs residents by the groin and makes inappropriate sexual comments to residents and staff;</li> <li>-Resident #3 reported to him/her that Resident #1 wheeled up to him/her and asked if he/she could touch his/her private area. Resident #3 reported this to the RN immediately. RN A spoke with Resident #1 asking if this happened. Resident #1 admitted that this occurred stating I'm horny. RN A educated the resident to not speak to other residents in this manner and said that the resident went to his/her room;</li> <li>-RN A said this was sexual abuse;</li> <li>-RN A said the physician was aware of Resident #1's behaviors as well as the Administrator;</li> <li>-RN A said that the resident has been on 15-minute checks since he/she has been a resident at the facility.</li> </ul> <p>During an interview on 01/09/25, at 12:45 P.M., Licensed Practical Nurse (LPN) C, who also updates care plans, said the following:</p> <ul style="list-style-type: none"> <li>-Resident #1 tried to touch the other residents at the facility. The resident tried to touch their butts or grab at their crotches or tells them I want to fuck you;</li> <li>-The resident targeted Resident #2 and Resident #3;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff have it care planned and have the resident on 15-minute checks. Someone was always watching the resident every time he/she came out of his/her room. The resident only came out to smoke or eat, and only came out to eat if he/she didn't have any snacks in his/her room. The resident could only go outside to smoke with staff present.</p> <p>-The resident was sexually inappropriate and very impulsive.</p> <p>-The aides had been directed to redirect the resident when he/she exhibited this type of sexually inappropriate behavior.</p> <p>-The resident's family member said that the resident was sexually inappropriate when he/she had a UTI, but that is not accurate. The last two times staff have sent him/her to the hospital, he/she tested negative for a UTI. Staff have kept him/her on antibiotics for this reason.</p> <p>-Staff always notify the physician when the resident has inappropriate sexual behaviors. They also notify the DON and the Administrator and document the behavior.</p> <p>-LPN C said that it should have been reported to DHSS by either the DON or the Administrator. LPN C said that staff receives abuse and neglect training but not sure how often.</p> <p>During an interview on 01/15/25, at 11:35 A.M., the Social Services Director (SSD) said the following:</p> <p>-He/she had not witnessed any inappropriate sexual behaviors from Resident #1, but had been told about them;</p> <p>-There have been many episodes documented in the resident's chart and he/she has had many conversations with the resident about his/her inappropriate behaviors. He/she had told the resident that he/she cannot tell another resident that he/she wants to have sex with them and cannot touch them, especially on their butt or groin areas. He/she told the resident that was considered abuse. The resident would close his/her eyes and pretend to go to sleep during these conversations.</p> <p>During an interview on 01/09/25, at 1:45 P.M., the Director of Nursing (DON) said the following:</p> <p>-Resident #1 has been on 15-minute checks since admission;</p> <p>-The resident's inappropriate behaviors started almost immediately. The resident had been inappropriate with staff and residents and staff know to keep an eye on him/her when he/she is out of his/her room.</p> <p>-Resident #1 had patted butts and groped groins and asked other residents to have sex;.</p> <p>-Resident #1's family member said that these behaviors only come out if the resident has a UTI. Staff have relayed that information to the physician and have sent the resident out to the hospital numerous times. The first time the resident was sent out, he/she tested positive for a UTI, but every time after that he/she has tested negative for a UTI. The resident is on antibiotics prophylactically (intended to prevent) but the behaviors have continued;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Rocky Ridge Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  3111 Highway A Mansfield, MO 65704	
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident's actions are considered abuse.</p> <p>During an interview on 01/15/25, at 12:43 P.M., the Nurse Practitioner said that he/she was at the facility at least once per week and was aware of the continued inappropriate sexual behaviors of Resident #1. Resident #1 had been on 15-minute checks for a while due to inappropriate behaviors and the facility was not able to provide the resident with one-on-one care due to staffing. The Nurse Practitioner said that the resident had a history of inappropriate sexual behaviors prior to admitting to the facility. They are in the process of finding better suited placement for the resident.</p> <p>During an interview on 01/15/25, at 2:51 P.M., the Physician said that he/she had been notified of the inappropriate sexual behaviors of Resident #1. The resident had been on 15-minute checks for quite some time due to the inappropriate behaviors. The resident had been sent to the emergency room several times due to inappropriate behaviors and the facility has been looking for other placement. The physician said that if he had known Resident #1's behaviors were this bad, the facility would not had accepted him/her. The physician said that Resident #1's inappropriate sexual behaviors are beyond what the facility is capable of handling.</p> <p>During an interview on 01/15/25, at 11:50 A.M., the Administrator said that Resident #1 had been having inappropriate sexual behaviors for a couple of months. The resident has been on 15-minute checks since having inappropriate behaviors. The facility was currently looking for other placement for the resident. The facility had sent the resident out to the emergency room on at least three different occasions and no hospital would admit her for a psych evaluation. The sexual verbal comments from the resident to other residents at the facility is verbal abuse. They were doing everything they knew to do and didn't have any other options besides making Resident #1 a one-on-one, which was unrealistic due to not having the staff for that.</p> <p>MO00247542, MO00247576, MO00247787</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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to report all allegations of resident-to-resident abuse to the State Survey Agency (Department of Health and Senior Services- DHSS) within the required two hours when staff did not report multiple allegations of sexual abuse by one resident (Resident #1) towards other residents to DHSS. The facility census was 49.</p> <p>Review of the facility policy, titled Abuse Prohibition Protocol Manual, revised 11/28/16, showed the following:</p> <ul style="list-style-type: none"> <li>-Educate all staff to report to the Administrator and/or designees any alleged violations involving abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property;</li> <li>-The Administrator or designee must report to the State Survey agency no later than two hours after the allegation is made if the event involved abuse or resulted in injury.</li> <li>-All residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation;</li> <li>-Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents regardless of their age, ability to comprehend, or disability;</li> <li>-Sexual abuse is defined as non-consensual sexual contact of any type with a resident that includes all unwanted intimate touching of any kind especially of breasts or perineal area and nudity.</li> </ul> <p>1. Review of Resident #1's face sheet (brief resident profile sheet) showed the following information:</p> <ul style="list-style-type: none"> <li>-admission date of 08/01/24;</li> <li>-Diagnoses included schizoaffective disorder (mental health condition including delusions and hallucinations), anxiety, and bipolar disorder (mood swings ranging from depressive lows to manic highs), alcohol abuse and pyelonephritis (chronic kidney infections).</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/08/24, showed the following information:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Independent with bed mobility, transfer, dressing, toilet use, and personal hygiene;</li> <li>-Used a walker or wheelchair for ambulation;</li> <li>-Physical behavioral symptoms directed at others exhibited.</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>Review of the resident's care plan, revised 11/14/24, showed the following information:</p> <ul style="list-style-type: none"> <li>-The resident had a history of being sexually inappropriate with peers;</li> <li>-Staff will accompany the resident when going outside;</li> <li>-The resident may need additional monitoring at times;</li> <li>-The resident may become sexually inappropriate at times;</li> <li>-Remove the resident from public area when behavior is unacceptable.</li> </ul> <p>Review of the resident's progress note dated 11/18/24, at 8:46 A.M., showed the following information:</p> <ul style="list-style-type: none"> <li>-The nurse documented observing Resident #1 grabbing Resident #3's genitals;</li> <li>-Resident #3 said this has happened four times this weekend;</li> <li>-The resident has been redirected multiple times since admission for inappropriate behaviors with staff and residents. The resident does not respond or even act like she has been told not to do this;</li> <li>-The resident has had UTI's with behaviors which exacerbate the sexual behaviors, however, the behaviors are ongoing.</li> </ul> <p>(Staff did not document reporting the allegation of abuse to DHSS.)</p> <p>Review of DHSS records showed the facility did not self-report the allegation of abuse on 11/18/24.</p> <p>Review of the resident's progress note dated 11/20/24, at 1:21 P.M., showed the following information:</p> <ul style="list-style-type: none"> <li>-The nurse documented that Resident #3 reported that Resident #1 propelled his/her wheelchair up to Resident #3 and asked him/her if he/she could touch his/her private area;</li> <li>-Resident #3 reported this immediately to staff and appeared to be upset by the behavior;</li> <li>-The nurse spoke with Resident #1 asking him/her if this happened. Resident #1 said yes it did, I'm horny. The resident was educated not to speak to other residents in that manner.</li> </ul> <p>(Staff did not document reporting the allegation of abuse to DHSS.)</p> <p>Review of DHSS records showed the facility did not self-report the allegation of abuse on 11/20/24.</p> <p>Review of the resident's progress note dated 12/01/24, at 7:40 P.M., showed the following information:</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>-The nurse documented that Resident #1 was observed standing in Resident #2's room, naked from the waist down;</p> <p>-The nurse redirected Resident #1 back to his/her room and reeducated the resident not to go in other residents' rooms and not to leave his/her room without clothing;</p> <p>-Resident #1 denied the behavior;</p> <p>-Staff notified the Director of Nursing (DON);</p> <p>-Staff notified the physician notified and received orders to send resident to hospital for psych evaluation and possible urinary tract infection (UTI);</p> <p>-Staff notified family;</p> <p>-The resident was transported to the hospital for evaluation.</p> <p>(Staff did not document reporting the allegation of abuse to DHSS.)</p> <p>Review of DHSS records showed the facility did not self-report the allegation of abuse on 12/01/24.</p> <p>Review of the resident's progress note dated 12/09/24, at 4:45 P.M., showed the following information:</p> <p>-The nurse documented that another resident (Resident # 3) reported that while at supper in the dining room, Resident #1 propelled his/her wheelchair up to his/her table and asked Resident #3 if he would fuck her. Resident #3 told her no and Resident #1 went on his/her way;</p> <p>-The nurse spoke to Resident #1 who admitted to saying the above statement and didn't care or see why it was inappropriate;</p> <p>-Resident #1 ate his/her supper then stayed the remainder of the evening in his/her room.</p> <p>(Staff did not document reporting the allegation of abuse to DHSS.)</p> <p>Review of DHSS records showed the facility did not self-report the allegation of abuse on 12/09/24.</p> <p>Review of the resident's progress note dated 12/17/24, at 4:42 P.M., showed the following information:</p> <p>-The nurse documented that the resident propelled his/her wheelchair up to Resident #3, reached out and grabbed his/her genitals;</p> <p>-Resident #2 began to scold Resident #1, until staff removed Resident #1;</p> <p>-Resident #2 was very upset and requested anxiety medication.</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>(Staff did not document reporting the allegation of abuse to DHSS.)</p> <p>Review of DHSS records showed the facility did not self-report the allegation of abuse on 11/18/24.</p> <p>During an interview on 01/15/25, at 10:15 A.M., Certified Nurse Aide (CNA) F said he/she would report any inappropriate behaviors to the charge nurse immediately and the charge nurse should report to state within two hours.</p> <p>During an interview on 01/15/25, at 10:00 A.M., CNA E said he/she would report any inappropriate behaviors to the charge nurse immediately so it could be reported to state within two hours.</p> <p>During an interview on 01/15/25, at 9:51 A.M., CNA H said when he/she saw abuse he/she notified the nurse immediately. He/she knew they [NAME] two hours to report to state. He/she considered Resident #1's sexually inappropriate behavior abuse.</p> <p>During an interview on 01/15/25, at 9:44 A.M., Certified Medication Tech (CMT) D said that abuse and neglect (A/N) is any kind of hitting or yelling at residents. Inappropriate touching and verbal is also considered sexual abuse. He/she would report any abuse immediately to the charge nurse and the charge nurse should report to DHSS within two hours. CMT D said that it is not his/her responsibility to report to DHSS, that only the charge nurse, DON or Administrator reports to DHSS.</p> <p>During an interview on 01/09/25, at 9:50 A.M., Registered Nurse (RN) A said he/she reported the sexual inappropriate behavior to the DON and did not think that he/she needed to report it to DHSS.</p> <p>Resident #1's behaviors was sexual abuse.</p> <p>During an interview on 01/09/25, at 12:45 P.M., Licensed Practical Nurse (LPN) C said Resident #1 was sexually inappropriate and very impulsive. Staff notify the physician when the resident has inappropriate sexual behaviors. They also notify the DON and the Administrator and document the behavior. LPN C said that it should have been reported to DHSS by either the DON or the Administrator. He/she considered the behaviors abusive.</p> <p>During an interview on 01/09/25, at 1:45 P.M., the said the Resident #1 had been inappropriate with staff and residents and staff know to keep an eye on him/her when he/she is out of his/her room. Resident #1 had patted butts and groped groins and asked other residents to have sex. This is considered abuse, and it should have been reported to DHSS.</p> <p>During an interview on 01/15/25, at 11:35 A.M., the Social Services Director (SSD) said he/she had told the resident that he/she cannot tell another resident that he/she wants to have sex with them and cannot touch them, especially on their butt or groin areas. The SSD told the resident that is considered abuse. He/she was not sure if these allegations were reported to DHSS or not, but said they should have been and if he/she had been told, he/she would have made sure they were reported to DHSS as he/she is aware that they have two hours to report. The SSD said that the Administrator is responsible for reporting all abuse and neglect allegations.</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 01/15/25, at 11:50 A.M., the Administrator said that Resident #1 had been having inappropriate sexual behaviors for a couple of months. The sexual verbal comments from the resident to other residents at the facility was verbal abuse and that the comments should have been reported to DHSS.</p> <p>MO00247542, MO00247576, MO00247787</p>		