STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Ridge Manor	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interview and record review, the facility failed to ensure all residents were treated in a dignified manner, when one staff member (Social Services Director (SSD)) would not allow one resident (Resident #1) to smoke after the resident displayed behaviors. The facility census was 49. Review of the facility policy titled Resident's Rights, undated, showed the following: -The resident has a right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility; -The resident has the right to exercise his/her rights as a resident of the facility and as a citizen or resident of the United States; -The resident has the right to be free of interference, coercion, discrimination and reprisal form the facility in exercising his/her rights, and be supported by the facility in the exercise of his/her rights. 1. Review of Resident #1's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included transient cerebral ischemic attack (disruption of blood flow to the brain), dementia (loss of memory), major depressive disorder, severe with psychotic symptoms (person experiences sadness and a loss of contact with reality), anxiety disorder (feelings of worry and fear), post-traumatic stress disorder (PTSD - mental health condition that can develop after experiencing or witnessing a traumatic event). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/03/25, showed the following information: -Moderate cognitive impairment; -Behaviors; -Independent with eating and required set up with oral hygiene; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Substantial assistance required with toileting hygiene, showers, and upper/lower body dressing; -Dependent on staff for personal hygiene. Review of the resident's care plan, last revised on 04/01/25, showed the following: -Resident had history of verbal and physical aggression towards staff related to underlying psychiatric disorder and cognitive impairment. Staff to speak softly and avoid confrontational or punitive language, and redirect if the resident becomes physically aggressive; -Resident ad diagnosis of dementia, persistent mood (affective) disorder as evidence by persistent forgetfulness and disorientation. Have anxiety, fear and paranoia associated with memory loss; -Resident had chronic pain in back, knees, and ankles. Also muscle spasms. He/she takes narcotics; -Resident was unable to perform all activities of daily living (ADL) functions without extensive assistance of one to two staff due to weakness and impaired use of left leg, arm, and hand. Review of the resident's progress note dated 04/16/25, at 2:40 P.M., showed the SSD documented he/she and another staff took the resident to the social security office. The resident was throwing a fit in the social security office. The resident blurted out he/she had gotten two facilities closed down and was working on the current facility next. The resident would not quit with his/her yelling so staff could write down what paperwork the resident needed from the facility in order to get the resident's money to come to the facility. Workers and clients in the office could hear the resident yelling and causing an ugly scene. We were outside and the resident yelled give me my goddamn cigarette. The SSD replied the resident would not get a cigarette because he/she caused a whole scene in the building and outside the building. The resident's smoke breaks were taken away for the rest of the day. During interviews on 04/30/25, at 9:17 A.M. and 1:30 P.M., the resident said the SSD took away his/her smoke breaks. During an interview on 04/30/25, at 12:15 P.M., the SSD said the following: -If a resident had a guardian and the guardian has given permission, one smoke break can be withheld from the resident for having bad behaviors; -The resident was having behaviors at the social security office and missed his/her 11:00 A.M., cigarette, but had them the rest of the day. During an interview on 04/30/25, at 11:40 A.M., Certified Nurse's Aide (CNA) A said the following: -Staff can't take away a resident's smoke breaks if they don't have a guardians; -Taking away a resident's privileges, such as smoking, is against their rights; -The resident was his/her own person. He/she was not aware of staff taking away the resident's smoke breaks. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/25, at 11:50 A.M., CNA B said the following: -When a resident had a guardian and the guardian gave permission, the resident's smoke breaks could be taken if they have behaviors; -If the resident was their own person, staff were not allowed to take away their smoke breaks; -Taking away a resident's smoke break as a punishment would be against their rights; -He/she didn't know if the resident had smoke breaks taken away. During an interview on 04/30/25, at 12:05 P.M., Certified Medication Tech (CMT) D said the following: -Staff were not allowed to take away a resident's smoke breaks when the resident misbehaves. That would be taking away their rights; -He/she knew of one occasion when the resident's smoke break was taken away. During an interview on 04/30/25, at 12:25 P.M., Registered Nurse (RN) E said the following: -It would not be appropriate to withhold a resident's smoke break as punishment. This would be against their rights; -He/she knew they tried to withhold the resident's cigarette break at least once, but staff was told they couldn't do that. He/she didn't know the date. During an interview on 04/30/25, at 12:50 P.M., the Business Office Manager (BOM) said the following: -If a resident had a guardian, and it was okay with the guardian, a resident's smoke break could be withheld; -If a resident was their own person, like the resident, staff can not take the smoke break; -He/she was not aware of the resident missing any smoke breaks. During an interview on 04/30/25, at 12:30 P.M., the Director of Nursing (DON) said the following: -Staff didn't have the right to take away a resident's smoke break when they have behaviors. That would be against their rights; -It did happen one time with the resident, but it was a miscommunication as one side of the building didn't know the resident was his/her own person and did not have a guardian; -All staff know that only those with guardians, that give permission to withhold smoke breaks, can have those smoke breaks taken away; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Only social services, administration, or nurses can decide when a smoke break was taken; -It was not appropriate for the SSD to withhold the resident's smoke break on 04/16/25. During an interview on 05/01/25, at 10:15 A.M., the Administrator said the following: -He/she had told staff when residents are their own person, they can not withhold smoke breaks; -He/she was not aware of the resident missing any smoke breaks; -On 04/16/25, the SSD encouraged the resident to get into the vehicle as they were on a time frame and it there wasn't a scheduled smoke break. The resident did smoke when he/she arrived back to the facility. MO00253134

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interviews and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to management and within two hours to the state licensing agency (Department of Health and Senior Services - DHSS) when staff failed to report two allegations of abuse involving one resident (Resident #1) to management and DHSS in a timely fashion. The facility census was 49. Review of the facility policy titled Abuse Prohibition Protocol Manual, revised 11/28/16, showed the following: -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; -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. -All residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation; -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; -Physical abuse is defined as hitting, slapping, pinching, kicking, biting, etc. It also includes controlling a resident's actions through personal punishment; -Report immediately, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury. 1. Review of Resident #1's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included transient cerebral ischemic attack (disruption of blood flow to the brain), dementia (loss of memory), type II diabetes, (body doesn't produce enough insulin), major depressive disorder, severe with psychotic symptoms (person experiences sadness and a loss of contact with reality), anxiety disorder (feelings of worry and fear), post-traumatic stress disorder (PTSD - mental health condition that can develop after experiencing or witnessing a traumatic event). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/03/25, showed the following information: -Moderate cognitive impairment; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Behaviors; -Independent with eating with set up assistance with oral hygiene; -Substantial assistance with toileting hygiene, showers, and upper/lower body dressing; -Dependent on staff for personal hygiene. Review of the resident's care plan, last revised on 04/01/25, showed the following: -Resident had history of verbal and physical aggression towards staff related to underlying psychiatric disorder and cognitive impairment. Staff to speak softly and avoid confrontational or punitive language, redirect if becomes physically aggressive, -Resident had diagnosis of dementia, persistent mood (affective) disorder as evidence by persistent forgetfulness and disorientation. Resident had anxiety, fear, and paranoia associated with memory loss; -Resident had chronic pain in back, knees, and ankles and muscle spasms. Resident takes narcotics; -Resident was unable to perform all ADL functions without extensive assistance of one to two staff due to weakness and impaired use of left leg, arm, and hand. Review of the resident's progress note dated 03/31/25, at 11:54 A.M., showed SSD documented he/she went to the resident and sat down to list to what the resident had to say. The resident said that two staff members were abusing him/her and he/she had bruising all over his/her body. SSD replied well I have to take a look at your complaint and see bruising and SSD had the charge nurse look as well. There was no bruising found by the SSD or the charge nurse. The two staff members the resident accused had not been at work. (The SSD did not document notification of facility administration or DHSS of the allegation of abuse.) Review of DHSS records showed the facility did not report the allegations of abuse. Review of the resident's progress note dated 04/16/25, at 2:40 P.M., showed the SSD documented he/she and another staff took the resident to the social security office. The resident was throwing a fit in the social security office. The resident blurted out he/she had gotten two facilities closed down and was working on the current facility next. The resident said we abuse him/her and leave residents in the floor. (The SSD did not document notification of facility administration or DHSS of the allegation of abuse.) Review of DHSS records showed the facility did not report the allegation of abuse. During an interview on 04/30/25, at 12:15 P.M., the SSD said the following: -When staff are told a resident is being abused, they come to him/her; -He/she talked to the resident to see what's going on and what type of abuse was being alleged; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 03/31/25, the resident came to him/her and said staff were hitting and abusing him/her and he/she had bruises on his/her body; -He/she got the charge nurse and they assessed the resident and he/she did not have bruises on him/her; -He/she went to the Administrator and let him/her know what was going on; -The charge nurse documented in the chart an assessment of the skin was completed; -The resident did not know the names of the staff that abused him/her; -He/she didn't know if the incident was reported to the state, but should be reported in either 24 or 2 hours; -On 04/16/25, he/she took the resident to the social security office. The resident yelled in the office that staff abused him/her, don't do anything for the resident, and they were starving the resident. The resident had never been abused at the facility; -The Administrator looked into the allegations, but the SSD didn't know if the allegations were reported to the state. During an interview on 04/30/25, at 11:40 A.M., Certified Nurse's Aide (CNA) A said the following: -If a resident accuses staff of abuse, and he/she was in the room and believes it's a misunderstanding, he/she would speak to the resident to explain that it wasn't abuse; -If he/she witnessed abuse, or was told by the resident they've been abused, he/she would speak to the SSD and the charge nurse; -Allegations of abuse are to be reported to the state in less than 24 hours. During interviews on 04/30/25, at 11:50 A.M., CNA B said the following: -If a resident reported abuse, he/she told the charge nurse and the nurse called the state within two hours. -The resident accused him/her of abuse. He/she didn't recall when that was, but he/she wasn't working the day the resident made the accusations; -The resident has said staff hit him/her. During an interview on 04/30/25, at 12:00 P.M., Certified Medication Technician (CMT) C said the following: -If a resident reported abuse, he/she notified the charge nurse; -He/she assumed it should be reported to the state, possibly in two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/25, at 12:05 P.M., CMT D said the following: -When a resident reported abuse, he/she told the charge nurse; -The charge nurse tells the Administrator and Director of Nursing (DON) and the state is called within two hours. During an interview on 04/30/25, at 12:25 P.M., Registered Nurse (RN) E said the following: -If a resident reported abuse, he/she reported it to the DON or the Administrator. The state is notified in two hours; -They have training on abuse at most in-services; -The resident had not reported abuse to him/her. He/she heard other staff talk about the resident accusing staff of abuse that wasn't working or no longer worked at the facility; -He/she didn't know if the allegations were reported to the state. During an interview on 04/30/25, at 12:50 P.M., the Business Office Manager (BOM) said the following: -Allegations of abuse were reported to the DON and Administrator, or the supervisor; -The Administrator reported to the state in two hours. During an interview on 04/30/25, at 12:30 P.M., the DON said the following: -Abuse allegations should be reported to the charge nurse, DON, and Administrator; -The allegations of abuse are reported to the state if the abuse allegations are valid. He/she didn't know for sure what the time frames of reporting the abuse; -The resident had made allegations of abuse; -Skin assessments were completed and there was no bruising; -On 3/31/25, he/she believed the Resident accused the two evening shift people, the SSD talked to the staff, the next time they were in the building. He/she doesn't know if the SSD documented anything. It was not reported to the state; -On 4/14/25, he/she was not aware of the resident made allegations of abuse on this date. During an interview on 05/01/25, at 10:15 A.M., the Administrator said the following: -He/she did remember the one event, possibly from 03/31/25, where the SSD and a nurse interviewed the resident saying an aide put him/her to bed too hard. A skin assessment was done and they did not find anything; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she was not aware of allegations of abuse from 04/16/25; -When abuse is alleged, staff are to tell him/her and he/she investigates, speaks with the resident, and other residents and staff, and calls the state within two hours; -The two incidents were not reported to the state. MO00253134

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interview and record review, the facility staff failed to complete and document a full investigation of all allegations of abuse with steps taken to protect residents during the investigation documented when staff failed to fully investigate two allegations of abuse made by one resident (Resident) alleging abuse by staff. The facility census was 49. Review of the facility policy titled Abuse Prohibition Protocol Manual, revised 11/28/16, showed the following: -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; -All residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation; -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; -Physical abuse is defined as hitting, slapping, pinching, kicking, biting, etc. It also includes controlling a resident's actions through personal punishment; -During an investigation, if a staff member is accused, that person will be suspended immediately, pending investigation, and all staff on duty need to complete witness statements and cannot leave until they complete one. 1. Review of Resident #1's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included transient cerebral ischemic attack (disruption of blood flow to the brain), dementia (loss of memory), type II diabetes, (body doesn't produce enough insulin), major depressive disorder, severe with psychotic symptoms (person experiences sadness and a loss of contact with reality), anxiety disorder (feelings of worry and fear), post-traumatic stress disorder (PTSD - mental health condition that can develop after experiencing or witnessing a traumatic event). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/03/25, showed the following information: -Moderate cognitive impairment; -Behaviors; -Independent with eating and required set up help with oral hygiene; (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required substantial assistance with toileting hygiene, showers and upper/lower body dressing; -Dependent on staff for personal hygiene. Review of the resident's care plan, last revised on 04/01/25, showed the following: -He/she had a history of verbal and physical aggression towards staff related to underlying psychiatric disorder and cognitive impairment. Staff to speak softly and avoid confrontational or punitive language, and redirect if resident becomes physically aggressive, -He/she had diagnoses of dementia and persistent mood (affective) disorder as evidence by persistent forgetfulness and disorientation. Resident had anxiety, fear, and paranoia associated with memory loss; -He/she had chronic pain in back, knees, and ankles and muscle spasms. He/she took narcotics; -He/she was unable to perform all ADL functions without extensive assistance of one to two staff due to weakness and impaired use of left leg, arm, and hand. Review of the resident's progress note dated 03/31/25, at 11:54 A.M., showed the SSD documented he/she went to the resident and sat down to listen to what the resident had to say. The resident said that two staff members were abusing him/her and he/she had bruising all over his/her body. The SSD replied well I have to take a look at your complaint and see bruising and SSD had the charge nurse look as well. There was no bruising found by the SSD or the charge nurse. The two staff members the resident accused had not been at work. Review of the facility records shows the facility did not provide a documented full investigation, to include interviewing other residents and staff. Review of the resident's progress note dated 04/16/25, at 2:40 P.M., showed the SSD documented he/she and another staff took the resident to the social security office. The resident was throwing a fit in the social security office. The resident blurted out he/she had gotten two facilities closed down and was working on the current facility next. The resident said the staff abuse him/her and leave residents in the floor. Review of the facility records shows the facility did not document an investigation of the allegations of potential abuse. During an interview on 04/30/25, at 12:15 P.M., the SSD said the following: -When staff are told a resident is being abused, they come to him/her; -He/she talked to the resident to see what's going on and what type of abuse was being alleged; -On 03/31/25, the resident came to him/her and said staff were hitting and abusing him/her and he/she had bruises on his/her body; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she got the charge nurse and they assessed the resident and he/she did not have bruises on him/her; -He/she went to the Administrator and let him/her know what's going on; -The charge nurse documented in the chart an assessment of the skin was completed; -The resident did not know the names of the staff that abused him/her; -If the Administrator knew the names of the accused staff, he/she will suspend them pending an investigation; -On 04/16/25, he/she took the resident to the social security office, the resident yelled in the office that the facility abused him/her, don't do anything for the resident, and were starving the resident; -The Administrator looked into the allegations. During an interview on 04/30/25, at 11:40 A.M., Certified Nurse's Aide (CNA) A said the following: -If a resident accused staff of abuse, and he/she was in the room and believed it was a misunderstanding, he/she would speak to the resident to explain that it wasn't abuse; -If he/she witnessed abuse, or was told by the resident they had been abused, he/she would speak to the SSD and the charge nurse; -The accused staff would be suspended pending the outcome of the facility investigation. During an interview on 04/30/25, at 11:50 A.M., CNA B said the following: -If a resident reported abuse, he/she told the charge nurse and the nurse; -He/she didn't know if the accused staff was suspended. He/she did know the facility was supposed to investigate;. -The resident accused him/her of abuse. He/she didn't recall when that was but he/she wasn't working the day the resident made the accusations; -He/she was not suspended, however the Director of Nursing (DON) did ask him/her questions. During an interview on 04/30/25, at 12:00 P.M., Certified Medication Technician (CMT) C said the following: -If a resident reported abuse, he/she notified the charge nurse; -He/she believed the facility suspended the staff that's been accused and investigates. During an interview on 04/30/25, at 12:05 P.M., CMT D said the following: (continued on next page)

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	265494	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Ridge Manor	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When a resident reported abuse, he/she told the charge nurse; -The charge nurse told the Administrator and DON, and they begin an investigation. During interviews on 04/30/25, at 12:25 P.M., Registered Nurse (RN) E said if a resident reported abuse, he/she reported it to the DON or the Administrator, and they complete an investigation. The accused staff was sent home. During an interview on 04/30/25, at 12:50 P.M., the Business Office Manger said the following: -The administrator investigates allegations of abuse; -He/she didn't know of any physical or verbal abuse allegations the resident had made against staff. During an interview on 04/30/25, at 12:30 P.M., the DON said the following: -Abuse allegations should be reported to the charge nurse, DON, and Administrator; -The resident is interviewed to find out what's going on, as well as the roommate, and the staff member; -The accused staff is suspended, an investigation is completed, including interviews with other staff and residents; -The resident has made allegations of abuse. Skin assessments were completed and there was no bruising; -On 03/31/25, he/she believed the resident accused the two evening shift people and the SSD talked to the staff, the next time they were in the building. He/she didn't know if the SSD documented anything. The two staff were not suspended; -On 04/14/25, he/she was not aware of the resident making allegations of abuse on this date. During an interview on 05/01/25, at 10:15 A.M., the Administrator said the following: -He/she had not completed an investigation for abuse on the resident. He/she knew the SSD did one or two. He/she was not certain the dates on those; -He/she was not aware of allegations of abuse from 04/16/25; -When abuse is alleged, staff are to tell him/her and he/she investigates, speaks with the resident and other residents and staff. If he/she knew the names of the staff, he/she would suspend them; -He/she was not aware of whether the two incidents were investigated. MO00253134