

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  01/13/2026
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 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 interviews and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to Administrator and within two hours to the state licensing agency (Department of Health and Senior Services - DHSS) when staff failed to report an allegation of abuse involving one resident (Resident #1) to management and DHSS in a timely fashion. The facility census was 48. Review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property, undated, showed the following:-Each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse;-All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown sources, and misappropriation of resident property by facility employees, contract employees, or volunteers will be reported immediately, but no later than the following timeframes. If abuse is alleged or the allegation results in serious bodily injury, the allegation must be reported within two hours after the allegation was made;-All employees of the facility are mandated reporters:-The facility will ensure that all reports are made within two hours if abuse or serious bodily injury. 1. Review of Resident #1's face sheet (admission data) showed the following:-admission date of 06/26/25;-Diagnoses included metabolic encephalopathy-acute (brain suddenly isn't working right because of a chemical imbalance or problem with the body's metabolism), restlessness and agitation, acute pain due to trauma, schizophrenia (serious, chronic brain disorder that disrupts how a person thinks, feels and behaves, making it hard to tell what's real from what isn't), generalized anxiety disorder (excessive, persistent, and hard to control worry about everyday things), and impulse disorder (individual struggles to control sudden, powerful urges to do things that might harm themselves or others). 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:-Cognitively intact;-Physical behaviors symptoms directed towards others, verbal behavioral symptoms directed towards others, and other behavioral symptoms not directed towards others occurred one to three days of the lookback period. Review of the resident's care plan, last revised on 12/29/25, showed the following:-History of cussing, yelling, agitation with staff and other residents;-History of lying about staff behavior or other residents;-History of using manipulative tactics to gain attention or avoid certain actions;-Hits objects and threatens to hit staff or others;-Speak softly and avoid confrontational or punitive language;-Identify triggers such as frustration, or miscommunication;-If resident becomes physically aggressive attempt redirection;-Always ask for help if the resident becomes abusive or resistive;-Keep environment calm and relaxed as possible;-Remove resident from public area when behavior is unacceptable;-Encourage diversional activities;-Administer as needed medications;-Resident takes medications to treat schizophrenia, anxiety, and impulse disorder. Review of the resident's progress note dated 01/06/25, at 9:05 A.M., showed the Director of Nursing (DON) documented the following;-Resident came to his/her office first thing this morning, stating Restorative Nurse Aide (RNA) E was making the resident suck his/her</p> <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:  265494	Facility ID:  265494  If continuation sheet Page 1 of 6

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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>RNA E had asked the resident to suck his/her boob and play with RNA E. -He/she had CMT F in the room for a witness and called RNA E to the office. When the resident was asked to repeat the accusation, the resident did repeat the accusation but with his/her head down and in a low voice;-RNA E said he/she only asked the resident to change his/her pants and did not ask the resident to do anything inappropriate;-He/she did not report the allegations of sexual abuse to the state. During an interview on 01/13/26, at 12:22 P.M., the Administrator said the following:-He/she would consider a staff asking a resident to suck their boob, or play with them, to be a sexual abuse allegation;-He/she would call the state immediately;-He/she was aware of an incident where the resident got made at RNA E because the resident had gone to the bathroom and RNA E asked the resident to change his/her clothes. The resident went to the DON and told the DON to fire RNA E and that he/she knew how to get RNA E fired. The resident said if he/she made the accusation of a staff wanting the resident to suck their boob and play with them;-He/she was not told the resident accused the staff of doing this;-When the note from the resident's record was read to the Administrator agreed the accusation should have been reported as sexual abuse;-He/she did not know if the accusation was turned into the state within two hours. Complaint #2713651</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>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 one allegation of abuse made by one resident (Resident #1) alleging abuse by one staff member (Restorative Nurse Aide (RNA) E. The facility census was 48. Review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property, undated, showed the following:-Each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse;-All employees who have been alleged to commit abuse will be suspended immediately, pending investigation;-Facility will complete an investigation. 1. Review of Resident #1's face sheet (admission data) showed the following:-admission date of 06/26/25;-Diagnoses included metabolic encephalopathy-acute (brain suddenly isn't working right because of a chemical imbalance or problem with the body's metabolism), restlessness and agitation, acute pain due to trauma, schizophrenia (serious, chronic brain disorder that disrupts how a person thinks, feels and behaves, making it hard to tell what's real from what isn't), generalized anxiety disorder (excessive, persistent, and hard to control worry about everyday things), and impulse disorder (individual struggles to control sudden, powerful urges to do things that might harm themselves or others). 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:-Cognitively intact;-Physical behaviors symptoms directed towards others, verbal behavioral symptoms directed towards others, and other behavioral symptoms not directed towards others occurred one to three days of the lookback period. Review of the resident's care plan, last revised on 12/29/25, showed the following:-History of cussing, yelling, agitation with staff and other residents;-History of lying about staff behavior or other residents;-History of using manipulative tactics to gain attention or avoid certain actions;-Hits objects and threatens to hit staff or others;-Speak softly and avoid confrontational or punitive language;-Identify triggers such as frustration, or miscommunication;-If resident becomes physically aggressive attempt redirection;-Always ask for help if the resident becomes abusive or resistive;-Keep environment calm and relaxed as possible;-Remove resident from public area when behavior is unacceptable;-Encourage diversional activities;-Administer as needed medications;-Resident takes medications to treat schizophrenia, anxiety, and impulse disorder. Review of the resident's progress note dated 01/06/25, at 9:05 A.M., showed the Director of Nursing (DON) documented the following;-Resident came to his/her office first thing this morning, stating Restorative Nurse Aide (RNA) E was making the resident suck his/her boob and play with him/her. DON asked when this had happened, and the resident stated for a while;-DON called RNA E and Certified Medication Tech (CMT) F for witness into the DON's office;-DON asked the resident to repeat his/her accusation. The resident quietly without looking at anyone repeated his/her accusation;-RNA E stated that the resident had just left the therapy room after urinating on the floor, and blaming RNA E. The resident then became angry when RNA E told the resident he/she did it and would need to go change his/her clothes. The resident told RNA E that he/she was going to get RNA E fired. Resident denied this;-RNA E and Resident agreed to have no contact, and the RNA left the room;-CMT F still present and the resident stated see, I knew RNA E would get his/her way, she didn't get fired. Review of DHSS records showed the facility did not provide a documented, complete, and timely investigation of the allegation of abuse. During an interview on 01/13/26, at 1:30 P.M., Certified Medication Technician (CMT) F said the following:-If a staff asked a resident to suck their boob or play with them, it would be considered sexual abuse and should be reported;-He/she was pulled into the DON's office on 01/06/26, where the DON, RNA E, and the resident were located. The</p> <p>(continued on next page)</p>		

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