STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265504	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Current River Rehabilitation & Health Care Center	1015 North Grand Avenue Doniphan, MO 63935

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. Based on observation, interview, and record review, the facility failed to ensure two residents (Resident #1 and Resident #2) out of three sampled residents remained free from abuse when staff failed to immediately report and respond after observing resident-to-resident sexual abuse/inappropriate sexual contact by one resident (Resident #3). Resident #3 inappropriately touched Resident #1's breasts while Resident #1 was asleep and approximately 30 minutes later reached underneath Resident #2's blanket in an attempt to touch Resident #2 inappropriately. Although both incidents were witnessed by Certified Nursing Assistant (CNA) B, the incidents were not immediately reported to nursing management. As a result, the facility failed to promptly initiate an abuse investigation, implement protective interventions, assess the residents, notify required parties, and monitor Resident #3 to prevent additional incidents. The Director of Nursing did not become aware of the allegations until approximately two days later after discovering documentation in the electronic medical record alerts. The facility census was 46.Review of facility's policy titled, Abuse, Prevention and Prohibition Policy, dated February 2026, showed:-Each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers;-The facility's abuse prohibition program includes seven components: screening, training, prevention, identification, investigation, protection, and reporting/response;-Prevention: The resident has the right to be free from sexual abuse. Resident behaviors will be monitored for changes, which trigger abusive behaviors;-Investigation: Resident abuse must be reported immediately to the Administrator. While a facility investigation is under way, steps will be taken to prevent further abuse. The person identified in the allegation of abuse will have no contact with residents or other employees during the investigation process;-Initiate investigation including initial reporting to all required agencies;-A licensed professional nurse will assess the resident for signs of injury and notify the resident's physician and responsible party;-When another resident is the alleged perpetrator of the abuse, a licensed professional shall immediately evaluate the resident's physical and mental status, care plan, monitor behaviors, and notify the physician for a determination regarding treatment and/or discharge options. Changes in room assignments and seating arrangements will be recommended as needed. The safety of other residents and employees of the facility is of primary concern;-Sexual abuse is non-consensual sexual contact of any type with a resident. Sexual contact includes intentional touching of intimate body parts, either directly or through clothing. Both resident's capacity to consent to a sexual or intimate relationship must be assessed. 1.Review of the facility's investigation report, completed on 06/26/26, showed:- Allegation of sexual abuse;- Initial intervention: On 06/25/26 Resident #3 put on 15 min checks pending an Interdisciplinary Team (IDT) meeting, medical director (MD), durable power of attorney (DPOA) notified, MD made med change, police made aware with case number 2026-0549;- Investigation: On 06/23/26, Resident #1 was asleep on the couch;Resident #3 intentionally pressed/touched Resident #1's breasts;CNA B redirected Resident #3;Approximately 30 minutes later Resident #3 entered Resident #2's room;Resident #3 reached underneath Resident #2's blanket;Resident #2 stopped Resident #3 by pushing the resident's hands away and telling Resident #3 to stop;CNA B redirected (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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3;CNA B did not immediately notify the charge nurse, DON, or Administrator.Review of CNA B's written statement dated 06/26/26 showed: Incident around 4:00 P.M., found Resident #3 touching Resident #1 on the leg around perineal area and moving up. I grabbed Resident #3's wheelchair and move him to the other side of the dining room and got coffee. Resident #1 was telling Resident #3 no, and had a mad look. Around 5:00 P.M., CNA B went to get Resident #2 up and found Resident #3 beside his/her bed with hand under the blanket. Resident #2 pushed Resident #3 away and put blanket down and said no, go away. CNA B removed Resident #3 from room to dining room. - Conclusion: Resident #3 did touch both residents. The facility concluded Resident #3 was attempting to awaken Resident #1. Resident #3 was educated on abuse and neglect policy and that if he/she was worried about a resident to inform staff. With Resident #2, Resident #3 had his/her hand under the blanket and Resident #2 kept Resident #3's hand from touching him/her inappropriate areas by pushing his/her hands down. When CNA entered room Resident #3 said, oh come on. Resident #3 was redirected. The CNA didn't report this to the Director of Nursing (DON) or Administrator. Incidents found on the alerts section on Electronic Medical Record (EMR);- Final Interventions: Resident educated (Resident has dementia and a BIMS of 5, Resident placed on 15 minute checks pending IDT meeting, all staff educated on reporting A&N, Resident #1 and #2 had skin assessments with no injuries, facility started a past non-compliance (PNC) correction, CNA suspended pending investigation 07/01/26;- Facility failure CNA aware on 06/23/26 of Resident #3 being physical with two female residents Resident #1 and #2. Allegation was Resident #3 was touching Resident #1 and #2 inappropriately on two separate occasions. Resident #3 inappropriately touched Resident #1's breasts. 30 minutes later Resident #3 placed his/her hands under Resident #2's cover, and Resident #2 told him/her to stop;-Action: -Residents #1 and #2 assessed for injury, sample of other memory care residents interviewed if others abused with none found, responsible parties notified, Primary Care Provider notified, trauma informed care completed and will be done weekly for three weeks or longer if behaviors or changes are noted; 06/25/26; Administrator or designee provided staff education prior to working next shift covered abuse, prevention, and prohibition policy, all new staff will have the same info reviewed with them at time of orientation, police report filed 06/25/26 and Qapi meeting held with MD on 06/25/26;-Systemic changes to ensure compliance: Administrator or designee will ask two staff members a day 5 days a week regarding A&N policy to ensure staff are aware of responsibility. Will continue until compliance achieved. Compliance achieved 06/26/26. 2. Review of Resident #1's medical record showed:- An admission date of 02/01/25;- Diagnosis of Alzheimer's disease (progressive mental deterioration), major depressive disorder (long-term loss of pleasure or interest in life);Review of the resident's Care Plan, revised 06/25/26, showed:- Impaired cognitive function/dementia or impaired thought processes;- Resident has a communication problem due to hearing deficit and Alzheimer's;- At risk for trauma-related emotional and behavioral response related to recent incident. Will monitor for signs/symptoms of trauma, document findings, and report significant changes to provider;- Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by the facility staff), dated 06/17/26, showed severe cognitive impairment;Nurse's note dated 06/25/26 at 12:20 P.M., showed Resident's spouse notified of allegation involving another resident reportedly inappropriately touching resident's breast. Facility started investigation and implemented interventions to ensure resident safety and reduce risk of further incidents. Spouse voiced understanding;Nurse's note dated 06/25/26 at 2:00 P.M., showed Resident identified as being involved in an alleged incident. Investigation initiated by facility. Resident assessed with no concerns. Resident will continue to be monitored for any changes and appropriate notifications made. Resident #1 was unable to provide reliable interview responses due to severe cognitive impairment.3. Review of Resident #2's medical record showed:- admission date of 11/01/25;- Diagnosis of Alzheimer's, dementia with anxiety (persistent worry and fear about everyday situations), need for assistance with personal care, unspecified psychosis (a mental disorder with a severe loss of contact with reality), unspecified dementia without behavioral (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disturbance;Review of the resident's Care Plan, revised 06/25/26, showed:- Impaired cognitive function/dementia or impaired thought processes;- Resident moved to secured unit due to increased confusion;- Resident has a communication problem with alteration in neurological status;- At risk for trauma-related emotional and behavioral response related to recent incident. Will monitor for signs/symptoms of trauma, document findings, and report significant changes to provider;- Resident has a mood problem due to dementia with anxiety and psychosis;Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by the facility staff), dated 06/29/26, showed severe cognitive impairment;Nurse's note dated 06/25/26 at 1:00 P.M., showed Resident's power of attorney notified of allegation involving another resident reportedly being in resident's room and inappropriately touching the resident under covers. Investigation started with interventions implemented to ensure resident safety.Nurse's note dated 06/25/26 at 2:00 P.M., showed Resident identified as being involved in an alleged incident. Investigation initiated by facility. Resident assessed with no concerns. Resident will continue to be monitored for any changes and appropriate notifications made. Resident #2 was unable to provide reliable interview responses due to severe cognitive impairment. 3. Review of Resident #3's medical record showed:- An admission date of 09/22/25;- Diagnoses of dementia with behavioral disturbance;Review of the resident's Care Plan, revised 6/29/26, showed impaired cognitive function/dementia or impaired thought processes.-The resident's BIMS score is a five placing him in the impaired cognitive functioning status;-The Resident has allegations for inappropriate behavior with IDT meeting held 06/29/26 to discontinue 15 minute checks and will reassess any new behaviors. Resident started on Zoloft (an antidepressant used off-label in geriatric care to manage neuropsychiatric symptoms of dementia, such as agitation, low mood, and inappropriate behaviors) 25 milligrams (mg) on 06/25/26;- The resident has behavior problem of screaming out and has been observed attempting to trip staff and will refuse care at times. Respond to resident by being calm and talking in a soothing manner with attempting to re-direct. - Uses an NMDA (N-methyl-D-aspartate) receptor antagonist. It is primarily classified as an antidementia agent or central nervous system agent;- Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by the facility staff), dated 06/17/26, showed severe cognitive impairment. - Prior behavior notes dated 10/30/25 of aggression toward staff.Resident #3 was unable to be interviewed due to severe cognitive impairment.Attempted to contact CNA B for interview twice on 07/01/26 and again on 07/08/26 with no return call.During an interview on 07/01/26 at 10:00 A.M., Licensed Practical Nurse (LPN) A said that evening he/she was giving medications on the unit. He/she was at her cart outside of the dining room and noticed the Certified Nursing Assistant (CNA) B moving Resident #3 to the other side of the dining room table and tell Resident #3, lets get you ready for dinner. LPN A said he/she gave CNA B a look to question what was going on and all CNA B said was Resident #3 was trying to touch Resident #1. LPN A moved on with medication administration since CNA B did not indicate there was any concern with the situation. Resident #3 has no history of being inappropriate sexually and only has a history of being physically aggressive with staff and that was only when Resident #3 first moved into the facility. Nothing further was mentioned throughout the remainder of the shift about Residents #1, #2 or #3.During an interview on 07/01/26 at 12:20 P.M., the Director of Nursing (DON) said no one notified her or the administrator of the incidents until the DON came across them on the alerts in the electronic medical chart. As soon as she saw it she notified the administrator and regional office. They contacted CNA B who said Resident #3 was fondling Resident #1's breasts and verified the alerts. They followed protocol and reported it and started Resident #3 on 15 minute checks until the IDT meeting. The CNA was suspended pending investigation and should have reported it immediately. Resident #3 should have been placed on checks immediately to ensure no other incidents occurred and monitor his/her behaviors. During an interview on 07/01/26 at 1:15 P.M., MDS coordinator said the IDT was completed for Resident #3 on 06/29/26 and 15 minute checks stopped due to no other behaviors. She has worked the unit for a year and been back there in her office for the last two months doing MDS and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 has never had sexual behaviors before.During interview on 07/01/26 at 3:00 P.M., the Administrator stated CNA B should have immediately reported both incidents to the charge nurse or administration. Had the incidents been reported when they occurred, Resident #3 would have immediately been placed on increased supervision, an abuse investigation would have been initiated, and protective interventions would have been implemented. The Administrator acknowledged the facility was unaware of the incidents for approximately two days because CNA B failed to report them and stated facility protocol was not followed.Complaint #3055423The Administrator was notified on 07/01/26 of the Past Non-Compliance which occurred on 06/23/26. On 06/25/26, facility staff started an investigation, completed disciplinary action, and began in-servicing all staff on abuse policies and procedures. No additional allegations of resident-to-resident sexual abuse involving Resident #3 were identified after the corrective actions were implemented. The non-compliance was corrected on 06/25/26.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure staff immediately reported allegations of abuse to facility administration for two residents (Residents #1, #2 and #3) and failed to ensure staff immediately reported an injury of unknown origin for one resident (Resident #4), affecting four of four sampled residents reviewed for abuse. These failures delayed implementation of the facility's abuse prevention and investigation process, including resident assessment, protective interventions, and timely collection of investigative information. The facility census was 46. Review of the facility policy titled, Abuse, Prevention and Prohibition Policy, dated February 2026, showed:- Resident abuse must be reported immediately to the Administrator;- The facility's abuse prohibition program included identification, investigation, protection, and reporting/response;- Allegations of abuse required initiation of an investigation, implementation of protective interventions, assessment of the resident, notification of the physician and responsible party, and reporting to required agencies. 1.Review of the facility's investigation, completed 06/26/26, showed:-On 06/23/26, Resident #3 inappropriately touched Resident #1's breasts while Resident #1 was asleep;-Approximately 30 minutes later, Resident #3 reached underneath Resident #2's blanket, and Resident #2 pushed Resident #3's hands away while telling Resident #3 to stop;-Certified Nurse Aide (CAN) B witnessed both incidents and redirected Resident #3;-CNA B did not immediately notify the charge nurse, Director of Nursing (DON), or Administrator;-The incidents were later identified by the DON on 06/25/26 through documentation entered into the electronic medical record alerts. Review of CNA B's written statement, dated 06/26/26, showed CNA B observed Resident #3 inappropriately touching Resident #1 and later found Resident #3 beside Resident #2's bed with a hand underneath the blanket. CNA B redirected Resident #3 during both incidents but did not notify nursing management or Administration when the incidents occurred.Attempted contact with CNA B for interview on 07/01/26 and again on 07/08/26 was unsuccessful.During an interview on 07/01/26 at 12:20 P.M., the DON said no one notified her or the Administrator when the incidents occurred. The DON said she became aware of the allegations only after discovering the electronic medical record alerts approximately two days later. The DON said CNA B should have immediately reported both incidents to the charge nurse or administration so the facility could have initiated its abuse investigation and implemented protective interventions.During an interview on 07/01/26 at 3:00 P.M., the Administrator said CNA B should have immediately reported both incidents to the charge nurse or administration. The Administrator said if the allegations been reported when they occurred, the facility would have immediately initiated an abuse investigation, implemented protective interventions, and increased supervision of Resident #3. The Administrator acknowledged facility protocol requiring immediate reporting of abuse allegations was not followed.2. Review of the facility's investigation, completed 06/29/26, showed:- On 06/29/26 at approximately 8:00 A.M., CNA C and CNA D identified multiple bruises of unknown origin, including bruises resembling handprints on Resident #4;-The CNAs immediately notified Registered Nurse (RN) E and Licensed Practical Nurse (LPN) A; -Neither RN E or LPN A notified the DON or Administrator regarding the bruising on Resident #4;-The DON was not informed during evening shift report, approximately 11 hours later;-Resident #4 transferred to the hospital before the facility initiated an abuse investigation. Review of CNA C's written statement, undated, showed at approximately 8:00 A.M. on 06/29/26, CNA C observed new bruising on Resident #4's arms, behind the knees, and buttocks while providing care. CNA C immediately notified RN E and LPN A.Review of CNA D's written statement, undated, showed CNA D assisted CNA C with Resident #4's care at approximately 8:00 A.M. on 06/29/26, observed bruising on multiple areas of the resident's body, completed a skin audit identifying the bruising, and notified RN E and LPN A.Review of RN E's incident statement, undated, showed:-On 06/29/26 CNAs C and D reported bruising on Resident #4; Date of incident 06/29/26;-Resident #4 assessed, no signs or symptoms of distress. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations showed bruising of unknown origin;-Bruising also reported to LPN A by CNA's C and D and LPN A took over; Review of LPN A's written statement, dated 06/29/26, showed:-At approximately 8:00 A.M., LPN A overheard CNAs C and CNA D discussing bruises that resembled handprints on Resident #4 with the charge nurse, RN E that was discovered during care;-The CNAs talked about calling the State, and RN E told them they should not call the State until they talked with the DON;-CNA C said she would follow the chain of command;-LPN A continued to provide care to other residents and did not notify the DON or Administrator at that time. Review of Resident #4's Skin Monitoring CNA Shower Review, dated 06/29/26, showed:-Bruising to right posterior upper forearm, left anterior thigh, left posterior thigh, left posterior calf, right anterior wrist;-Body audit: multiple bruises that resembled handprint. Reported to the nurses;-Signed by CNA D;-Forwarded to DON. During a phone interview on 07/01/26 at 12:23 P.M. the DON said LPN A informed her during evening shift report that CNA C and CNA D had discovered bruising earlier that morning on Resident #4. The DON said no one had notified her prior to the shift report. The DON said the Administrator had been in the building throughout the day, and neither she nor the Administrator had been notified. The DON said that by the time she learned of the allegations, Resident #4 had already been transferred to the hospital and could not be assessed as part of the initial abuse investigation.During an interview on 07/01/26 at 1:59 P.M., RN E said CNA C notified him/her at approximately 8:30 A.M. on 06/29/26 that Resident #4 had bruising that resembled handprints. RN E said he/she assessed Resident #4 and observed bruising on the resident's arms and a partial bruise on one thigh. RN E said he/she did not believe the bruising appeared concerning because the resident had fragile skin and received a blood thinner medication. RN E said she did not notify the DON or Administrator of the allegation.During an interview on 07/01/26 at 2:10 P.M., LPN A said at approximately 8:30 A.M. on 06/29/26 he/she was at the nurse's station when CNA C and CNA D told RN E about the bruises on Resident #4. LPN A said CNA C wanted to call State regarding the allegation. RN E told the CNAs to wait and talk to the DON. LPN A said he/she did not go and assess the resident at that time, or contact the DON or the Administrator since the CNAs were discussing Resident#4 with RN E. LPN A said if reports of abuse or bruising is reported to him/her, he/she would expect to assess the resident, and then contact the person above him/her, which would be the RN, then the DON, and then the Administrator.During an interview on 07/01/26 at 3:00 P.M., the Administrator said since he was in the building throughout the day shift on 06/29/26, one of the staff members (nurse or CNAs) should have immediately reported both incidents to him. The Administrator had the allegations been reported when they occurred, the facility would have immediately initiated an abuse investigation, and Resident #4 could have been assessed and/or reassessed at that time. The Administrator acknowledged facility protocol requiring immediate reporting of abuse allegations was not followed.MO3055423, MO3064675 The Administrator was notified on 07/01/26 of the Past Non-Compliance which occurred on 06/23/26. On 06/25/26, facility staff started an investigation, completed disciplinary action, and began in-servicing all staff on abuse policies and procedures and reporting. No additional allegations of resident-to-resident sexual abuse involving Resident #3 were identified after the corrective actions were implemented. The non-compliance was corrected on 06/25/26 regarding reporting abuse. The Past Non-Compliance regarding reporting an injury of unknown origin, which occurred on 06/29/26 at 8:00 A.M. On 06/29/26 at 7:30 P.M., facility staff started an investigation, in-servicing all staff on abuse policies, injuries of unknown origin, and reporting, and skin audits initiated. The non-compliance was corrected on 06/29/26 at 7:30 P.M., 11 hours later, regarding reporting injury of unknown origin.