STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265526	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chariton Park Health Care Center	902 Manor Drive Salisbury, MO 65281

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to maintain resident dignity when residents on the secured unit only had plastic forks and spoons provided to use for meal service. The facility provided no knives for resident use. Residents reported having to use their hands to eat meat because the meat could not be cut with a plastic fork or spoon. Fifty-seven residents resided on the secured unit. The facility census was 113. Review of the facility's policy for Promoting/Maintaining Dignity, last revised on 09/21/25, showed the following:-It was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and an environment that maintained or enhanced resident's quality of life by recognizing each resident's individuality;-The resident's former lifestyle and personal choices would be considered when providing care and services to meet the resident's needs and preferences. 1. Observation of the lunch meal served in the secured unit on 11/17/25 at 12:34 P.M. showed the following: -Staff served residents meatballs, mashed potatoes, mixed vegetables, and tapioca pudding;-Staff provided all the residents in the secured unit dining room with plastic forks and spoons to eat the meal. During an interview on 11/17/25 at 12:35 P.M, Certified Nurse Assistant (CNA) L said staff always served the residents' meals with plastic utensils for safety. During an interview on 11/17/25 at 2:00 P.M., Resident # 8 said the facility served the residents' meals with plastic forks and spoons and no knives. Staff did not provide a plastic or metal knife to cut the meat. He/She had to pick up the meat with his/her fingers to eat it, which he/she considered barbaric. Staff told him/her plastic utensils were used because metal silverware was lost, and the count would be off. Staff told the residents they would take away smoke break if silverware could not be located. He/She did not like to use plastic silverware. Observation of staff preparing lunch trays for the secured unit on 11/18/25 at 11:40 A.M. showed the following:-The lunch meal included a pork chop, baked potato, stewed tomatoes with zucchini, and bananas;-Staff provided the residents with a metal fork and spoon to eat the meal. Staff did not provide a knife to cut the meat. During an interview on 11/18/25 at 11:58 A.M., the Dietary Manager said metal silverware was used at lunch today, because the facility was out of plastic utensils. She said this was okay because it would be easier for the residents to eat the pork chop with metal silverware. Staff and residents preferred plastic utensils because metal silverware had to be accounted for. The residents could not go to smoke until all the metal silverware was accounted for. During an interview on 11/17/25 at 3:00 P.M., Resident #9 said staff served meals with plastic utensils. He/She did not like to eat with plastic utensils. It was difficult to cut meat with a plastic fork and spoon. Staff did not provide the residents with any type of knife. During an interview on 11/18/25 at 9:36 A.M., Licensed Practical Nurse (LPN) H said the residents preferred using plastic utensils because cigarette breaks were delayed if the metal silverware count was not correct. Staff do not provide a knife, but butter knives were available upon request. During an interview on 11/18/25 at 4:45 P.M., Certified Medication Tech (CMT) C said residents were served meals with plastic utensils because metal silverware could be used as a weapon. During an interview on 11/17/25 at 3:40 P.M., the Administrator said all metal silverware had to be accounted for after the meal before residents could go to smoke break. The residents preferred to use plastic utensils, because if the metal silverware count was not correct, the residents' smoke break was delayed until the metal silverware was accounted for. The residents did not want to wait to smoke so they requested to use plastic utensils. She did not expect residents to pick up meat with their fingers to eat it. There were butter knives available upon a resident's request. Complaint #2629015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one resident (Resident #2), in a review of 14 sampled residents, from abuse. Resident #1, who had a diagnosis of intermittent explosive disorder (a mental health condition marked by frequent impulsive anger outbursts or aggression) and had a history of assault, approached Resident #2 and forcefully slammed Resident #2's head against the vending machine and struck Resident #2 multiple times in the face with a closed fist. Resident #2's sustained lacerations to the right eyebrow and upper lip that required sutures. The facility census was 113. Review of the facility's Abuse and Neglect Policy, last reviewed on 06/12/24, showed the following:-Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish which included certain resident to resident altercations;-Physical abuse was purposefully beating, striking, wounding, or injuring any resident or any manner. Physical abuse included but was not limited to hitting, slapping, punching, biting, and kicking;-The facility would identify and correct by providing interventions in which abuse was more likely to occur. This would include assessment of the physical environment which might make abuse more likely to occur such as a secluded area, the deployment of staff on each shift in sufficient numbers to meet the resident's needs and that the staff were knowledgeable of resident care needs;-Prevention also included assessment, care planning, and monitoring of residents with needs or behaviors which might lead to conflict. The facility would identify events, patterns, and trends that might constitute abuse and investigate thoroughly. 1. Review of Resident #1's Preadmission Screening and Resident Review (PASRR), a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability who apply or reside in a nursing facility to ensure proper placement, dated 06/04/25, showed the following:-Diagnoses included schizophrenia (a mental disorder characterized variously by hallucinations, delusions, disorganized thinking or behavior), major depressive disorder (a mood disorder that causes persistently low or depressed mood), and stimulant dependence;-He/She had a history of erratic and aggressive behaviors, impulse control issues, anger, labile mood, limited insight, history of hallucinations, and history of assaultive behaviors;-Behavioral symptoms included withdrawn/depressed, suspicious/paranoid, hallucination, delusions, abnormal thought process, and aggressiveness;-He/She had history of assault charges that required jail time;-He/She required 24-hour protective oversight due to severity of behaviors or mental illness symptoms. He/She could not be left without supervision at any time;-Provisions of a structured environment he/she required included an environment with low stimulation, minimum of visual/auditory distractions and/or sensory supports. Assess and plan for the level of supervision required to prevent harm to self or others. Provide individual personal space, and establish consistent routines, providing a schedule of daily tasks/activities, etc. Review of the resident's face sheet showed the following:-He/She was admitted to the facility on [DATE];-He/She had a guardian;-His/Her diagnoses included schizophrenia, bipolar disorder (is a chronic mood disorder that causes intense shifts in mood, energy levels and behavior), and intermittent explosive disorder. Review of the resident's care plan, dated 6/30/25 and last updated 8/13/25, showed the following:-The resident was at risk for the following signs and symptoms related to his/her diagnosis of schizophrenia: aggression, cannot make own decisions, delusions (fixed false beliefs that cannot be reasoned with), and irritability;-The resident had a behavior problem related to intermittent explosive disorder. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 10/01/25, showed the following: -His/Her cognition was mildly impaired;-He/She exhibited physical, verbal, and other behaviors one to three days out of the previous seven-day look back period. Review of the resident's progress notes, dated 11/10/25 at 8:55 A.M., showed at approximately 8:30 A.M., peers (Resident #2 and Resident #3) were in the vending room purchasing a soda when Resident #1 entered the room. Without provocation, Resident #1 forcefully slammed peer's (Resident 2's) head against the vending machine. Peer (Resident #2) fell to the floor at which point Resident #1 struck him/her (Resident #2) multiple times in the face with a closed fist. Review of the facility's investigation, dated 11/10/25, showed the following:-The resident attacked Resident #2 unprovoked on the secure unit. The resident was noted to have struck Resident #2's head against the vending machine then struck Resident #2 while he/she was on the ground several times in the face with a closed fist. Resident #2 sustained lacerations to the right side of his/her face on the eyebrow and right lower lip;-Law enforcement was notified, and the resident was taken into custody;-Injuries were obtained as the

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff documented the rationale for use of as needed (PRN) antipsychotic medications to ensure adequate indication for use as directed in facility policy for one resident (Resident #1), in a review of 14 sampled residents. The facility's census was 113. Review of the facility's policy for PRN Medication Use, last reviewed on 05/18/24, showed the following:-PRN medications referred to a medication that is taken as needed for a specific situation. It was not provided routinely and required assessment for need and effectiveness;-Indications for use is the identified, documented clinical rationale for administering a medication that was based upon assessment of the resident's condition and therapeutic goals and is consistent with the manufacturer's recommendations and/or current evidence-based practice or standards;-Documentation would be provided in the resident's medical record to show adequate indications for medications use and the diagnosed condition for which it was prescribed;-When administering a PRN medication, document the reason voiced by the resident and/or assessment findings that show why the resident needed the medication, verify the reason was for the prescribed indication for the medication, document the time of the administration, evaluate effectiveness of the medication, and document the findings. Review of the facility's Use of Psychotropic Medications Policy, last revised on 06/26/24, showed the following:-Residents were not given psychotropic medications unless the medication was necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication was beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medications;-A psychotropic medication is any medication that affects brain activities associated with mental processes and behaviors. Psychotropic medications include, but are not limited to, antipsychotics, antidepressants, anti-anxiety, and hypnotics;-In the event of an acute or emergent situations (i.e., acute onset or exacerbation of symptoms or immediate threat to health or safety of resident or others), a clinician in conjunction with the IDT shall evaluate and document the situation to identify and address any contributing and underlying causes of the acute condition and verify the need for a psychotropic medication;-An evaluation shall be documented to determine that the resident's expressions or indications of distress are not due to a medical condition or problem that could be expected to improve or resolve as the underlying condition was treated or the offending medication(s) are discontinued, not due to environmental stressors alone, that could be addressed to improve the symptoms or maintain safety, not due to psychological stressors, anxiety, or fear stemming from misunderstanding related to his/her cognitive impairment that could be expected to improve or resolve as the situation was addressed, and persistent and negatively affect his/her quality of life. 1. Review of Resident #1's Preadmission Screening and Resident Review (PASRR), a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability who apply or reside in a nursing facility to ensure proper placement, dated 06/04/25, showed the following:-Diagnoses included schizophrenia (mental disorder characterized variously by hallucinations, delusions, disorganized thinking or behavior) and major depressive disorder (a mood disorder involving persistently low or depressed mood);-He/She had a history of erratic and aggressive behaviors, impulse control issues, anger, labile mood, limited insight, history of hallucinations, and history of assaultive behaviors;-Behavioral symptoms included withdrawn/depressed, suspicious/paranoid, hallucination, delusions, abnormal thought process, and aggressiveness;-He/She required an environment with low stimulation, minimum of visual/auditory distractions and/or sensory supports, assess and plan for the level of supervision required to prevent harm to self or others, provide individual personal space, and establish consistent routines, providing a schedule of daily tasks/activities, etc. Review of the resident's face sheet, dated 11/10/25, showed the following:-He/She admitted to the facility on [DATE];-He/She had a guardian;-His/Her diagnoses included schizophrenia, bipolar disorder (is a chronic mood disorder that causes intense shifts in mood, energy levels and behavior), and intermittent explosive disorder. Review of the resident's care plan, initiated on 06/30/25 and updated on 8/13/25, showed the following:-He/She had a mood problem related to intermittent explosive disorder;-Administer medications as ordered. Monitor/document for side effects and effectiveness;-Monitor/Record mood to determine if problems seem to be related to external causes;-Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes;-He/She used anti-anxiety medications related to adjustment issues;-Administer anti-anxiety

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents from obtaining illegal substances when staff failed to follow their policy to search and inventory one resident's (Resident #3's) personal belongings upon admission and failed to remove items that were not allowed in the facility. Resident #3 reported he/she brought a dab pen (a portable device that contains cannabis/marijuana concentrate), 20 tablets of Adderall (a prescription medication used to treat attention deficit hyperactivity disorder and narcolepsy. It is also used recreationally as a euphoriant), and bath salts (an illegal synthetic substance that increases brain and central nervous system activity similar to cocaine and methamphetamines) to the facility upon his/her admission and shared the illegal substances and prescription medication with other residents including three residents (Residents #5, #6, and #7), in a review of 14 sampled residents. The facility census was 113.Review of the facility's policy for admission Process, last revised on 12/01/22, showed the following:-The admission coordinator/designee was responsible for completing the initial inventory sheet, checking all the resident's items, and ensuring the residents were not allowed to have any type of contraband or items which directly went against policy;-Floor staff under the direction of the charge nurse would inventory and address the resident's personal items, noting accurate completion of inventory and removal of items that the resident would not be allowed to keep in their room per facility policy. 1. Review of Resident #3's Preadmission Screening and Resident Review (PASRR), a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability who apply or reside in a nursing facility to ensure proper placement, dated 11/16/18, showed he/she had an extensive history of polysubstance abuse, including methamphetamines (a synthetic stimulant that provides a feeling of euphoria and is highly addictive; also referred to as meth). Review of the resident's undated face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's progress note, dated 10/28/25 at 11:03 P.M., showed he/she arrived at the facility at approximately 9:30 P.M. (Review showed no documentation staff searched his/her personal belongings per facility protocol.) Review of Certified Nurse Assistant (CNA) I's written statement, provided by the facility, dated 11/18/25, showed the resident approached him/her and said he/she brought illegal items into the facility. He/She reported this to the Director of Nursing (DON) and Administrator who had him/her take the resident to the Administrator's office. Review of the facility's investigation, dated 11/18/25, showed the following:-The resident approached staff and said he/she brought illegal substances into the building from his/her previous placement. He/She reported bringing into the facility. He/She gave the dab pen to Resident #5 and shared the bath salts with Resident #6 and Resident #7 and took some himself/herself;-Resident #3, Resident #6, and Resident #7 tested positive for methamphetamines;-Resident #5 tested positive for THC (cannabis/marijuana);-Resident #3 said he/she found the items in his/her belongings and staff did not find them when they did his/her inventory because items were hidden in his/her stuff. During an interview on 11/18/25 at 5:15 P.M., Resident #3 said he/she brought 20 tablets of Adderall, bath salts, and a THC dab pen into the facility. He/She obtained the Adderall from a staff at his/her previous facility, and he/she received the bath salts and THC dab pen from a resident at the previous facility. None of the staff searched his/her belongings when he/she arrived at the facility. The items were in his/her duffle bag. He/She gave the THC pen to a resident, but did not know the resident's name. He/She shared the Adderall with other residents but was unable to recall their names. He/She denied sharing the bath salts with any residents. He/She consumed the Adderall and the bath salts. Review of the resident's physician's orders, dated November 2025, showed the resident did not have an order for Adderall. During an interview on 11/18/25 at 3:10 P.M., Resident #6 said he/she received meth from Resident #3 a couple of weeks ago (unable to recall the date). He/She was drug tested yesterday (11/17/25) and tested positive for methamphetamines. Review of Resident #5's undated written statement, provided by the facility, showed Resident #3 gave him/her (Resident #5) a dab pen which he/she hit a couple of times then threw away. During an interview on 11/20/25 at 8:49 A.M., Nursing Assistant (NA) J said staff should check a resident's belongings and remove any contraband upon admission. He/She worked the night Resident #3 was admitted . Staff did not go through the whole process of checking the resident's belongings properly, because another resident was attempting to elope, staff were admitting two other residents, and no other staff were available to help. By the time the other situations had calmed down, Resident #3 was asleep, and he/she did not want to disturb him/her to search his/her belongings. During an interview on 11/20/25 at 11:10