

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/31/2025
NAME OF PROVIDER OR SUPPLIER  Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0627  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.  (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow proper immediate discharge procedure for one resident (Resident #10), in a review of eight sampled residents, by not identifying a proper discharge location. Resident #10 experienced increased aggressive behaviors and was sent to the hospital for psychiatric evaluation on 12/19/25. Once the resident was at the hospital, the facility determined they were unable to meet the resident's needs and sent an immediate discharge notice to the hospital on [DATE]. The facility identified the psychiatric hospital was the discharge location and did not plan to readmit the resident until after a decision was made following a hearing on 01/07/26. The facility did not amend the immediate discharge notice with an appropriate discharge location. The facility's census was 114. Review of the facility's Immediate Discharge Policy, last reviewed on 06/12/25, showed the following: -In a situation where the facility initiates a discharge while the resident is in the hospital following an emergency transfer, the facility must have evidence that the resident's status is not based on his/her condition at the time of transfer and meets one of the criteria listed above. If a resident appeals the notice of discharge, the resident must be allowed to return to the facility during the time that the appeal is pending unless there is evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility;-The Administrator, Social Service Manager or their designee is responsible for drafting the transfer/ discharge letter. This letter shall be sent to the Management Company Chief Compliance Officer for review. The legal review will ensure that the letter meets all the legal requirements, but the decision to discharge the resident and where to discharge the resident is fully the facility's decision.(The facility's policy did not address identifying a proper discharge location.) 1. Review of Resident 1's face sheet showed the following:-He/She admitted to the facility on [DATE];-He/She had a guardian. Review of the resident's progress note, dated 12/16/25 at 1:00 P.M., showed the resident had physical and verbal aggression directed toward staff members. The resident attempted to shove through the nurses' station door. The resident shoved one certified nurse assistant (CNA) to the floor. Staff tried to intervene when the resident struck certified medication technician (CMT) in the throat with a closed fist, causing the CMT to fall to the floor. Staff called 911 and law enforcement arrived. Police transported the resident out of the facility. Review of the resident's progress notes, dated 12/17/25 at 5:58 A.M., showed the resident returned to the facility at 5:30 A.M. Review of resident's progress notes, dated 12/18/25 at 11:28 A.M., showed local law enforcement arrested the resident and took him/her into custody. (Review showed no documentation why the resident was taken into custody on 12/18/25.) Review of the resident's progress notes, dated 12/19/25 at 11:25 A.M., showed the resident was released from a local jail at 11:20 A.M. and transported to a psychiatric facility. Review of the resident's progress notes, dated 12/19/25 at 5:30 P.M., showed the facility sent an immediate discharge letter via email and fax to the psychiatric hospital due to the facility's inability to provide adequate care and to ensure the safety of staff and other residents. The resident had a documented history of multiple physical assaults against staff and peers during his/her stay at the facility. Review of the resident's Immediate Notice of Discharge, dated 12/16/25, showed the following:-The letter served as formal notice of immediate discharge, effective 12/17/25, due to an immediate and serious threat to the health and safety of staff and others;-Reason for discharge: The resident physically assaulted three staff. The incident involved acts of physical violence requiring staff intervention, activation of emergency safety procedures, and law enforcement involvement. This behavior constitutes an immediate danger to staff and residents and cannot be safely managed within the facility. Due to the severity and escalation of behaviors, the facility is unable to ensure the safety of other should the resident remain in the facility. Continued placement is therefore not appropriate;-Discharge location: hospital psychiatric center.(Review of an email from the facility's Administrator, dated 01/16/26 at 3:23 P.M., showed the immediate discharge letter was provided on 12/19/25, but was improperly dated as 12/16/25.) During interview on 01/02/25 at 9:00 A.M., the resident's guardian said the facility provided an immediate discharge letter on 12/19/25 after the resident was sent to the hospital on [DATE]. The resident's immediate discharge was for incidents that occurred three days prior to the facility providing the discharge letter. She appealed the discharge while the resident was at the hospital, and the facility filed a motion to set aside the stay. The resident remained in the hospital (discharge location) until there was a judgement from the hearing. During interviews on 12/30/25 at 3:20 P.M. and 1/20/26 at 12:45 P.M. the Administrator said the following:-The resident assaulted staff on 12/16/25 was</p>		