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	03/12/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide protective oversight and complete 15 minute safety checks (procedure for staff to verify the resident's location) as directed for one resident (Resident #1), in a review of seven residents. Resident #1 was a known elopement risk and was on 15 minute face checks for safety when the resident removed the security block from the windowsill (a rubber block screwed into the windowsill preventing the slide window from opening more than five inches) in his/her room, opened the window, removed the screen and climbed through the window to the exterior fenced courtyard. The resident pushed a picnic table next to the building, stood on the picnic table and climbed onto the roof, crossed the roof, and then jumped down into an open area. The resident walked from the back of the building, down the street, five blocks, until he/she was approached by a local police officer. The facility census was 111. On 3/12/26 at 11:15 A.M. the Administrator was notified of the Immediate Jeopardy Past Non-Compliance which occurred on 02/28/26. On 02/28/26, the Administrator identified Resident #1 eloped from the facility through his/her room window to a 12-foot-high fenced in courtyard, climbed onto the roof and jumped down to an open area, and walked down the street five blocks without staff knowledge. Upon discovery, Resident #1 was located and transferred to the hospital by ambulance per the resident's request. The resident returned to the facility on [DATE] at 2:16 A.M. and immediately placed on one-on-one observation for safety. The resident's guardian and physician were notified of the elopement, and the resident was evaluated by psychiatric services. Additional interventions were implemented to ensure the security of the resident's window as well as all windows in the facility. The courtyard picnic table was secured to the concrete patio. Education for all staff was started immediately regarding the resident elopement policy, residents at risk for elopement, intensive monitoring procedures including one-on-one observation and every 15-minute face checks including documentation of the face checks and window security. The deficiency was corrected on 03/01/26. Review of the facility Elopement and Wandering Residents policy, dated 06/12/24, showed the following:-The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk;-Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so;-The facility is equipped with door locks/alarms to help avoid elopements;-Alarms are not a replacement for necessary supervision;-The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment or risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary;-Resident will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the care interdisciplinary care plan team;-The interdisciplinary team will evaluate the unique factors contributing to risk to develop a person-centered care plan;-Interventions to increase staff awareness of the resident's risk, modify (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff;-Adequate supervision will be provided to help prevent accidents or elopements;-Charge nurses and unit managers will monitor the implementation of interventions, response to interventions and document accordingly;-The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff;-Following an elopement a nurse will perform a physical assessment, document and report findings to the physician;-A social service designee will re-assess the resident and make any referrals for counseling or psychological/psychiatric consults;-The resident and family/authorized representative will be included in the plan of care;-Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. Review of the facility Intensive Monitoring policy, dated 04/30/24, showed the following:-The purpose was to ensure a system for residents who required increased monitoring for crisis, behavioral, or psychiatric issues;-Intensive monitoring is defined as periodic checks by a facility staff member; intensive monitoring based on the crisis, behavioral, psychiatric issues. The level of monitoring shall be identified by the specific situation or resident assessment;-Residents who show poor impulse control such elopement ideations, may be placed on intensive monitoring or one-on-one or two-to one (within eyesight of staff) monitoring at the discretion of the administrative staff or supervisor;-The facility's Interdisciplinary Team (IDT) will address the resident's behavioral concerns and ensure interventions are in place to address the resident's needs (psychiatry follow up, counseling, medical needs);-Once the resident has stabilized and/or returned to prior level of function, the facility's IDT will meet to discuss determination of discontinuation of intensive monitoring;-The facility staff will document the intensive monitoring in the resident's electronic medical record. Review of Resident #1's Preadmission Screening and Resident Review (PASRR, a screening tool used to ensure appropriate placement of persons known or suspected of having a mental impairment, serious mental illness and/or intellectual disability/developmental disability) dated 07/24/25, showed the following:-Diagnoses of schizoaffective disorder (chronic mental illness psychoactive substance abuse (harmful or hazardous consumption of substances that alter the brain function, mood, perception or consciousness);-Long family history of mental health issues. hospitalized at [AGE] years old due to suicidal thoughts. Used drugs as a teenager and became addicted. He/She was in and out of different rehabilitation units and left without completing the program. Lived on the streets, was homeless and overdosed on fentanyl (powerful opioid pain medication, illicitly used is a major contributor to fatal overdoses) about two months ago. Reported being physically abused by a parent and sexually abused by someone who drugged the resident;-Needs or continues to need individual, family or group psychotherapy, health behavior assessment and intervention and required ongoing psychiatric care and treatment;-The resident needed support and services. Maintain environment with low stimulation, minimum of visual/auditory distraction and/or sensory supports. Provide for individual personal space. Establish consistent routines, providing a schedule of daily tasks and activities. Provide environmental supports to prevent elopement. Review of the resident's care plan, dated 11/01/25, showed the following:-Diagnoses of schizoaffective disorder (chronic mental illness combining schizophrenia symptoms of hallucinations, seeing and hearing things that are not real, and delusions, a firm belief something is real despite evidence the belief is false, with a major mood disorder such as depression and bi-polar disease, a disease with intense mood swings from depression to mania), psychoactive substance abuse (harmful or hazardous consumption of substances that alter the brain function, mood, perception or consciousness), suicidal ideations (thoughts of killing self), mood disorder, attention-deficit hyperactivity disorder (ADHD, neuro disorder with persistent inattention, hyperactivity and impulsivity that interferes with daily functioning), opioid abuse (abuse of narcotic medication), anxiety disorder, insomnia (inability to sleep) due to other mental disorder, adjustment disorder with depressed mood;-The resident was at risk for elopement due to feelings of anxiety, had a history of elopement from prior, secured facility. Staff should (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	complete an elopement risk assessment on admission, readmission, and quarterly, and complete face checks/intensive monitoring. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 12/09/25, showed the following:-Cognitively intact;-No hallucinations or delusions;-No impaired mobility and required no assistive device;-The resident's wandering placed the resident at significant risk of getting to a potentially dangerous place such as outside of the facility. Review of the resident's elopement risk evaluation, dated 10/28/25, showed staff documented the following:-History of elopement or attempts of leaving the facility without informing staff;-Verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door;-Score of two. Indicating risk of elopement (score of one or higher indicated risk of elopement). Review of the resident's nurses' note, dated 10/28/25 at 11:06 P.M., showed the resident arrived at 9:30 P.M. He/She was hard to redirect, walked independently with a steady gait, was agitated and drug seeking. He/She made several attempts to get out the door. Review of the resident's nurses' note, dated 10/29/25 at 12:07 P.M., showed the Interdisciplinary Team met with the resident. The resident spoke about elopement from previous facilities, and he/she did not feel like he/she needed to be in a facility. Review of the resident's nurses' note, dated 11/1/25 at 7:50 P.M., showed staff documented the resident's guardian called and reported the resident was at a gas station. Code [NAME] initiated. Staff contacted the resident by the resident's personal cell phone, the resident provided his/her exact location. Staff located the resident and safely transported the resident back to the facility. Review of the resident's elopement risk evaluation, dated 11/01/25, showed staff documented the following:-History of elopement while at home;-History of elopement or attempts of leaving the facility without informing staff;-Verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door;-Pattern of goal-directed wandering behavior;-Wandering behavior likely to affect the safety or well-being of self/others;-Wandering behavior likely to affect the privacy of others;-Recently admitted or re-admitted to the facility (within the past 30 days) and had not accepted the situation;-Score of seven. Indicating risk of elopement (five points higher than the elopement risk score from the previous assessment dated [DATE]). Review of the resident's nurses' note, dated 02/26/26 at 11:04 P.M., showed staff documented completing intensive monitoring with every 15-minute face checks. Review of the resident's 15-minute face check documentation (located in the resident's electronic medical record) dated 02/28/26 showed staff documented at 12:00 P.M., 1:10 P.M., 3:32 P.M., 3:35 P.M., and 3:38 P.M. the resident was in the building. Review of the resident's nurses' note, dated 02/28/26, showed staff documented the following:-At 4:58 P.M., a phone call received from off duty staff at 4:40 P.M. Laundry Aide F asked if the resident had a pass because the resident just walked by Laundry Aide F's home. Staff went directly to the resident's room and noted the window was open and the screen was not in place. Code [NAME] was called. Emergency Medical Services (EMS, 911 dispatcher) called the facility asking about the resident. The resident refused to give his/her name to the police officer;-At 5:15 P.M., EMS dispatch informed staff the resident requested an ambulance and cooperated with the police officer;-At 5:45 P.M., hospital emergency department informed the facility staff the resident would return by ambulance and he/she was a very high elopement risk. Review of the Police department report, dated 02/28/26 at 4:20 P.M., showed on 02/28/26 at approximately 4:20 P.M. the police officer observed a person walking near the city park, wearing a bulky winter jacket, pajama pants, and slip-on sandal style shoes which appeared unusual for the weather and location. The police officer drove to the fairgrounds parking area (four city blocks from the facility), parked the vehicle and continued to observe the subject. At 4:40 P.M. a person who identified themselves as a facility employee parked next to the police officer and advised the subject walking was a resident of the facility and not authorized to be out. The employee was on the phone with the facility and verified the resident did not have permission or a pass to leave the facility. The employee said the facility was notified the resident was walking around, but was unsure what actions would be taken or if staff were enroute to locate the resident. The police officer followed the resident southbound on Highway (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PP (five blocks from the facility) and contacted the resident. The resident said he/she was walking to a local store and did not live at the facility. The police officer stopped at an intersection two blocks further down the street and contacted dispatch to request they contact the facility and determine if a resident was missing. While on scene, the police officer observed the resident walk down the roadway. A few minutes later, the resident turned around and walked back toward the police officer. The resident then admitted he/she lied during the initial contact. The resident identified himself/herself and said he/she left the facility by exiting through a window, climbed onto the roof, sat there for a period of time, jumped off the roof, and left the property. He/She denied any injuries. The resident requested help and said he/she did not feel well and wanted to go to the hospital. Dispatch called EMS. The resident was transported to the emergency department. During an interview on 03/11/26 at 10:00 A.M., the resident said he/she just wanted out of the facility, the place was not right for him/her. The resident bent his/her metal watch band and used the edge of the metal to loosen the screws on the blocks in the windowsill, broke the block out, slid the window open, pushed the screen out and went out the window. It was about a four-foot drop to the ground in a fenced in area. It took about an hour to get the block out of the windowsill and the window open. The resident closed the curtain when staff came in the room to check on him/her. Staff did not notice he/she was trying to open the window. Staff did not always complete 15-minute checks. He/She pushed a picnic table near the building, stood on the picnic table where he/she could reach the guttering and pulled himself/herself up on the roof. He/She walked to the end of the roof line and jumped down to the ground in an open area, walked down the street past the school and park area. A police officer came and asked if the resident was from the facility. At first he/she said no then said yes, he/she was from the facility. The resident knew the police and the staff would come to find him/her. Observation on 03/11/26 at 10:30 A.M. showed the following:-The resident's room window was large (approximately six feet wide by four feet high) with three sections. The large window in the center did not open. The smaller windows on each end slide open towards the center window. Each side window was approximately one and one-half feet wide with screens. Directly out the window was a fenced in courtyard area with a picnic table and chairs. The courtyard was surrounded by a 12-foot-high fence. The roof extended beyond the fenced in courtyard and accessed open space to the back of the building and the street;-The resident walked down the neighborhood street past the high school, city park area to an intersection four blocks from the facility. A parking lot at the fairgrounds was on the corner, the location the police officer observed the resident. The resident crossed a black top, two lane highway and walked another block down a black top, two lane highway leading to another neighborhood. He/She walked two blocks down the neighborhood street to the location the police officer approached the resident. The police officer called an ambulance and transported the resident to the hospital. During an interview on 03/11/26 at 11:00 A.M., the Maintenance Director said the resident ripped the rubber block out of the windowsill, slid the window open, removed the screen and exited the building to the fenced in courtyard. The resident moved the picnic table to the side of the building, stood on the picnic table, accessed the roof, jumped off the roof and walked down the street. The courtyard fence was 12 feet tall. During an interview on 03/11/26 at 11:20 A.M., Nurse Assistant (NA) A said on 02/28/26 the resident was on 15-minute checks due to a previous elopement and risk of elopement. Staff should lay eyes on the resident every 15 minutes and document in the electronic medical record the 15-minute check was completed. During an interview on 03/12/26 at 9:35 A.M., NA C said on 02/28/26 the resident was spiraling, he/she took the resident one time that day to a department head for help getting the resident to calm down. Staff spoke to the resident after lunch and a couple of hours later the resident eloped. Earlier that day the resident tried to open a door and said he/she would run away. On 02/28/26 the resident was on 15-minute checks and staff needed to be monitoring the resident's location and complete the face checks timely and do not miss completing a check. During an interview on 03/12/26 at 12:15 P.M., Certified Nurse Assistant (CNA) E said he/she worked 02/28/26 on the resident's hall and was responsible for completing the resident's 15 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	minute face checks in addition to other staff working the hall. The resident was irritated, staff knew he/she was irritated before the resident eloped. CNA E was getting another resident out of bed and heard Resident #1 was gone. CNA E completed face checks by opening the resident's door and seeing if the resident was in the room and documented the face checks when he/she had time; 02/28/26 was a busy day with other residents. He/She was behind on completing face checks that day. During an interview on 03/12/26 at 1:00 P.M., Laundry Aide F said on 02/28/26 he/she was driving home and noticed the resident on the street. It was in the afternoon, but he/she was unsure of the exact time. The resident wore pajamas and a coat. He/She called the facility, and staff were not aware the resident had eloped. He/She approached the police officer and told the police officer the resident was from the facility and was not supposed to be outside the facility grounds. During interviews on 03/11/26 at 8:40 A.M. and 12:30 P.M the Administrator said the following:-The resident had a history of elopement. On 02/28/26 the resident unscrewed and broke the window block, slid the window open, pushed the window screen out and went out the window into a fenced area. The resident stood on a picnic table and climbed on the roof, jumped off the roof outside of the fenced area and walked down the street. A police officer found the resident and an off-duty staff member Laundry Aide F saw the resident on the street near Laundry Aide F's home. Laundry Aide F notified the facility the resident was on the street and the police notified the facility. The staff were not aware the resident had eloped;-On 02/28/26 the resident was on 15-minute face checks, the point of care charting in the resident's medical record triggered every 15-minute face checks. Staff should go lay eyes on the resident and document the face check was completed every 15 minutes;-Staff were aware of the resident's elopement risk since admission. The resident had eloped from previous facilities and eloped a few days after admission to the facility. The resident had the ability to figure out how to get out of the facility. He/She was not aware the resident used his/her metal watch band to remove the window block;-The administrator expected staff to complete every 15-minute face checks as directed and document the face checks in point of care charting (electronic medical record). Staff should have observed what the resident was doing when face checks were completed. Staff should not just open the door and ask if the resident was in the room. Staff was aware the resident could manipulate the windows. MO# 2799195

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #1), in a review of seven sampled residents, with diagnoses of mental illness and a history of trauma, received appropriate treatment and services to attain the highest practicable mental and psychosocial well-being. The medical record showed on 02/10/26 at 5:48 P.M the resident's guardian/parent said the resident had voiced self-harm ideations. Two days later, on 02/12/26, the resident repeatedly asked for his/her television to watch Animal Planet, a known coping mechanism. Staff failed to provide additional interventions or a television to watch while supervising the resident one-on-one. As a result of not implementing the interventions as care planned, the resident became agitated and broke out a window (inside pane of a double pane glass window) in his/her room, picked up a shard of glass and cut his/her forearm from elbow to wrist. The resident was transported by ambulance to the psychiatric hospital for medical and psychiatric treatment. The resident returned to the facility on [DATE]. On 02/21/26, the resident picked up glass shards that remained in the windowsill from 02/12/26, cut his/her forearm, was transported by ambulance to the emergency room for treatment of the lacerations and returned to the facility. No additional interventions were implemented and on 03/04/26 the resident again found a shard of glass in his/her room that remained from 02/12/26, cut the same forearm and required a bandage for bleeding. The facility census was 111. Review of the facility policy, Behavioral Health Services, dated 10/31/24, showed the following:-It is the policy of the facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning;-Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty and trauma or post-traumatic stress disorders;-The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety; -Conditions that are frequently seen in nursing home resident and may require the facility to provide specialized services and supports based upon residents' individual needs, include, but are not limited to depression, anxiety, schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves that can cause hallucinations, delusions and disorganized thinking including paranoia), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs);-The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;-Staff will monitor the resident closely for expressions or indications of distress, evaluate whether the resident's distress was attributable to their clinical condition and that the change in behavior was unavoidable, utilize Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff) and care area assessments, assess and develop a person-centered care plan for concerns identified, share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnoses, accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record, ensure appropriate follow up assessments, discuss potential modifications to the care plan, and evaluate the resident and care plan routinely to ensure the approaches are meeting the needs of the resident;-The care plan shall have interventions that are person-centered, evidence based, culturally competent, trauma-informed, and in accordance with professional standards of (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	practice, provide meaningful activities which promote engagement and positive, meaningful relationships, and meet the needs of the residents. Review of the facility policy, Behavioral Emergency, dated 09/23/25, showed the following:-The purpose was to provide safe treatment and humane care to the resident in a behavioral crisis, to outline steps to follow to correctly care for the resident in a behavioral crisis, to ensure the resident is not being coerced, punished or disciplined for staff convenience;-Care will be directed by the resident's plan of care and will help to respond to difficult behaviors in the safest and most effective way possible;-Proactive management for the resident is the best plan. All staff should recognize when the resident becomes or can become a danger to themselves or someone else. De-escalation techniques should be utilized as the first resort;-Should the resident exhibit extreme behaviors such as suicidal, homicidal, self-mutilation which did not respond to the non-violent crisis intervention, the licensed nurse and/or nursing administration will assess the resident ensuring the safety of the resident and others. Monitoring of the resident will be initiated, if appropriate. The licensed nurse will document the behavioral emergency in the medical record and notify the administration, physician and/or psychiatrist and responsible party;-The IDT will ensure the care plan is updated if appropriate;-At regular intervals, the company will review incidents to obtain root cause analysis which will facilitate improvements of care management and further prevention of incidents. Review of the facility Intensive Monitoring policy, dated 04/30/24, showed the following:-The purpose was to ensure a system for residents who required increased monitoring for crisis, behavioral, or psychiatric issues;-Intensive monitoring is defined as periodic checks by a facility staff member;-One-on-one monitoring is defined as a designated staff member assigned and within eyesight of the resident;-Residents may require more intensive monitoring based on the crisis, behavioral and psychiatric issues. The level of monitoring shall be identified by the specific situation or resident assessment;-Residents who show poor impulse control such as verbal or physical aggression, elopement ideations, suicidal/homicidal ideations, and decompensation mentally or crisis may be placed on intensive monitoring or one-on-one or two-to one (within eyesight of staff) monitoring at the discretion of the administrative staff or supervisor;-Residents who require intensive monitoring of one-on-one will have an assigned staff member within eyesight until the resident is stabilized or returned to prior level of function. The assigned staff member is educated on the reasoning for the intensive monitoring, including triggers and interventions for that specific resident, the staff member will interact with the resident throughout to ensure the resident receives therapeutic interventions;-The facility's IDT will address the resident's behavioral concerns and ensure interventions are in place to address the resident's needs (psychiatry follow up, counseling, medical needs);-Once the resident has stabilized and/or returned to prior level of function, the facility's IDT will meet to discuss determination of discontinuation of intensive monitoring;-The facility staff will document the intensive monitoring in the resident's electronic medical record. 1. Review of Resident #1's Preadmission Screening and Resident Review (PASRR, a screening tool used to ensure appropriate placement of persons known or suspected of having a mental impairment, serious mental illness and/or intellectual disability/developmental disability) dated 07/24/25, showed the following:-Diagnoses of schizoaffective disorder (chronic mental illness psychoactive substance abuse (harmful or hazardous consumption of substances that alter the brain function, mood, perception or consciousness);-Long family history of mental health issues. Around the age of 12 to[AGE] years old, he/she was bullied at school to the point the other teenager was arrested for the bullying. His/Her sibling committed suicide when the resident was in high school and then the resident stopped going to school. hospitalized at [AGE] years old due to suicidal thoughts. Used drugs as a teenager and became addicted. He/She was in and out of different rehabilitation units and left without completing the program. Lived on the streets, was homeless and overdosed on fentanyl (powerful opioid pain medication, illicitly used is a major contributor to fatal overdoses) about two months ago. Reported being physically abused by a parent and sexually abused by someone who drugged the resident;-Needs or continues to need (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	individual, family or group psychotherapy, health behavior assessment and intervention and required ongoing psychiatric care and treatment;-The resident needed support and services. Maintain environment with low stimulation, minimum of visual/auditory distraction and/or sensory supports. Provide for individual personal space. Establish consistent routines, providing a schedule of daily tasks and activities. Review of the resident's physician order sheet (POS) dated 10/28/25 showed the following:-admission date 10/28/25;-Psychiatric evaluation and treatment as needed;-Buprenorphine (medication used to treat opioid use disorder and manage chronic pain by reducing cravings and withdrawal symptoms) 2 milligram (mg) administer one tablet under the tongue at bedtime;-Bupropion (antidepressant medication used to treat major depressive disorder) 300 mg daily;-Clonazepam (antianxiety medication) 1 mg three times daily for anxiety;-Clonidine (medication used to treat high blood pressure, ADHD and sometimes substance withdrawal) 0.5 mg, administer one-half tablet three times daily;-Diphenhydramine (antihistamine medication used to treat allergies, insomnia, motion sickness) 25 mg every eight hours as needed for itching;-Doxepin (antidepressant medication used to treat insomnia, depression and anxiety) 25 mg two capsules at bedtime;-Hydroxyzine (antianxiety medication also used for tension, allergic reactions and pre-surgical sedation) 50 mg every eight hours as needed for anxiety;-Melatonin (over the counter sleep aid medication) 5 mg, administer two at bedtime;-Gabapentin (medication used for neurological pain and also used for anxiety) 600 mg three times daily;-Olanzapine (antipsychotic medication used to treat schizophrenias and bipolar disorder) 10 mg at bedtime. Review of the resident's comprehensive Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 12/09/25, showed the following:-Cognitively intact;-No hallucinations or delusions;-No impaired mobility and required no assistive device;-Independent in Activities of Daily Living (ADLs). Review of the resident's care plan, updated 12/19/25, showed the following:-Diagnoses of suicidal ideations, mood disorder, attention-deficit hyperactivity disorder (ADHD, neuro disorder with persistent inattention, hyperactivity and impulsivity that interferes with daily functioning), opioid abuse (abuse of narcotic medication), anxiety disorder, insomnia (inability to sleep) due to other mental disorder, adjustment disorder with depressed mood;-The resident was at risk for nervousness, pacing on the unit and restlessness related to anxiety. Staff should closely watch for signs of anxiety and act before the resident lost control. Do not argue or tell the resident they are wrong when he/she was upset, do not get into a power struggle with the resident, offer activities to keep the resident from getting bored and provide opportunity to release energy in a healthy way, offer medication before a behavioral outburst occurred, offer non-invasive coping mechanisms first to try to reduce anxiety level. Assist with finding the cause of the anxiety;-The resident had a diagnosis of ADHD. Staff should establish consistent routines;-History of post-traumatic stress disorder (PTSD). PTSD affected the resident's symptoms and may flare up without any known trigger. PTSD was attributed to his/her sibling's suicide and loss of a child. Staff should assess anxiety level, determine severity of condition and course of treatment or therapy needs, assess for suicidal or homicidal ideations to ensure safety of the resident and others, encourage resident o express emotions in a safe environment. Allow resident the freedom to acknowledge feelings and release any repressed emotions. A safe environment should be free from actual or perceived judgement and physical or perceived danger. Encourage the resident to verbally identify current ineffective coping techniques, provide calming and reassuring environment and provide counseling when needed;-The resident's history included a long family history of mental health issues, being significantly bullied at school, sibling committed suicide when the resident was in high school and led to the resident quitting school. At [AGE] years old the resident lost two friends in a car accident. Became homeless but still saw his/her child weekly until the child passed away;-The resident had a coping psychotic disorder. Staff should determine the resident's coping methods, encourage participation in self-calming behaviors such as breathing exercise, meditation or guided imagery, encourage times of rest and relaxation between care activities, evaluate verbal expressions (continued on next page)

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	265526	A. Building B. Wing	03/12/2026

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

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F 0742 Level of Harm - Actual harm Residents Affected - Few	of fear, provide reassurance and when possible, provide continuity of care amongst care providers;-The resident was independent with ADLs. Staff should provide protective oversight and assist as needed. Review of the resident's suicide severity risk assessment, dated 02/09/26, showed the resident had not wished they were dead or could go to sleep and not wake up in the past month, had not thought about killing self in the past month, had not previously done anything or prepared to do anything to end his/her life. The resident scored zero and was considered low risk on the suicide severity rating scale. Review of the resident's nurses' notes showed staff documented the following:-On 02/10/26 at 5:48 P.M., call received from guardian/parent, reported the resident voiced self-harm ideations. The resident came to the dining room while staff spoke with the guardian. Resident had flat affect. Assessed the resident for any marks or self-harm, no red marks noted on arms, neck or torso. Placed resident one-on-one staff supervision. Administrative staff, physician and psychiatric Nurse Practitioner (NP) notified;-On 02/10/26 at 6:13 P.M., resident was one-on-one with staff for safety. Staff needed to search the resident's room and remove any harmful objects for safety. Review of the resident's nurses' notes showed the following:-On 02/12/26 at 4:00 P.M., phone call received from 911 dispatcher. The resident called 911 (Emergency Medical Services - EMS) from the bathroom on his/her personal cell phone. The one-on-one staff member sat outside the resident's bathroom door. The resident refused to leave the bathroom. The Assistant Director of Nursing (ADON) arrived, and the resident came out of the bathroom. The ADON spoke with the 911 dispatcher and the phone call ended. Another resident had an emergency on the other side of the facility. The ADON and charge nurse responded to the other emergency. The one-on-one staff member remained with the resident. The resident became agitated and knocked over linen carts and threw things. The resident went to his/her room and tried to break the window to get out. Staff calmed the resident; the resident called his/her parent/guardian. The resident was safe and continued with one-on one staff monitoring;-On 02/12/26 at 5:00 P.M., the resident broke the glass window in his/her room. The resident was not speaking, sat on the bed surrounded by glass. Resident escorted to the dining room, three scratches on the inside of the forearm. Pressure held to stop bleeding, wounds cleansed and covered with a wound bandage. Small cut on the middle finger of the right hand. The resident's physician and guardian were notified. Review of the resident's psychosocial post-incident impact note, dated 02/12/26 at 5:45 P.M., showed the resident was the aggressor in an incident. He/She did not answer when asked if he/she felt safe or felt the need to talk with someone. The resident did not answer when asked if he/she could identify a staff member the resident felt safe with to share thoughts and feelings. The resident said he/she wanted to go to the hospital. Review of the resident's nurses' notes showed staff documented the following:-On 02/12/26 at 5:56 P.M., EMS transported the resident to the emergency department for evaluation;-On 02/12/26 at 6:57 P.M., report called to the emergency department. Reported recent behavior of breaking the window, laceration to the left inner forearm, increased anxiety and elopement risk. Review of the resident's care plan, updated 02/12/26, showed the resident broke out the window in his/her room. Staff should provide intensive monitoring, education on use of coping skills and review of coping skills. Review of the resident's nurses' notes dated 02/18/26 at 11:00 P.M. showed staff documented the resident returned from the hospital to the facility at 5:15 P.M. Resident placed on every 15-minute checks for safety. Pleasant mood, no complaints of suicidal ideations. Attended smoke break and ate a snack. Review of the resident's hospital discharge orders dated 02/18/26 showed the following new medication and treatment orders:-hospitalized for suicidal ideations and self inflicted superficial lacerations of the left forearm;-Buprenorphine-Naloxone (Suboxone) (a combination drug used to treat opioid use disorder and treat overdose) 8-2 mg one film under the tongue (a film containing the medication absorbed when placed under the tongue) every morning;-Bupropion increase to 300 mg daily;-Discontinue clonazepam, gabapentin and buprenorphine;-The resident's medications had been reviewed and/or adjusted. The resident was no longer a danger to self or others;-Follow up with facility providers. Review of the resident's POS dated 02/18/26 showed the following:-Psychiatric evaluation and treatment as (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	needed;-Buprenorphine-Naloxone 8-2 mg one film under the tongue every morning;-Bupropion 300 mg daily;-Clonidine 0.1 mg, administer one-half tablet three times daily;-Diphenhydramine (antihistamine medication used to treat allergies, insomnia, motion sickness) 25 mg every eight hours as needed for itching;-Melatonin (over the counter sleep aid medication) 5 mg, administer two at bedtime;-Olanzapine (antipsychotic medication used to treat schizophrenias and bipolar disorder) 10 mg at bedtime. Review of the resident's suicide severity risk assessment, dated 02/19/26, showed the resident had wished they were dead or could go to sleep and not wake up in the past month, had thoughts about killing self in the past month and thought about how he/she might kill self with some intention of acting on these thoughts, started to work out details of how to kill themselves with no intention to carry out the plan. The resident had previously done something or prepared to do something to end his/her life in the past month. The resident scored 36 and was considered high risk on the suicide severity rating scale. The care plan was updated. Review of the resident's care plan, updated 02/19/26, showed the following:-The resident's suicide risk assessment indicated a high risk for suicide. Staff should keep the resident safe in a protected environment, provide proper tools and coping skills to aide through a crisis to reduce suicidal ideation by administering medications as ordered, relocate to soothing environment, remove items from the room that could be used in the resident's suicide plan and provide suicide/crisis hotline and resources;-The resident had a behavior management problem. Staff should ensure the safety of the resident and others, establish boundaries and limits with the resident, monitor cognitive, emotional and environmental factors that contributed to a behavior, provide emotional support regarding new onset delusions and repetitive behavior, utilize diversion techniques as needed and provide protective oversight. Staff should initiate visual supervision during acute episodes. Review of the resident's nurses notes showed staff documented the following:-On 02/21/26 at 4:54 P.M., the resident approached the charge nurse and said he/she needed attention. Blood leaked moderately from several slash wounds on the resident's forearm. The resident said he/she did it again, clarifying the resident cut his/her arm while alone in his/her room. Several long slash marks noted from the elbow to the wrist some with depth up to two millimeters. Wounds cleansed and bandages applied with pressure to stop bleeding. The resident expressed his/her feelings of sadness and hopelessness. The resident was embarrassed and tried to hide the wounds from the staff. Allowed the resident to express his/her emotions and pointed out several peers and staff members to build a friendship with or talk to. Staff checked the resident's room for objects that could cause harm. The physician and guardian were notified. Physician orders received for transfer to the emergency department for treatment. The guardian reported the resident was increasingly hostile toward him/her making frequent statement such as I hope you die, you stupid whore and the resident felt as though he/she was losing his/her mind;-On 02/22/26 at 2:00 A.M., the resident returned to the facility. Resident one-on-one staff observation. Dressing to left forearm. The resident said he/she planned to break out the window and get out of the facility tomorrow or sooner;-On 02/22/26 at 2:22 A.M., the resident was angry about being one-on-one with staff. The resident tried to pull the privacy curtain and close the door to obscure the view of the resident and window leaving him/her unsafe and unattended. Re-educated the resident of need to be in arm's length and full view for safety/supervision related to his/her suicidal ideations and self-harm attempts;-On 02/22/26 at 1:54 P.M., the resident remained one-on-one for safety. Staff checked the resident's room for safety. The resident initiated conversation with the charge nurse about the incident, saying he/she felt better than the previous day but was still depressed;-On 02/22/26 at 2:28 P.M., the resident approached the charge nurse and asked for something for anxiety. The resident had a nervous look on his/her face, turned away slightly toward the wall when speaking and was running fingers through his/her hair. When asked what coping skills the resident used, the resident said he/she sat in his/her room with one-on-one staff member and talked with other residents. The charge nurse called the psychiatric NP and received as needed order for Haldol (antipsychotic medication used to treat schizophrenia and behavioral problems). Review of the resident's physician order sheet (continued on next page)

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