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	04/30/2026

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 adequate supervision for one resident (Resident #88), who was under guardianship, resided on a locked behavior unit, and had a history of elopement and polysubstance abuse, in a review of 30 residents, to ensure the resident did not leave the facility without staff's knowledge. Staff identified the resident was at risk for elopement. Staff reported they were to conduct 15-minute checks, and the resident's care plan identified staff were to ensure the resident was in view when outside in the courtyard. Staff did not consistently document 15 minute checks were completed. On 2/13/26, a resident notified staff he/she observed Resident #88 leave the facility through the plexiglass window in his/her room, hopped the fence, got into a car with someone in the parking lot, then came back in the same way he/she went out. Staff placed the resident on one-on-one supervision following the incident and then placed the resident on 15 minute face checks. On 04/24/26, while in the locked behavioral unit courtyard, the resident climbed onto the facility's roof and over a fence without being seen by staff. Staff outside the courtyard observed the resident leave the facility in a sports utility vehicle that was waiting for the resident. The resident reported he/she left the facility to buy drugs for other residents. The resident told police he/she had been selling methamphetamine (illegal drug) inside the facility. Resident #41 reported he/she purchased illegal drugs from Resident #88 while in the facility. Resident #88 reported he/she left the facility without staff's knowledge multiple times prior to 04/24/26 to purchase drugs for other residents. The facility also failed to secure hazardous chemicals in a storage room on the 400 hall (a secured behavioral health unit) to ensure residents did not have access to the chemicals. The facility census was 116.The administrator was notified of the Immediate Jeopardy (IJ) on 04/26/26 at 5:00 P.M. which began on 04/24/26. The IJ was removed on 04/28/26 as confirmed by the surveyor onsite verification. Review of the facility policy, Elopement and Wandering Residents, dated 06/12/24, showed the following:-The facility ensures 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;-Residents 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 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 (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	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;-Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol;-Code [NAME] for elopement from the facility;-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;-Documentation in the medical record will include findings from nursing and social service assessments, physician/family notification, care plan discussions and consultant notes as applicable. Review of the facility policy, Intensive Monitoring, 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 interdisciplinary team (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 08/26/25, showed the following:-Diagnoses of bipolar disorder (mood disorder that can cause intense mood swings), schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder), post-traumatic stress disorder (PTSD, mental health condition triggered by experiencing or witnessing terrifying events), antisocial personality disorder (mental health condition characterized by a lack of regard or remorse for others), psychosis (mental health condition characterized by a disconnection from reality), generalized, and substance abuse;-History of severe polysubstance abuse. The individual's limitations include limited insight, poor judgment and ongoing behavioral concerns (aggression, sexually inappropriate); -The resident needed support and services. Provide environmental support to prevent elopement. Assess and plan for the level of supervision required to prevent harm to self or others. Provide for individual personal space. Establish consistent routines, providing a schedule of daily tasks and activities. Review of the resident's care plan, dated 04/25/25, showed the following:-Special instructions included high elopement risk. May be outside in smoke area 15 minutes at a time by himself/herself. Must be in view and not past 600 hall. May have no visitors at the facility unless it is guardian approved. -The resident was at risk for elopement due to a history of elopement from a prior secure facility. The resident will be monitored closely, remain safe and will not elope from facility. The facility will complete an elopement risk assessment on admission, readmission and quarterly. Face checks/intensive monitoring will be completed per facility protocol. The resident will not go into courtyard without staff supervision. Review of the resident's elopement risk evaluation, dated 02/11/26, showed the following:-History of elopement or an attempted elopement while at home;-History of elopement or attempts to leave the facility without informing staff;-The resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door;-The resident's wandering behavior is a pattern, goal-directed, aimlessly (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and non-goal directed, likely to affect the safety or well-being of self/others and the privacy of others;-Score of seven, indicating the resident was at risk of elopement (score of one or higher indicated risk of elopement). Review of the resident's nurses' notes, dated 02/13/26, showed at 11:00 P.M., a resident notified the team lead that Resident #88 went out the plexiglass window, hopped the fence, got into a car with someone, sat in the parking lot, then came back in the same way he/she went out. The team leader alerted the nurse. Staff searched the resident's room and discovered the screen was missing out of the left window, but the window was intact. When they tried to close the left window, they noticed the top left of the middle window looked like it was poking out. When the staff member poked at the window to see if it was still attached, the plexiglass window fell out. There was evidence of wood shavings and paint shavings on the inside of the windowsill. The resident said he/she did not go anywhere, and a hurricane broke the window. Staff placed the resident on one-on-one for safety. Maintenance staff boarded up the window until they could fix it properly. During an interview on 04/27/26, at 10:34 A.M., the Staffing Coordinator said he fixed the window in the resident's room in February. It looked like the resident moved the window repeatedly until the glass popped out. Review of the resident's care plan, dated 02/13/26, showed the following:-Special instructions included high elopement risk. May be outside in smoke area 15 minutes at a time by himself/herself. The resident must be in view and not past the 600 hall. May have no visitors at the facility unless it is guardian approved. -The resident was at risk for elopement due to a history of elopement from a prior secure facility. The resident will be monitored closely, remain safe and will not elope from facility. The facility will complete an elopement risk assessment on admission, readmission and quarterly. Face checks/intensive monitoring will be completed per facility protocol. The resident will not go into courtyard without staff supervision. One-on-one for protective oversight unless agitates resident. Educate residents about not leaving the facility, not tampering with facility property and covenant guidelines. Educate staff on elopement risk, face checks, monitoring lighters, checking residents when returning from leave of absence and management notification. Review of the resident's elopement risk evaluation, dated 02/14/26, showed the following:-History of elopement or attempts to leave the facility without informing staff;-The resident wanders;-Score of two, indicating the resident was at risk of elopement (score of one or higher indicated risk of elopement). Review of the resident's nurses notes, dated 02/17/26, showed staff documented the following:-At 3:46 A.M., the resident remains on 15-minute checks for protective oversight;-At 5:33 P.M., the resident was on 15-minute checks. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 04/18/26, showed the following:-Cognitively intact;-No impaired mobility and required no assistive device. -No wandering behaviors. Review of the resident's monitoring task documentation, dated 4/14/26 through 4/24/26, showed the following:-The resident was on 15-minute face checks during the day and every hour face checks during hours of sleep (HS);-On 4/14/26, staff documented a face check on 1:51 A.M. and not again until 4:34 A.M. (2 hours and 43 minutes between checks) and at 6:29 A.M. (1 hour and 55 minutes between checks);-On 4/14/26, staff documented a face check at 12:05 P.M. and not again until 2:04 P.M. (1 hour and 59 minutes between checks) and again at 3:10 P.M. (1 hour and 6 minutes between checks);-On 4/14/26, staff documented a face check at 4:55 P.M. and not again until 6:15 P.M. (1 hour and 20 minute between checks) and then again at 8:18 P.M. (2 hours and 3 minutes since the last check); -On 4/15/26, staff documented a face check at 12:14 A.M. and not again until 2:24 A.M. (2 hours and 10 minutes between checks) and not again until 5:01 A.M. (2 hours and 37 minutes between checks);-On 4/15/26, staff documented a face check at 6:27 A.M. and not again until 11:01 A.M. (4 hour and 34 minutes between checks);-On 4/15/26, staff documented a face check at 11:42 A.M. and not again until 1:59 P.M. (2 hours and 17 minutes between checks);-On 4/15/26, staff documented a face check at 2:00 P.M. and not again until 4:46 P.M. (2 hours and 46 minutes between checks);-On 4/15/26, staff documented a face check at 6:11 P.M. and not again until 8:27 P.M. (2 hours and 16 minutes between checks);-On (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	made four or five runs (out of the facility) to get drugs, but staff caught him/her on 04/24/26. He/She shouldn't have tried to leave in the middle of a weekday. Usually, he/she jumped the fence and was back to the facility within an hour. He/She called people to take him/her to get the drugs. Sometimes, the people he/she called brought drugs to him/her. He/She went to their vehicle and then came back into the facility. He/She purchased the drugs with money he/she received from other residents;-He/She called friends he/she met when in another facility to pick him/her up on 04/24/26;-He/She went with them to their home in another town (approximately 20 miles away); -He/She cannot tell if he/she took anything or not; that would make it worse for him/her;-He/She had $200 when he/she left the facility but did not have money or drugs when he/she arrived back at the facility. During interviews on 04/26/26 and 04/29/26 at 8:58 A.M. and 11:44 A.M., CMT B said the following: -Resident #88 had special instructions on the care plan before the elopement that he/she could be outside unsupervised for 15 minutes;-He/She worked on Station Two where Resident #88 resides;-On 04/24/26, he/she was the Team Lead (TL) or staff member in charge on Station Two;-On 04/24/26, he/she saw the resident on the unit in the dining room around 11:30 A.M.;-He/She left the facility, and when he/she returned, staff told him/her someone saw the resident get into an older black SUV with white decals on the back;-He/She and the Activity Director searched for the resident in his/her personal vehicle and saw the black SUV leaving town; -They followed the vehicle to a residence in another town approximately 20 minutes away from the facility;-The resident was cooperative and got in the car with them; -The resident had purple discoloration on the back of both of his/her arm. The resident complained of cotton mouth, and his/her eyes were dilated;-The resident looked high (under the influence), but never admitted to using any substances;-He/She heard the resident went over the fence, got in a car and came back in once a couple of months ago but no other times. During an interview on 04/26/26, at 4:25 P.M., the Activity Director said the following;-The Staffing Coordinator saw Resident #88 get into a black SUV in the facility's parking lot;-The staff called a Code [NAME] (missing person); staff could not find the resident;-She and CMT B looked for the resident in the community;-They saw an SUV that matched the description from the Staffing Coordinator, headed out of town;-They lost the vehicle, so they called back to the facility;-When the resident was in another facility (in the same town where staff found the resident), some staff were friendly with the resident;-They got the address of one of the people who was close to the resident;-She and CMT B drove around those neighborhoods, and they saw an SUV matching the description; -She and CMT B saw Resident #88 walking to the vehicle with two people;-The resident said he had $200 on him/her when he/she left, but did not have the money now;-The resident got into the car with them and they returned to the facility. Review of the Police department report, dated 04/24/26 at 11:58 A.M., showed on 04/24/26 at approximately 11:58 P.M., Police Officer J responded to the facility for a reported missing person. Police Officer J arrived on scene and spoke to a staff member who observed the resident getting into the back seat of an unknown black SUV at approximately 11:35 P.M. After staff looked for the resident for approximately 25 minutes, the police were notified and reported the resident missing. Police Officer J was told the resident told other residents he/she was going to get drugs. Police Officer J went to the last known location of the resident which was a grassy enclosed area behind the facility. Police Officer J observed ductwork with a large dent on the top and above it, saw a gutter which appeared to be loose and had a large, loose nail falling out. Police Officer J, while standing on the ground with flat feet, could easily reach the gutter at that spot. It is possible for a resident in good physical condition to hoist themselves up on the roof by themselves, or with the aid of another resident. The administrator said the resident has escaped before and is always located in the same town approximately 20 miles away. Later the same day, a staff member located the resident in a residential area in the town 20 miles away. The resident was secured in the staff member's vehicle and brought back to the facility. Staff searched the resident before going into the facility. The resident told Police Officer J he/she had been selling methamphetamine inside the facility so he/she could acquire enough funds to go to Honduras and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	cure cancer. Call closed at 02:41 P.M. During an interview on 04/27/16 at 01:16 P.M., Police Officer J said the following:-Staff reported a staff member saw the resident get in the back seat of a black SUV in the facility parking lot at 11:35 P.M.;-Staff reported the resident was outside before leaving the facility property without staff supervision;-After the facility identified the resident was missing, staff looked for the resident for 20-30 minutes before reporting to the police;-A staff member drove through a residential area in another town, saw the resident, and picked him/her up;-The resident returned to the facility approximately at 2:30 P.M.;-He/She was still at the facility when the resident returned;-The resident said he/she told another resident he/she was getting dope (slang for drugs);-The resident said he/she was selling dope in the facility to get enough money to go to Honduras to cure cancer. During an interview on 04/26/26, 4/27/26 and 04/30/26, at 5:27 P.M., 12:21 P.M. and 3:00 P.M., the Administrator said the following:-The resident had a history of elopement in his/her previous facility;-At the previous facility the resident used a chair and climbed on the roof;-Staff were aware of the resident's elopement history; -The resident had been working the program and was doing well and was allowed to go outside unsupervised;-The resident's care plan had an intervention of one-on-one for protective oversight in the past, but the resident had not been on one-on-one for some time;-If a resident had a known history of elopement, staff should supervise them when outside; -The resident eloped from the facility on 04/24/26 right after the 11:00 A.M. smoke break;-The Staffing Coordinator was outside and saw someone matching Resident #88's build run and get into a black SUV;-Staff called a Code [NAME] and searched for the resident in the building and in the community;-When the resident eloped from the previous facility, he/she was found with the previous facility's employees;-She sent staff to drive through the areas in the town where the individuals (from the previous facility) resided; -Facility staff spotted the resident carrying a speaker and walking with two people to the black SUV;-The facility staff returned the resident to the facility;-The resident was gone less than two hours and was back at the facility around 1:30 P.M.;-When the resident returned to the facility, he/she said he/she was trying to go to Honduras to help his/her family member;-The resident said he/she did not take any illicit drugs while he/she was out. The facility did not drug test the resident. She did not feel the resident was impaired. During an interview on 04/26/26, at 11:08 A.M., Resident #23 said the following:-Resident #88 eloped from the facility on 04/24/26;-When Resident #88 returned, he/she was high and was stumbling and slurring his/her words. During an interview on 04/26/26, at 11:19 A.M., Resident #6 said the following:-Resident #88 eloped the facility on 04/24/26;-When Resident #88 came back, he/she was strung out;-Resident #88 couldn't even hold a conversation when he/she returned and his/her pupils were dilated. During an interview on 04/27/26 at 9:38 A.M., Resident #41 said the following:- Runners sneak out of the facility by going over the fence and bring drugs back into the facility;-The residents coordinate drug deals on their cell phones. Resident #88 coordinated a drug deal last Friday (04/24/26).-He/She saw Resident #88 get onto the roof and climb over the fence on 04/24/26;-He/She took methamphetamines and cocaine while in the facility; -He/She purchased drugs in the facility from Resident #88;-He/She would not confirm what drugs he/she purchased from Resident #88;-Other residents bring drugs back when going out of the facility on pass;-The residents give whoever is going to get the drugs money before the resident leaves and then gets drugs when the resident returns to the facility;-Residents can get any drugs they want in this facility, such as cocaine, crack, meth, Xanax and Adderall. During an interview on 04/28/26 at 9:52 A.M., CMT A said the following:-He/She worked 04/24/26 on Station Two when Resident #88 eloped;-He/She was in another resident's room providing care;-Staff should supervise any resident at risk for elopement, including Resident #88, when they were outside;-He/She did not know if staff were in the courtyard when the resident eloped on 04/24/26. During an interview on 04/27/26 at 07:38P.M., Staffing/Mentor/Educator said the following:-The resident eloped on 04/24/26;-The resident was on 15-minute checks before he/she eloped on 04/24/26. During an interview on 04/30/26 at 04:18 P.M., the resident's guardian said the following:-The facility notified him/her of Resident #88's elopement (continued on next page)

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	265526	A. Building B. Wing	04/30/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on 04/24/26;-The Administrator said the resident got into a car around 11:30 A.M. and left the facility;-The SSD notified his/her office when the resident returned to the facility;-The SSD said the resident was located in a residential area, and the resident said he/she was trying to buy meth (an illegal drug). 2. Review of the facility policy, Chemical Storage and Labeling, dated 02/02/24, showed the following:-To ensure all chemicals are stored safely:-Chemicals must be stored in a vented room;-The chemical storage room must remain locked at all times when someone is not in the storage room;-Only the Housekeeping/Environmental Services Manager and his/her designee will have access to the chemical room. Observation on 04/26/26 at 10:50 A.M., showed the following:-The door to the storage room on the 400 hall (located in a locked unit) was not closed and locked and stood open 2 inches;-Four unidentified residents walked back and forth in the hallway past the room;-No staff were on the hall or site of the storage room;-Observation inside the storage room showed: -Seven bottles of Acid Bowl Cleaner (Royal); -Three bottles of Restroom Disinfectant (SparCling); -Seventeen containers of Comet Deodorizing Cleaner; -Five large bottles of Heavy-Duty Degreaser and Cleaner Concentrate (All-Pro); -Spray bottle with Peroxy handwritten on the bottle; -Spray bottle with Peroxy 4 D handwritten on the bottle; -Five one-gallon bottles of Enzyme Floor Cleaner (Sure Step); -One large spray bottle of Coffee and Tea Carafate Cleaner (SparClean); -Three one-gallon Delimer (SparClean); -Five one-gallon bottles Silverware Pre-Soak (SparClean); -Six one-gallon bottles Clean by 4D; -Two five-gallon buckets of Low Temperature Rinse Aid (SparClean); -One five-gallon bucket of LIQ Nature's Way (Natural Digestant for Municipal and Industrial Wastewater Treatment, Consume); -One five-gallon bucket of Pot and Pan Detergent (SparClean); -One five-gallon bucket of Metal Safe Machine Dish Detergent (SparClean); -Two five-gallon bucket of Low Temperature Dish Machine Detergent (SuperSmart). Observation 04/26/26 at 2:33 P.M., showed the door to the storage room on the 400 hall was not latched into the door frame and was able to be opened freely. The storage room contained bottles and buckets of chemicals as observed on 04/26/26 at 10:50 A.M. Two unidentified residents walked up and down the 400 hall. No staff were present on the hall. Review of the Material Safety Data Sheet (MSDS) for Royal Acid Bowl Cleanser showed the following:-Hazards Identification: -Signal Word: DANGER; -Hazards: Corrosive to metals, causes severe skin burns and serious eye damage; -Inhalation: Harmful if inhaled; may cause damage to respiratory tract; -Ingestion: Harmful or fatal if swallowed;-Handling and Storage: keep in a locked area in the original container. Review of the MSDS for SparCling Restroom Disinfectant showed the following:-The product was highly acidic;-Hazards: Contains Hydrochloric Acid, causing severe skin burns and eye damage;-Safety Measures: Harmful if inhaled; -First Aid: If in eyes or on skin, immediately rinse with water and seek medical attention;-Harmful if swallowed - symptoms may cause nausea, vomiting, pain and diarrhea. Review of the MSDS for Comet Deodorizing Cleaner showed the following:-Hazardous by OSHA criteria;-Ingestion may cause gastrointestinal irritation, nausea, vomiting and diarrhea; Review of the MSDS for Heavy-Duty Degreaser and Cleaner Concentrate (All-Pro) showed the following:-Signal word: DANGER; Hazardous;-If swallowed could cause gastric perforation or perforation of the esophagus and stomach;-Store securely, locked up. Review of the MSDS for Peroxy showed the product was hazardous and harmful if swallowed. Review of the MSDS for Peroxy 4 D showed the following:-Combustible liquid;-Harmful if swallowed and causes severe skin burns and eye damage;-Corrosive. Review of the MSDS for Sure Step Enzyme Floor Cleaner showed the product was hazardous and may be harmful if swallowed. Review of the MSDS for SparClean Coffee and Tea Carafate Cleaner showed product was hazardous and may be harmful if swallowed. Review of the MSDS for SparClean Delimer showed the following:-Corrosive; -Danger: harmful if inhaled or swallowed;-Store locked up. Review of the MSDS for Silverware Pre-Soak (SparClean) showed the following:-Causes serious eye irritation and may be harmful if swallowed;-Hazard Category: Acute Toxicity;-Keep it stored locked up. Review of the MSDS for Clean by 4D showed the following:-Product is a combustible liquid;-Can cause serious eye damage, skin irritation and harmful if inhaled or swallowed;-Hazard category: Acute toxicity;-Keep it stored locked (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to treat one resident (Resident #79), in a review of 30 sampled residents, with dignity and respect when staff did not provide reasonable accommodation with toileting and told the resident to urinate and defecate in his/her bed. The facility census was 85. Review of the facility policy, Promoting/Maintaining Resident Dignity, revised 9/21/25, showed the following:-It is the practice of this facility protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality;-Every resident has a right to be treated with dignity and respect;-All staff will speak to and treat all residents with dignity and respect;-All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights;-The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences;-When interacting with a resident, pay attention to the resident as an individual;-Respond to requests for assistance in a timely manner;-Groom and dress residents according to resident preference. Review of Resident #79's face sheet, showed the following:-admitted on [DATE];-He/She was his/her own responsible party.-Diagnoses included generalized anxiety disorder, major depressive disorder, borderline personality disorder (a mental health condition characterized by pervasive pattern of instability in moods, self-image, behavior and relationships), post-traumatic stress disorder (PTSD) (a mental health condition triggered by experiencing or witnessing terrifying events, causing long-lasting flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the trauma), agoraphobia with panic disorder (an intense fear of situations where escape might be difficult or help unavailable), need for assistance with personal care, and closed (fracture with the skin intact) displaced (out of alignment) intertrochanteric (a fracture of the hip) fracture or right femur. Review of the resident's comprehensive care plan, dated 3/27/26, showed the following:-He/She had an activities of daily living (ADL) self-care performance deficit related to activity intolerance, impaired balance, limited mobility and leg fracture;-He/She was totally dependent on one staff for personal hygiene;-He/She required assistance from one staff for toileting and to move between surfaces;-Provide the resident with as many situations as possible which give the resident control over the resident's environment and care delivery. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/30/26, showed the following:-Cognitively intact;-Dependent on staff for toileting hygiene and personal hygiene;-Dependent on staff for toilet transfers;-Frequently incontinent of bowel and bladder. Review of the resident's orthopedic consult note, dated 4/16/26, showed the following:-Continue therapy as ordered;-Weight bearing as tolerated to the right lower extremity, no restrictions. Observation on 4/26/26 at 2:37 PM showed the following:-Nursing Assistant (NA) E, NA S and NA T transferred the resident from his/her wheelchair to the bed with a hoyer lift (mechanical lift);-After the transfer, the resident told staff he/she would like to use the bathroom;-NA S asked the resident if he/she wanted staff to remove his/her pants so he/she could go, then staff could clean him/her after going;-The resident was visibly uncomfortable with the question and said he/she was uncomfortable with the amount of staff present (three aides, one supervisory staff, and the state agency (SA) staff);-Seeing the resident's discomfort, the SA staff excused themselves from the room. Review of the resident's progress notes, dated 4/26/26 at 4:08 P.M., showed staff transferred the resident to bed with a hoyer lift. The resident refused the bedpan and had a bowel movement in the bed. Staff provided perineal care. During interviews on 4/27/26 at 5:50 P.M. and 4/29/26 at 4:01 P.M., the resident said the following:-He/She no longer used the bedpan because it left an indentation when staff left him/her sitting on it for a long period of time when (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	he/she first arrived at the facility;-Since that time, he/she had a fear of being forgotten when using the bedpan, so staff told him/her to soil himself/herself, then staff cleaned him/her;-Staff never offered a way to transfer him/her to a toilet or commode;-He/She did not like being told to soil himself/herself;-He/She felt embarrassed, dirty, and undignified when staff told him/her to soil himself/herself and to wait for staff to clean him/her. During an interview on 4/30/26 at 4:15 P.M., NA S said the following:-The resident used a hoyer lift to transfer;-Sometimes, the resident refused to use the bedpan because it hurt him/her too much;-He/She did not believe the facility had any hoyer lift pads with openings for residents to use the commode; he/she had never asked;-He/She just made sure the resident took his/her pants off before going (to the bathroom) so the resident wouldn't soil his/her clothes. During an interview on 4/30/26 at 4:21 P.M., Licensed Practical Nurse (LPN) U said the following:-The resident was cleared for weight-bearing as tolerated, but therapy had not released him/her, so he/she was still a hoyer transfer;-He/She believed the facility had a hoyer lift pad with an opening if the resident preferred to use the toilet or commode;-He/She did not believe it was ever acceptable to have a resident soil themselves. Staff should offer every available option. If the resident refused, staff should document the refusal. During an interview on 4/30/26 at 6:03 P.M., the interim Director of Nursing (DON) said the following:-Staff should treat residents with dignity and respect;-Staff should speak to residents as they would like to be spoken to;-Staff should offer a residents the restroom, commode or bedpan, according to their condition;-Staff should not tell residents to soil themselves. During an interview on 4/30/26 at 6:03 P.M. the Administrator said the following:-Staff should treat residents with dignity and respect;-Staff should speak to residents with kind words;-Staff should offer residents the toilet or commode first. If the resident was unable to use these, the bedpan would be an acceptable alternative;-The facility had a hoyer lift pad with a hole that would allow staff to transfer resident to the toilet or commode.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure one resident (Resident #4) was free from physical abuse when Resident #3 hit Resident #4 in the head multiple times. The facility also failed to ensure one resident (Resident #7) was free from verbal abuse and intimidation when Residents #3, #5, and #6 entered Resident #7's room and verbally intimidated and threatened to harm Resident #7 if he/she snitched on them for doing drugs and/or bringing drugs into the facility. The facility census was 111. Review of the facility's policy, Abuse and Neglect, dated 06/12/26, showed the following:-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish, which can include resident to resident altercations;-Physical abuse is purposefully beating, striking, wounding, or injuring any resident or in any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner;-Physical abuse includes hitting, slapping, and punching;-Verbal abuse means the use of oral, written or gestured language that willfully includes disparaging derogatory terms to residents or within their hearing distance regardless of their age, ability to comprehend, or disability. This includes using profanity or speaking in a threatening or derogatory manner in a resident's presence. Examples include harassing a resident, insulting, ridiculing, yelling at a resident with the intent to intimidate, and threatening residents. Review of the facility policy, Resident Rights, dated 09/21/25, showed the residents have the right to be free from verbal, sexual, mental, and physical abuse. 1. Review of Resident #4's Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long-term care), dated 04/01/26, showed the following:-The resident's diagnoses included bipolar disorder (mood disorder that can cause intense mood swings), mood disorder, anxiety disorder, oppositional defiant disorder (ODD, frequent and ongoing pattern of anger, irritability and defiance), and schizophrenia;-The resident was verbally threatening;-The resident had significant emotional dysregulation including difficulty managing mood fluctuations, irritability, and anger. He/She had a history of aggression, agitation, and impaired impulse control;-The resident's condition resulted in significant functional impairment. His/Her insight and judgment are limited, and he/she demonstrates impaired decision making capacity;-The resident had serious difficulty interacting appropriately and communicating effectively with other persons. Review of the resident's progress note, dated 05/29/26 at 2:19 P.M., showed Certified Medication Technician (CMT) E documented the resident was appropriate with staff and peers. The resident had no behaviors this shift. (Review showed no documentation related to a resident-to resident physical altercation in the resident's progress notes dated 05/29/26.) Review of the facility Registered Nurse Investigation, dated 05/29/26, showed the following:-Type of incident: Physical aggression not involving the head;-Witnesses: Certified Nurse Assistant (CNA) E, CMT N, Resident #3 and Resident #4;-Investigative note: Resident #4 was in the dining room screaming, hollering, cussing, and said Resident #3 paid somebody to kill him/her. Resident #3 came in the dining room. Residents #3 and #4 started going off on one another. Resident #3 attacked Resident #4, had him/her on the ground and the residents hit each other. Staff intervened and separated the residents. Resident #3 was placed on one-on-one monitoring;-The altercation was not a result of abuse or neglect. The facility did not identify it as abuse; -The altercation was not preventable because in CMT N's interview she said she tried to talk to Resident #4 or get him/her to calm down in their room. CMT N felt that was all she could do at the time; -Staff provided education and intensive monitoring. During an interview on 06/10/26 at 11:13 A.M., the resident said the following:-Resident #3 gave him/her $140 to buy video games for him/her;-Resident #3 told him/her to keep $40 for getting the games while he/she went on pass on 5/27/26;-He/She returned to the facility and gave Resident #3 $40 and no video games;-On (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	05/29/26, he/she went outside to smoke. Resident #5 was already outside and yelled that he/she (Resident #4) was the type of person to take your money and run. He/She told Resident #5, I should slap the fuck out of you. Resident #5 said he/she and Resident #3 should beat the fuck out of him/her (Resident #4) because he/she (Resident #4) robbed Resident #3;-At this point, staff took him/her back inside the facility and he/she sat at a table in the dining room;-Resident #3 came in the dining room and sat a few tables away from him/her;-He/She confronted Resident #3 because Resident #3 said he/she robbed him/her and Resident #3 was going to pay another resident to beat him/her up;-Resident #3 said he/she was mad Resident #4 took his/her money and did not get a video game. Resident #4 and Resident #3 argued back and forth and then Resident #3 pushed him/her to the floor;-Resident #4 got on his/her knees and grabbed Resident #3's shirt. Resident #3 pinned his/her arms down on the floor and hit him/her (Resident #4) on the side of the head and face;-CMT N separated them and then Resident #3 threw his/her (Resident #4's) phone on the floor and stomped on it;-Resident #4 was sent to the hospital and had x-rays. During an interview on 06/12/26 at 9:27 A.M., CMT N said the following occurred on 05/29/26: -He/She went to the dining room and Resident #4 was screaming and yelling about how Resident #3 wanted to hire someone to beat up him/her;-He/She tried to talk to Resident #4 to calm him/her down or to get him/her to go to his/her room, but Resident #4 would not listen and continued to scream about Resident #3. -Resident #3 came in the dining room and sat a few tables away from Resident #4 and was fine for a few minutes. Resident #4 got up and went towards Resident #3 and they started hitting one another;-He/She immediately separated the residents and called the charge nurse to assess the residents. Review of the resident's Medication Administration Record (MAR), dated 05/29/26, showed the resident received 10 milligrams (mg) olanzapine (antipsychotic) at 3:50 P.M. and 650 mg acetaminophen for a pain level of seven out of 10 at 4:35 P.M. Review of the resident's progress note, dated 05/29/26 at 6:20 P.M., showed Licensed Practical Nurse (LPN) H documented the resident left with emergency medical services to the hospital. Review of the resident's progress note, dated 05/29/26 at 7:28 P.M., showed the following:-LPN I documented Resident #4 had a visit with the psychiatric provider via telehealth after an altercation;-The provider ordered scheduled medication and an as needed medication;-The resident had a hematoma (localized collection of blood caused by an injury to a blood vessel) on the left temple. The resident complained of head pain, blurred vision, and left shoulder pain;-The psychiatric provider ordered staff to send the resident to the hospital for evaluation of the hematoma obtained during the altercation. Review of the resident's hospital records, dated 05/29/26, showed the following: -The resident presented to the hospital with pain in the left side of his/her head above his/her ear and the back of his/her head with a pain level of eight out of 10 (on a scale of zero to 10 with 10 being the most pain). He/She also had left shoulder pain, a headache and blurred vision;-The resident was given intramuscular pain medication;-The resident had x-rays of his/her head, left shoulder, and neck that showed no acute injury or dislocation;-Discharge diagnoses included unspecified injury of head, pain in left shoulder and strain of muscle at the neck. Review of the resident's MAR, dated 05/30/26, showed the resident received 600 milligrams (mg) ibuprofen for a pain level of seven out of 10. Review of the resident's interdisciplinary team (IDT) progress note, dated 06/01/26 at 8:05 A.M. (documented as a late entry) showed the following:-The Social Service Director (SSD) documented the interdisciplinary team (IDT) met with the resident;-The resident said he/she was okay since the physical altercation with a peer;-The resident felt upset his/her phone was broken. IDT told the resident a phone was ordered;-The IDT reminded the resident to talk to staff if he/she had any other issues and the resident said he/she understood. -The resident felt safe at the facility. Review of the resident's MAR, dated 06/01/26, showed the resident received 600 mg ibuprofen for a pain level of six out of 10. During an interview on 6/12/26 at 2:35 P.M., the Regional Nurse said the following:-She investigated the altercation between Residents #3 and #4 and found the root cause was due to the residents trading money for video games;-Staff discouraged the residents from buying, selling, and trading with one another and provided education to the residents;-She did not (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	know Resident #4 had a verbal disagreement outside with Resident #5 before Residents #3 and #4 had a physical altercation. 2. Review of Resident #3's PASRR, dated 11/26/18, showed the following:-The resident's diagnoses included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), psychotic disorder (severe mental disorder that caused abnormal thinking and perceptions), and delusional disorder (serious mental illness where a person experienced one or more persistent fixed false beliefs);-The resident had occasional physical aggression toward staff and peers;-The resident did not make good decisions, destroyed property, and was verbally abusive and threatening;-The resident needed hourly checks and needed to be on a locked unit;-The resident needed a structured setting where he/she could be monitored for mental status changes. Review of the resident's care plan, dated 11/03/25, showed the following:-The resident was at risk for the following signs or symptoms related to his/her diagnosis of schizophrenia: aggression, anxiety, delusions, false beliefs that cannot be reasoned with, and hallucinations;-The resident had a history of behavioral challenges that required protective oversight in a secure setting;-The resident had the potential to be physically aggressive related to poor impulse control. Review of the resident's progress note, dated 05/29/26 at 3:30 P.M. (documented as a late entry), showed the resident said he/she walked up to peer (Resident #4) to explain he/she had the situation wrong. Peer (Resident #4) grabbed the resident's shirt, and the resident attempted to walk away. Peer (Resident #4) continued to grab the resident's shirt, so the resident pushed him/her away and the resident walked away;-The psychiatric physician conducted a telepsych visit with the resident with no new orders or concerns. Review of the resident's care plan, dated 05/29/26, showed the following:-Staff spent one-on-one time with the resident;-Staff educated the resident on going to staff when he/she had an issue with other residents;-Staff educated the resident on not borrowing or letting other residents borrow money from him/her. Review of the resident's telepsych visit, dated 05/29/26, showed the following:-Telepsych evaluated the resident after the resident was the aggressor in an altercation with another resident;-No new orders or concerns were identified at this time. Review of the resident's telehealth notes, dated 05/29/26, showed the following:-The resident was involved in an altercation with another resident;-The resident said the altercation started as verbal over money and turned physical;-The physician planned to continue the current plan of care and medication regimen. Review of the resident's progress note, dated 06/07/26, showed the following:-The resident was verbally abusive with peers (Residents #5, #6, and #7); -The staff intervened and de-escalated the situation;-The resident received an as needed (PRN) medication and felt better. During interviews on 06/11/26 at 8:03 A.M. and 8:13 A.M., the resident said the following:-He/She and Resident #4 were in the dining room when they began yelling at each other;-Resident #4 pulled at his/her shirt and he/she pushed Resident #4 away and Resident #4 fell on the floor; -He/She hit Resident #4 several times in the head when Resident #4 was on the floor. During an interview on 06/11/26 at 8:03 A.M. and 8:13 A.M., the resident said the following:-He/She, along with Residents #5 and #6, went into Resident #7's room and had a talk with Resident #7 (on 06/07/26);-He/She told Resident #7 it would not be wise to snitch on him/her.-Staff separated the residents and removed them from Resident #7's room [ROOM NUMBER]. Review of Resident #6's PASRR, dated 05/27/15, showed the following:-The resident's diagnoses included schizoaffective disorder, bipolar personality disorder, paranoid schizophrenia, borderline intellectual functioning (impairment that impacts learning and reasoning);-The resident did not make good decisions, was easily frustrated, impatient and demanding, and struck others unprovoked;-The resident had a history of agitation, delusions, threatening others, and threatened to scalp a family member:-The resident required an increased level of care and supervision for safety and stabilization of symptoms;-The resident needed a structured environment and a systematic plan to change inappropriate behavior. Review of the resident's care plan, dated 07/07/25, showed the following:-The resident was at risk for the following signs and symptoms related to anxiety: cursing, hollering, and nervousness;-The resident had impaired coping;-The resident was at risk for harm, either self-directed or directed at others;-The resident had potential to be physically aggressive (continued on next page)

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	265526	A. Building B. Wing	04/30/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	related to poor impulse control. Review of the resident's medical record on 06/11/26 showed staff did not document about the verbal altercation that took place in Resident #7's room. During an interview on 06/11/26 at 10:20 A.M., the resident said the following:-He/She went to Resident #7's room with Residents #3 and #5 on 06/07/26 because Resident #7 said Residents #3, #5, and #6 brought drugs to the facility and used drugs at the facility;-He/She told Resident #7 if he/she didn't quit running his/her mouth, they (Residents #3, #5, and #6) were going to beat the fuck out of him/her. 4. Review of Resident #5's PASRR, dated 09/06/23, showed the following:-The resident's diagnoses included schizoaffective disorder (mental health condition that included features of both schizophrenia and mood disorder), bipolar disorder; manic, severe, with psychotic features, and unspecified psychosis (mental disorder involving loss of contact with reality);-The resident had behavioral difficulties and/or mental illness symptoms that required 24-hour monitoring;-The resident had limited insight and poor judgment;-The resident needed continued monitoring of behavioral symptoms and a structured environment. Review of the resident's care plan, dated 3/17/26, showed the following:-The resident had a history of behavioral challenges that required protective oversight in a secure setting;-The resident had an impaired social interaction mood disorder. The resident was educated on appropriate interactions and boundaries with peers and staff;-The resident had a behavior problem related to bipolar and schizoaffective disorder;-Intervene as necessary to protect the rights and safety of others;-Monitor behavior episodes and attempt to determine underlying cause;-The resident had potential to be physically aggressive related to poor impulse control;-When the resident became agitated intervene before agitation escalates. Review of the resident's progress notes, dated 06/07/26, showed the following:-The resident was verbally abusive with peers;-Staff intervened and de-escalated the situation;-The resident was on 15-minute checks for protective oversight. During an interview on 06/11/26 at 10:31 A.M., the resident said he/she told Resident #7 to keep his/her name out of stuff because he/she (Resident #5) hadn't brought drugs into the facility recently. Review of the resident's physician order sheet, dated June 2026, showed an order on 06/07/26 for 50 mg chlorpromazine (an antipsychotic medication) for agitation and anxiety. Review of the resident's MAR, dated 06/07/26, showed CMT C administered 50 mg chlorpromazine for agitation and anxiety. Review of the resident's psychosocial post-incident impact note, dated 06/08/26, showed the resident did not directly involve himself/herself in the incident or witness the incident (no dates were documented for the incident or what the incident was about). 5. Review of Resident #7's PASRR, dated 07/24/18, showed the following:-The resident's diagnoses included bipolar disorder, attention deficit hyperactivity disorder, schizophrenia, learning disorder and borderline intellectual functioning;-The resident would benefit from a structured environment to reduce stress of daily living and to provide emotional support. Review of the resident's care plan, dated 07/27/2024, showed the following:-The resident had a safety plan that included music for distraction and/or comfort;-The resident was at risk for signs and symptoms related to anxiety, cursing and nervousness;-Offer non-invasive coping mechanisms first to try to reduce his/her anxiety level;-Offer medication before he/she had a behavioral outburst;-The resident was at risk for signs and symptoms related to a diagnosis of bipolar disorder;-Decrease stimulation around the resident when he/she displayed signs of anxiety;-Use a firm and calm approach;-The resident was at risk for signs and symptoms related to a diagnosis of schizophrenia;-Avoid arguing with or getting defensive the resident;-The resident had a history of behavioral challenges that required protective oversight in a secure setting;-Implement plans to change inappropriate behavior;-Use non-pharmaceutical interventions as needed, such as one-on-one with staff. Review of the resident's progress notes showed no documentation of an incident between this resident and Residents #3, #5, and #6 on 06/07/26. During an interview on 06/10/26 at 4:45 P.M., the resident said he/she did not know what Residents #3, #5, and #6 said on 06/07/26. (The resident would not look at the surveyor and changed the subject very quickly when asked about the incident.) 6. During an interview on 06/10/26 at 11:49 A.M., Certified Medication Technician (CMT) E said the following:-He/She was the team lead on the locked unit on 06/07/26;-Resident #16 told him/her (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Residents #3, #5, and #6 were in Resident #7's room arguing;-He/She arrived in Resident #7's room and all the residents were yelling and arguing;-He/She told all the residents to let it go. He/She told Residents #3, #5, and #6 to leave Resident #7's room;-He/She reported the incident to Licensed Practical Nurse (LPN) I and the nurse came to the locked unit;-All four residents cursed at each other after the incident throughout the day on 06/07/26. During interviews on 06/11/26 at 9:52 A.M. and on 06/12/26 at 10:45 A.M., LPN I said the following:-The staff on the locked unit told him/her Residents #3, #5, and #6 were going to beat up Resident #7; -He/She called the psychiatric nurse practitioner so all three residents could speak with him/her; -The psychiatric practitioner ordered a PRN antipsychotic for each of the three residents (Residents #3, #5, and #6).-He/She sent a group text to the Administrator, the DON, and the ADON and let them know there was an incident with Residents #3, #5, #6, and #7 and that he/she called the psychiatric nurse practitioner and got an order for PRN medications for Residents #3, #5, and #6. During an interview on 6/12/26 at 1:19 P.M., the Administrator said the following:-She was out of town on 05/29/26 (date of the incident involving Residents #3 and #4). The Regional Nurse was covering at the facility;-She did not know there was an incident with Residents #3, #5, #6, and #7 on 06/07/26. She was in the facility on the afternoon of 06/07/26 and staff did not report the incident to her;-She expected staff to notify her of incidents and altercations; -Residents #3, #5, and #6 threatened other residents in the past;-She felt it was Residents #3, #5, and #6 intent to intimidate other residents. She felt they were intelligent and used their intelligence to manipulate and intimidate residents. MO3028651

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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. Based on interview and record review, the facility failed to develop and implement meaningful interventions, including non-pharmacological interventions and alternate strategies, to ensure residents on the secured locked unit were not witness to or personally affected by one resident's (Resident #5's) known, sexually inappropriate behaviors when Resident #5 made sexual comments to other residents, exposed his/her genitals to residents, and rubbed his/her genitals on other residents. Residents were upset by Resident #5's actions. The facility failed to investigate an incident involving three residents (Resident #3, #5 and #6) to identify and address the root cause for their behaviors after the residents intimidated and verbally threatened to harm one resident (Resident #7). A sample of eight residents was selected for review. The facility census was 111. Review of the facility's Behavioral Emergency Policy, revised 9/23/25, showed the following:-Non-physical interventions are the first choice as an intervention unless safety issues demand immediate physical intervention;-Proactive management for residents is the best plan. All staff should recognize when the resident has become or can become a danger to themselves or someone else. De-escalation techniques should be utilized as first resort;-Should the resident exhibit extreme behaviors such as resident-to-resident altercations, the following will occur; -The licensed nursing staff and/or nursing administration will assess the resident who is displaying signs of crisis, ensuring the safety of the resident and others is the priority. Monitoring of the resident will be initiated, if appropriate; -The facility's administrative team will assess to see if the resident's needs can continue to be met safely or whether the resident continues to be appropriate for placement at the facility; -The facility will notify the physician and/or psychiatrist of the behavioral emergency; -If the resident is unable to be redirected or is personally requesting an as needed (PRN) medication for mood stabilization, the resident will be given PRN medication per the physician's orders. If the resident receives a by mouth (PO) or intramuscular (IM) PRN mood stabilizing medication, the licensed nurse will document the administration and effectiveness;-The licensed nurse will document the behavioral emergency in the medical record;-The licensed nurse is responsible for notifying the administration, physician, and/or psychiatrist and the responsible party;-The Interdisciplinary Team (IDT) will ensure the care plan is updated if appropriate;-The administrative team will review the incident to determine root cause and review the situation for contributing factors. Reviewing staff responses and documentation to ensure the situation is reflected clearly;-A post incident review with staff members involved shall take place following the use of physical holds or medication administration for a behavioral emergency in order to determine what led to the incident and what could be done differently; root cause determination. The team shall review modifications to the treatment plan made during the crisis and develop a plan;-At regular intervals, the facility will review incidents to obtain root cause analysis which will facilitate improvements of care management and further prevention of incidents. 1. Review of Resident #5's Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care), dated 09/06/23, showed the following:-The resident's diagnoses included schizoaffective disorder (mental health condition that included features of both schizophrenia and mood disorder), bipolar disorder; manic, severe, with psychotic features, and unspecified psychosis (mental disorder involving loss of contact with reality);-The resident had behavioral difficulties and/or mental illness symptoms that required 24-hour monitoring;-The resident had limited insight and poor judgment;-The resident needed continued monitoring of behavioral symptoms and a structured environment. Review of the resident's Care Plan, dated 03/17/26, showed the following:-The resident had a history of behavioral challenges that required protective oversight in a secure setting;-The resident had an impaired social interaction mood disorder. Staff educated the (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	resident on appropriate interactions and boundaries with peers and staff;-The resident had a behavior problem related to bipolar and schizoaffective disorder;-Intervene as necessary to protect the rights and safety of others;-Monitor behavior episodes and attempt to determine underlying cause;-The resident had potential to be physically aggressive related to poor impulse control;-When the resident became agitated, intervene before agitation escalates. Review of the resident's psychiatric notes, dated 05/20/26, showed the resident's sexual behaviors were not actively monitored on his/her problem list. Review of the resident's Progress Note, dated 06/05/26 at 2:49 A.M., showed the day shift reported the resident exposed his/her genitals, cussed, and made inappropriate sexual comments. Staff spoke with the resident about his/her behavior, and the resident said, I'm trying to get laid. Review of the resident's Care Plan showed staff did not update the plan with any interventions to address the resident's sexual behaviors documented in his/her progress note dated 06/05/26. Review of the resident's Physician Order Sheet, dated June 2026, showed an order on 06/07/26 for 50 mg chlorpromazine (antipsychotic medication) for agitation and anxiety. Review of the resident's Medication Administration Record (MAR), dated 06/07/26, showed Certified Medication Technician (CMT) C administered 50 mg chlorpromazine for agitation and anxiety. Review of the resident's Progress Note, dated 06/07/26 at 3:05 P.M., showed the following:-The resident was verbally abusive with peers;-Staff intervened and de-escalated the situation;-The resident calmly hung out in the dining room with peers;-Staff placed the resident on 15-minute checks for protective oversight. During interviews on 06/11/26 at 10:31 A.M. and 06/12/26 at 11:48 A.M., Resident #5 said he/she told Resident #7 to keep his/her name out of stuff because the resident hadn't brought drugs into the facility recently (on 06/07/26). During an interview on 06/12/26 at 11:48 A.M., the resident refused to talk about his/her sexual behaviors. The resident became agitated and asked the state surveyor to leave his/her room. During an interview on 06/12/26 at 8:52 A.M., the Activity Director said he/she had reported the resident's sexual behaviors to the management team and nursing staff, and nothing had been done about it. The resident exposed his/her genitals to residents and staff often. During interviews on 06/12/26 at 9:27 A.M. and 11:50 A.M., Resident #26 said the following:-Resident #5 exposed his/her genitals to residents and made sexual comments pretty regularly; -Resident #5 grabbed residents and humped them while his/her genitals were exposed;-He/She did not like it when the resident did that stuff, he/she tried to stay away from Resident #5. During an interview on 06/12/26 at 11:38 A.M., Resident #8 said Resident #5 exposed his/her genitals, swung his/her genitals around and said, I want to fuck you, as he/she got very close. Resident #8 told Resident #5 to stop because it was gross, and it made him/her uncomfortable. During an interview on 06/12/26 at 11:40 A.M., Resident # 9 said Resident #5 exposed his/her genitals to other residents and to him/her. Resident #5 got too close to him/her when he/she did that. He/She did not want to say anymore because he/she was afraid Resident #5 would hurt him/her. During an interview on 06/12/26 at 11:54 A.M., Certified Nurse Assistant (CNA) F said the following:-Resident #5 exposed his/her genitals all the time;-Resident #5 got aggressive with other residents at times when he/she exposed his/her genitals;-The resident grabbed other residents and humped on them while his/her genitals were exposed;-The Administrator and Director of Nursing (DON) knew the resident exposed his/her genitals to other residents. It had been reported many times;-The resident exposed his/her genitals in the dining room a lot; -The other residents didn't like it when Resident #5 exposed his/her genitals or humped on them. Staff were to separate Resident #5 from other residents when he/she acted in this way. During an interview on 0612/26 at 1:19 P.M., the Administrator said the following:-She was aware of Resident #5's sexual behaviors but did not know what to do about them;-She was aware the resident had inappropriate sexual behaviors and exposed his/her genitalia to other residents; -She expected staff to update Resident #5's care plan to reflect his/her sexual behaviors with interventions to address them. 2. Review of Resident #6's PASRR, dated 05/27/15, showed the following:-The resident had diagnoses that included schizoaffective disorder, bipolar personality disorder, paranoid schizophrenia (a serious mental illness that affects (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	how a person thinks, feels, and behaves), borderline intellectual functioning (impairment that impacts learning and reasoning);-The resident did not make good decisions, easily frustrated, impatient and demanding, and struck others unprovoked;-The resident had a history of agitation, delusions, threatening others, and threatened to scalp a family member:-The resident required an increased level of care and supervision for safety and stabilization of symptoms;-The resident needed a structured environment, and a systematic plan to change inappropriate behavior. Review of the resident's care plan, dated 07/07/25, showed the following:-The resident was at risk for the following signs and symptoms related to anxiety: cursing, hollering, and nervousness;-Offer medication before the resident had a behavioral outburst;-Offer non-invasive coping mechanisms first to try to reduce the resident's anxiety level. Assist with finding the cause of the anxiety;-The resident had impaired coping;-The resident had a risk for harm, either self-directed or directed at others;-Monitor for signs and symptoms of agitation;-Offer the resident alternatives to unacceptable situations;-The resident had potential to be physically aggressive related to poor impulse control;-Discuss the resident's behavior. Explain/Reinforce why the behavior was inappropriate and/or unacceptable. Review of the resident's progress note, dated 06/07/26 at 3:13 P.M, showed the following:-Staff administered a PRN antipsychotic medication for anxiety;-Staff did not document the resident was in Resident #7's room with Residents #3 and #5 and threatened Resident #7;-Staff did not document any interventions used per the resident's care plan regarding the incident. During an interview on 06/11/26 at 10:20 A.M., the resident said the following:-He/She went to Resident #7's room with Residents #3 and #5 on 06/07/26 because Resident #7 said Residents #3, #5, and #6 brought drugs to the facility and used drugs at the facility;-He/She told Resident #7 if the resident didn't quit running his/her mouth they were going to beat the fuck out of him/her;-He/She got a PRN medication to help him/her calm down after the incident. 3. Review of Resident #3's PASRR, dated 11/26/18, showed the following:-The resident had diagnoses that included schizophrenia, psychotic disorder (severe mental disorder that caused abnormal thinking and perceptions), and delusional disorder (serious mental illness where a person experienced one or more persistent fixed false beliefs);-The resident had occasional physical aggression toward staff and peers;-The resident did not make good decisions, destroyed property, and was verbally abusive and threatening;-The resident needed hourly checks and needed to be on a locked unit;-The resident needed a structured setting where he/she could be monitored for mental status changes. Review of the resident's Care Plan, dated 11/3/2025, showed the following:-The resident had a risk for the following signs or symptoms related to his/her diagnosis of schizophrenia: aggression, anxiety, delusions, false beliefs that cannot be reasoned with, and hallucinations;-The resident had a history of behavioral challenges that required protective oversight in a secure setting;-Staff should avoid arguing or getting defensive with the resident;-Implement plans to change inappropriate behavior, behavior management;-Non-pharmaceutical interventions; one-on-one;-Pharmaceutical interventions as needed. Review of the resident's care plan, updated 05/29/26, showed the following:-The resident had the potential to be physically aggressive related to poor impulse control;-The resident spent one-on-one time with staff;-Staff educated the resident on talking with staff when he/she had an issue with another peer;-Staff educated resident on not borrowing or letting residents borrow money from him/her;-Administer medications as ordered;-Psychiatric consult as indicated. Review of the resident's telehealth visit with the Psychiatric Nurse Practitioner, dated 05/29/26, showed the following:-The reason for the visit was an evaluation following a resident to resident altercation that the resident was the aggressor;-The resident felt safe, denied any safety concerns, or the need to speak with staff;-No new order or concerns were identified. Review of the resident's progress note, dated 06/07/26, showed the following:-The resident was verbally abusive with peers; -The staff intervened and de-escalated the situation;-The resident received an as needed (PRN) medication and felt better. During an interview on 06/11/26 at 8:03 A.M. and 8:13 A.M., the resident said the following:-He/She, along with Residents #5 and #6, went into Resident #7's room and had a talk with Resident #7. He/She told Resident #7 it (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	would not be wise to snitch on him/her. Staff came in Resident #7's room and sent him/her, and Residents #5 and #6 out of the room. 4. Review of Resident #7's PASRR, dated 07/24/18, showed the following:-The resident had diagnoses that included bipolar disorder, attention deficit hyperactivity disorder, schizophrenia, learning disorder and borderline intellectual functioning;-The resident required monitoring of medications;-The resident would benefit from a structured environment to reduce stress of daily living and to provide emotional support; Review of the resident's progress notes showed no evidence staff documented an incident between Resident #7 and Residents #3, #5, and #6 on 06/07/26. During interviews on 06/10/26 at 4:45 P.M. and 06/12/26 at 12:05 P.M., Resident #7 said the following:-Residents #3, #5, and #6 came into his/her room on 06/07/26 but he/she did not want to talk about it;-He/She did not know what Residents #3, #5, and #6 said on 06/07/26; (During the interview, the resident would not look at the surveyor and changed the subject very quickly.) 5. During an interview on 06/10/26 at 11:49 A.M., CMT C said the following:-He/She was team lead on 06/07/26 on Resident #7's unit;-A resident (unknown) told him/her Residents #3, #5 and #6 were in Resident #7's room;-He/She went to Resident #7's room and all the residents were arguing and yelling at each other. He/She told Residents #3, #5, and #6 to leave and let it go;-The residents cursed at each other throughout the day but were fine later. During an interview on 06/11/26 at 9:52 A.M. and on 06/12/26 at 10:45 A.M., Licensed Practical Nurse (LPN) I said the following:-CMT C said Residents #3, #5, and #6 were going to beat up Resident #7;-Staff separated the four residents before he/she arrived on the unit; -Resident #3, #5, and #6 asked for a PRN medication. LPN I called the psychiatric nurse practitioner and all three residents spoke with him/her;-The psychiatric practitioner ordered a PRN antipsychotic for each of the three residents;-He/She sent a group text to the Administrator, the DON, and the Assistant Director of Nursing (ADON) and let them know there was an incident with Residents #3, #5, #6, and #7. He/She called the psychiatric nurse practitioner and got an order for PRN medications. During an interview on 6/12/26 at 1:19 P.M. the Administrator said the following:-She did not know there was an incident with Residents #3, #5, #6, and #7 on 06/07/26. She was in the facility on the afternoon of 06/07/26, and staff did not report the incident to her. Staff did not investigate the incident to identify a root cause;-Residents threatened each other all the time. Staff talked to the residents to find out the problem, got it resolved and then the residents were usually okay;-Residents #3, #5, and #6 had threatened other residents in the past;-She felt it was Residents #3, #5, and #6 intended to intimidate other residents. She felt they were intelligent and used their intelligence to manipulate and intimidate residents;-She could not keep reporting bad behaviors of certain residents because then she could not refer them to other facilities where they wanted to move;-She expected staff to implement interventions regarding behaviors that were on residents' care plans. During an interview on 06/26/26 at 4:41 P.M., the Psychiatric Nurse Practitioner said the following:-She began seeing Resident #5 in March 2026. At that time the resident had sexual behaviors where he/she exposed his/her genitals to other residents;-She was not aware Resident #5 had continued to have sexual behaviors. She thought the resident stopped those behaviors since there was no documentation in his/her medical record of the behaviors and the facility had not mentioned the behaviors to her since March. She saw the resident about one time a week;-She saw Resident's #3 and #6 at the facility regularly;-She felt Residents #3, #5, and #6 intimidated other residents.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to date, seal or cover food items, ensure the ice/water dispensing machines were free of a buildup of debris, to cover all facial hear with beard restraints, and to ensure the floor next to the kitchen ice machine was free of a buildup of debris. The facility census was 116. 1. Review of the undated facility policy, Food Storage, showed the following:-Label and date all storage containers as follows;-The date received should already be on it;-Date opened;-Date the item expires. Observation on 04/26/26 at 9:58 A.M. showed the following:-A refrigerator contained six pitchers of lemonade (one dated 4-25) and eight undated pitchers of tea;-A refrigerator contained ten uncovered and undated bowls of pudding and brownies. During an interview on 04/26/26 at 9:58 A.M., Dietary Staff Y said he/she was going to throw the bowls of pudding and brownies away but had not. He/She placed older pitchers of tea and lemonade in the front of the refrigerator, and he/she placed new/fresh pitchers in the back. He/She was supposed to date the pitchers. Observation on 4/27/26 at 9:30 A.M. of the kitchen dry storage room showed a large white plastic tub on wheels contained a 25-pound bag of all-purpose flour and a 25-pound bag of granulated sugar. The bags were open and there was no lid on the plastic tub. During an interview on 4/28/26 at 1:12 P.M., the Dietary Manager said staff should label food and drink items when they place them in the refrigerator. Staff should label, date and properly cover food items. Staff should cover the pudding cups on a tray and should date each bowl. Staff should date each beverage pitcher. The lid for the white tub that held the flour and sugar was missing. Staff should close or seal the bags of flour and sugar. 2. Review of the facility policy, Ice Machine, dated 2026 showed the following:-Operation of Equipment: See manufacturer's instructions for operation of ice machine;-Sanitation of Equipment: Frequency: Daily, Wash exterior of machine. Use sanitizing solution and clean cloth. Allow to dry;-Frequency: Monthly, Remove ice. Wash inside of machine. Use sanitizing solution and clean cloth. Allow to air dry. Observation on 4/29/26 at 8:29 A.M. showed the dispensing spouts on the ice/water dispensing machine in the Station One dining room had a buildup of white crusty debris, dark-colored debris, and rusty-colored debris. Observation on 4/29/26 at 11:16 A.M. showed the dispensing spouts on the ice/water dispensing machine in the Station Two dining room had a buildup of white crusty debris, dark-colored debris, and rusty-colored debris. During an interview on 4/29/26 at 8:29 A.M., the Maintenance Supervisor said the vendor came to the facility quarterly to maintain the ice machines. Maintenance was instructed not to touch the units as it would void the warranty. During an interview on 4/29/26 at 1:45 P.M., the Dietary Manager said the vendor maintained the ice/water dispensing machines in both dining rooms. The vendor kept the units working and performed deep cleaning/sanitizing, but she was unsure how often this was done. Dietary staff wiped off the exterior and should clean the dispensing spout when they discovered any debris. 3. Review of the undated facility policy, Personal Hygiene, showed the following:-These are the guidelines for personal hygiene to promote a safe and sanitary department;-Head covering worn;-Hair must be covered with a hairnet;-Beards or excessive body hair that may be exposed must be covered. Observation on 4/27/26 at 12:19 P.M. showed Dietary Staff O had facial hair, a beard and sideburns. Dietary Staff O wore a beard restraint on his/her chin, however; the beard restraint did not cover all exposed facial hair. Dietary Staff O stood over prepared plates of food on the tray line and placed desserts onto each tray. Observation on 4/27/26 at 12:31 P.M. showed Dietary Staff M had a moustache, a beard and sideburns and stood over steam table pans of food while plating food items on residents' meal trays. Dietary Staff M wore a beard restraint on his/her chin, however; the beard restraint did not cover all exposed facial hair. Observation on 4/28/26 at 12:16 P.M., showed Dietary Staff M had a moustache, a beard and sideburns and stood over steam table pans of food while plating two veggie burgers, vegetables and rice on a resident tray. Dietary Staff M wore a beard restraint on his/her chin, however; the beard restraint did not cover all exposed facial hair. During an (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview on 4/28/26 at 1:12 P.M., the Dietary Manager said beard restraints should cover all facial hair. Staff needed to cover anything more than a light stubble. 4. Observation on 04/26/2026 at 9:58 A.M. showed an area of the tiled floor, located by the ice machine, which was soiled with dirt and dried food crumbs. During an interview on 4/28/26 at 1:12 P.M., the Dietary Manager said the dietary aides cleaned the floors. Staff should clean the floors daily on each shift. 5. During an interview on 5/5/26 at 2:11 P.M., the facility Consultant Dietitian said the following:-Food items should be labeled, dated, sealed or closed and appropriately covered. Beverage pitchers should be dated;-Beard restraints should cover sideburns and beards. She was unsure how moustaches would be handled;-The ice/water machines in the two dining rooms should be clean and free of debris. She had previously been told by dietary staff that the vendor had instructed staff to not touch these units and to contact vendor with issues;-Walls and floors should be clean and free of debris.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop complete policies and procedures to monitor the facility's water system and implement the facility policy to monitor for Legionella (a bacterium that can cause a serious type of pneumonia called Legionnaires' disease) that included specific control parameters based on the Center for Disease Control and Prevention (CDC) and the American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE)) standards. The facility failed to follow current infection control standards for multiple residents, in a review of 30 sampled residents, and one additionally sampled resident. The facility failed to follow infection control practices while performing blood glucose monitoring (a procedure where a drop of blood is obtained to test the amount of sugar in the blood) for one resident (Resident #44) when staff failed to perform hand hygiene to protect against the spread of infection. The facility failed to ensure staff washed their hands during medication administration for three residents (Residents #7, #10 and #53). Staff failed to clean insulin pen hubs before attaching a needle for administration of the medication for four residents (Residents #46, #56, #102 and #16). The facility failed to follow appropriate infection control standards when handling soiled linens for one resident (Resident #48) when staff placed soiled linens directly on the floor. The facility also failed to follow enhanced barrier precautions for one resident (Resident #71) when staff did not wear personal protective equipment (PPE) when changing linens on the resident's bed and failed to follow appropriate hand hygiene and gloving practices for two residents (Resident #12 and #113). The facility census was 116. 1. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed the following:-Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water;-CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html). Environmental, clinical and epidemiological considerations for healthcare facilities are described in this toolkit;-Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system;-Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens;-Specify testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. Review of the undated Centers for Disease Control and Prevention Legionella Environmental Assessment Form, showed Legionella generally grew well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Review of the Centers for Disease Control Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings Toolkit, dated 06/24/21, showed the following: -Clinicians should test patients with healthcare-associated pneumonia (pneumonia with onset ^48 hours after admission) for Legionnaires' disease. This is especially important among patients at increased risk for developing Legionnaires' disease among patients with severe pneumonia (particularly those requiring intensive care), or if any of the following are identified in your facility; -Other patients with healthcare-associated Legionnaires' disease diagnosed in the past 12 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	months;-Positive environmental tests for Legionella in the past two months; -Current changes in water quality that may lead to Legionella growth (e.g., low residual disinfectant levels, temperatures permissive to Legionella growth, nearby construction, areas of stagnation); -Other patients, besides those with healthcare-associated pneumonia, should also be tested for Legionnaires' disease. The preferred diagnostic tests for Legionnaires' disease are culture of lower respiratory secretions on selective media and the Legionella urinary antigen test.-Symptoms of Legionella include headache, confusion, cough, shortness of breath, nausea, vomiting, diarrhea, fever, chills, tiredness, muscle or body aches;-Symptoms usually begin two to ten days after being exposed to Legionella. Review of the facility's Legionella Surveillance Policy, dated 06/24/24, showed the following:-It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections;-Legionella grows best in water temperatures of 77 degrees F and 108 degrees F, particularly in water that is not moving or that does not have enough disinfectant (i.e. pH 6.5-8.5) to kill germs;-Legionella can make people sick when the germs spread in droplets small enough for people to breathe in. Medical devices, cooling towers, showers, hot tubs, and fountains create aerosols;-Although uncommon, Legionella may be contracted by aspiration of contaminated drinking water;-Residents with health-care associated pneumonia or who have failed antibiotic therapy for community-acquired pneumonia shall be tested for Legionella using both cultures of lower respiratory secretions and the Legionella urinary antigen test;-Investigation for a facility source of Legionella, which may include culturing of both culture of lower respiratory secretions and the Legionella urinary antigen test;-Physical controls: a. cooling towers and potable water systems shall be routinely maintained; b. At-risk medical equipment shall be cleaned and maintained in accordance with manufacturer recommendations; c. Non-potable water systems shall be routinely cleaned and disinfected; d. Nebulization devices shall be filled only with sterile fluid;-Temperature controls: a. Cold water shall be stored and distributed below 68 degrees F; b. Hot water shall be stored above 140 degrees F and circulated at a minimum return temperature of 124 degrees F.-A description of how water is received and processed, stored, heated, cooled, recirculated, and delivered to end-point uses;-Include a piping and instrumentation diagram or process diagram for each of the potable (hot and cold) water systems in the building. The facility's policy did not address who was responsible for monitoring the facility's water management program, members of the water management team, specific items monitored with measurable parameters (i.e. temperature, chlorine levels etc.) or inspecting for scaling and biofilm. The facility also did not establish acceptable parameters or actions to take if values were outside of the parameters. Review of a map the facility provided related to the water lines showed the water lines in the facility were highlighted in blue. The map did not show the locations of the hot water heaters or how the water flowed through the building. The facility did not have any other documentation to show which hot water heaters supplied different areas of the facility or where the water lines started or stopped on the halls. Review of the facility's Water Temperature Log, dated February 2026, showed the facility monitored hot water temperatures. The log did not include the temperature of the cold water in the facility. Review of the facility's Water Temperature Log, dated March 2026, showed the facility monitored hot water temperatures. The log did not include the temperature of the cold water in the facility. Review of the facility's Water Temperature Log, dated April 2026, showed the facility monitored hot water temperatures. The log did not include the temperature of the cold water in the facility. Observation on 04/30/26 at 1:40 P.M. to 2:02 P.M., showed the following: -At 1:40 P.M., the temperature of the cold water in the tub in the 100 hall shower room, was 82.2 degrees F, and the temperature of the hot water was 106.5 degrees F (legionella generally grows well between 77 and 113 degrees F); -At 1:47 P.M., the temperature of the hot water at the sink in occupied resident room [ROOM NUMBER] (located at the end of the hall) sink was 74.8 degrees F after two minutes. The temperature of the hot water after five minutes was 112 degrees; -At 1:56 P.M., the temperature of the hot water at the sink in occupied resident room [ROOM NUMBER] was 105.2 degrees F after five minutes;-At 2:00 P.M., the temperature of the hot water at (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the sink in occupied resident room [ROOM NUMBER] was 106.1 degrees F. During an interview on 04/30/26 at 9:00 A.M., the interim Director of Nursing (DON) said she did not know about a water management team. During an interview on 04/29/26 at 3:45 P.M., the Maintenance Director said the following:-The maintenance staff checked hot water temperatures; -He was not sure what the hot water temperature range should be;-The maintenance staff did not check any cold water temperatures;-The facility had some water lines that went into the ceiling. He did not know if that affected the cold water temperatures with the changes to the weather because he had never checked the cold-water temperatures;-The facility tested for legionella when a vendor told them to; -The vendor sends a box, and the facility follows the directions;-There was no water management team;-He did not know what the CDC legionella tool kit was;-He did not follow the ASHRAE guidelines because he was not a professional;-The facility did not have a water flow map;-If a faucet was not working, staff changed out the faucet. Sometimes the faucet do not work because of buildup of sediment and/or scaling. During an interview on 04/29/26, at 12:21 P.M., and 4:16 P.M., the Administrator said the following:-She was the only certified Infection Preventionist for the facility at that time;-The water management committee was required to meet once a month;-The facility sent samples in to be tested for Legionella; -The facility monitored hot water temperatures;-She did not know what ASHRAE was;-She was not aware of any cases of Legionella in the facility; -If a resident had pneumonia that persisted and was not responding to antibiotics, they would ask to test for Legionella;-The last case of facility acquired pneumonia was in October 2025. At that time, staff did not test the resident for Legionella. 2. Review of the facility policy, Hand Hygiene, revised 6/26/24, showed the following:-All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors;-Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice;-Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations;-Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom;-The use of gloves does not replace hand hygiene;-If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. 3. Review of resident #44's physician orders, dated 04/30/26, showed to monitor blood sugar (level of sugar in the blood stream) four times a day. Observation on 04/28/26 at 04:26 P.M., showed the following:-Certified Medication Technician (CMT) I did not perform hand hygiene and put on gloves;-CMT I prepared to obtain a blood sugar sample from the resident;-CMT I obtained the blood sample from the resident's finger, performed the blood sugar finger stick (BSFS) procedure by placing a blood-filled test strip in the glucometer, obtaining the result and then removing the blood filled test strip;-CMT I placed the blood glucose meter in the plastic box labeled with Resident #44's name;-CMT I removed his/her gloves and did not perform hand hygiene. During an interview on 04/28/26 at 4:32 P.M., CMT I said the following:-The procedure to perform a blood glucose check was to sanitize hands, put on gloves, and use a lancet to get the blood sample and get a reading;-He/She should perform hand hygiene before putting and taking off gloves;-He/She did not sanitize his/her hands and should have sanitized before he/she put on and took off his/her gloves. 4. Review of the facility's policy, Medication Administration, revised 06/26/24, showed the following: -Medications are administered as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. It is the policy of this facility to ensure the safe and effective administration of all medications by utilizing best practice guidelines;-Wash hands prior to administering medication per facility protocol and product;-Wash hands using facility protocol;-Perform hand hygiene before preparing medication and before and after direct contact with a resident. 5. Observation on 04/27/26 at 5:07 P.M. showed the following:-CMT AA stood in the hallway in front of the medication cart;-Without performing hand hygiene, CMT AA touched the computer keyboard, opened the medication cart, pulled bubble packs for Resident #15 from the cart, popped the medications from the bubble pack into a medication cup, and poured water into another cup;-Resident #15 stood at the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medication cart. CMT AA handed the resident the medication cup, a wooden spoon and a cup of water and observed the resident take the medications; -CMT AA took the medication cup, wooden spoon and water cup from the resident and threw them in the trash;-CMT AA did not wash or sanitize his/her hands. Observation on 04/27/26 at 5:13 P.M. showed the following:-CMT AA stood in the hallway in front of the medication cart and had just completed administering medications to Resident #15;-Without washing or sanitizing hands, he/she touched the computer keyboard, opened the medication cart, pulled bubble packs for Resident #7 from the cart, popped the medications from the bubble pack into a medication cup, and poured water into another cup; -While popping the medication from the bubble pack, one pill fell to the floor. CMT AA picked up the pill and set it on the side of his/her computer keyboard;-CMT AA walked to Resident #7's room, handed the medication cup, a wooden spoon and a glass of water to the resident and observed the resident take the medications; -He/She took the medication cup, wooden spoon and water cup from the resident and threw them in the trash. CMT AA exited the room. He/She washed his/her hands with soap and water then exited the resident's room; -CMT AA walked back to the medication cart, picked up the pill from his/her computer, walked to the nurse's station, used the keypad to get into the nurses station, and placed the pill in a sharps container on the treatment cart which sat inside of the nurses' station;-CMT AA did not wash or sanitize his/her hands. He/She placed his/her hand on the door handle of the nurse's station door to let him/herself out;-CMT AA walked back down the hall to his/her medication cart. Observation on 04/27/26 at 5:22 P.M., showed the following:-CMT AA returned to the medication cart from disposing the dropped medication in the sharp's container in the nurses station; -Without washing or sanitizing hands, he/she touched the computer keyboard, opened the medication cart, pulled bubble packs for Resident #100 from the cart, popped the medications from the bubble pack into a medication cup and poured water into a cup;-He/She walked to Resident #100's room, handed the medication cup and a glass of water to the resident, observed the resident take the medications, then took the medication cup and water cup from the resident and threw them in the trash;-CMT AA did not wash or sanitize his/her hands. Observation on 04/27/26 at 5:26 P.M., showed the following:-CMT AA stood in the hallway in front of the medication cart and had just completed administering medications to Resident #100;-Without washing or sanitizing hands, he/she touched the computer keyboard, opened the medication cart, pulled bubble packs for Resident #10 from the cart popped the medications from the bubble pack into a medication cup and poured house supplement into a cup;-CMT AA handed the medication cup and a glass of water to Resident #10, then took the medication cup and water cup from the resident and threw them in the trash;-CMT AA did not wash or sanitize his/her hands. Observation on 04/27/26 at 5:33 P.M. showed the following:-CMT AA stood in the hallway in front of the medication cart and had just completed administering medications to Resident #10;-Without washing or sanitizing hands, he/she touched the computer keyboard, opened the medication cart, pulled bubble packs for Resident #53 from the cart, popped the medications from the bubble pack into a medication cup, and poured water into a cup;-CMT AA handed Resident #53 the medication cup, a wooden spoon and a cup of water, and observed the resident take the medications. CMT AA took the medication cup, wooden spoon and water cup from the resident and threw them in the trash;-CMT AA did not wash or sanitize his/her hands. During an interview on 04/28/26 at 4:06 P.M., CMT AA said he/she should wash his/her hands with soap and water before and after contact with residents. He/She could use hand sanitizer between each medication administration but did not have sanitizer with him/her while he/she passed medications on 4/27/26. He/She did not remember to wash his/her hands with soap and water or use hand sanitizer during medication administration on 4/27/26. During interviews on 04/30/26 at 2:50 P.M. and 05/05/26 at 11:48 A.M., the Administrator said the following:-She expected staff to wash their hands with soap and water before and after providing care;-When administering medications, staff should wash their hands with soap and water between residents, after passing the medications to the resident, and before popping medications out of medication cards into medication cups. 6. Review of the facility policy, Administration of Insulin, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revised 05/14/24, showed the following:-Purpose: It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. It is also the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge;-Attach pen needle: Remove the cap from the insulin pen; Wipe the rubber seal with an alcohol pad; Screw the pen needle onto the insulin pen. Review of the Lantus Solostar (prefilled pen of long-acting injectable medication used to treat diabetes) manufacturer's guidelines, revised 11/2018, showed the following procedure to attach the needle:-Wipe the rubber seal with alcohol;-Remove the protective seal from a new needle;-Line up the needle with the pen and keep it straight as you attach it (screw or push on, depending on the needle type). Review of Humalog (rapid-acting injectable medication used to treat diabetes, also known as insulin lispro) manufacturer's administration guidelines, revised 07/2023, showed the following:-Wipe the rubber seal with an alcohol swab;-Select a new needle;-Pull off the paper tab from the outer needle shield;-Push the capped needle straight onto the pen and twist the needle on until it is tight. 7. Review of Resident #6's physicians order summary, dated April 2026, showed the following:-Lantus SoloStar subcutaneous solution pen injector 100 units/mL, inject 28 units subcutaneously (beneath the skin) at bedtime;-Humalog Kwik pen subcutaneous solution pen injector 100 units/mL, inject per sliding scale (an amount to be determined based off a finger stick procedure). Observation on 04/27/26 at 8:22 P.M., showed Licensed Practical Nurse (LPN) BB removed the resident's Lantus insulin pen from the medication cart and removed the cap from the insulin pen. LPN BB did not clean the hub of the insulin pen with an alcohol pad. He/She applied the needle to the hub and administered the resident his/her insulin. Observation on 04/27/26 at 8:28 P.M., showed LPN BB removed the resident's Humalog insulin pen from the medication cart and removed the cap from the insulin pen. LPN BB did not clean the hub of the insulin pen with an alcohol pad. He/She applied the needle to the hub and administered the resident his/her insulin. 8. Review of Resident #56's physicians order summary, dated April 2026, showed the following:-Lantus SoloStar subcutaneous solution pen injector 100 units/mL, inject 13 units subcutaneously at bedtime;-Humalog kwik pen subcutaneous solution pen injector 100 units/mL, inject per sliding scale. Observation on 4/27/26 at 8:32 P.M., showed LPN BB removed the resident's Lantus insulin pen from the medication cart and removed the cap from the insulin pen. LPN BB did not clean the hub of the insulin pen with an alcohol pad. He/She applied the needle to the hub and administered the resident his/her insulin. Observation on 04/27/26 at 8:33 P.M., showed LPN BB removed the resident's Humalog insulin pen from the medication cart and removed the cap from the insulin pen. LPN BB did not clean the hub of the insulin pen with an alcohol pad. He/She applied the needle to the hub and administered the resident his/her insulin. 9. Review of Resident #102's physicians order summary, dated April 2026, showed an order for Lantus SoloStar subcutaneous solution pen injector 100 units/mL, inject 18 units subcutaneously at bedtime. Observation on 04/27/26 at 8:46 P.M., showed LPN BB removed the resident's Lantus insulin pen from the medication cart and removed the cap from the insulin pen. LPN BB did not clean the hub of the insulin pen with an alcohol pad. He/She applied the needle to the hub and administered the resident his/her insulin. 10. Review of Resident #16's physicians order summary, dated April 2026, showed the following:-Lantus SoloStar subcutaneous solution pen injector 100 units/mL, inject 12 units subcutaneously at bedtime;-Insulin lispro subcutaneous solution pen injector 100 units/mL, inject per sliding scale. Observation on 04/27/26 at 8:52 P.M., showed the following:-LPN BB removed the resident's Lantus insulin pen from the medication cart and removed the cap from the insulin pen. Without cleaning the hub of the insulin pen with an alcohol pad, he/she applied the needle to the hub and administered the resident his/her insulin;-LPN BB removed the resident's insulin lispro pen from the medication cart and removed the cap from the insulin pen. Without cleaning the hub of the insulin pen with an alcohol pad, he/she applied the needle to the hub and administered the resident his/her insulin. During an interview on 04/28/26 at 5:57 P.M., LPN BB (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	said he/she never cleaned the hub of the insulin pen before he/she attached a new needle. He/She did not know the hub needed to be cleaned with alcohol before attaching a new needle. During interviews on 04/30/26 at 2:50 P.M. and 05/05/26 at 11:48 A.M., the Administrator said staff should clean the hubs of insulin pens with an alcohol pad before attaching a new needle to prevent contamination of the medication. 11. Review of the facility policy, Handling Clean and Dirty Linen, revised on 06/26/24, showed the following:-It is the policy of this facility to handle, store, process and transport clean and soiled linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection;-Contaminated linen is linen that has been soiled with blood or other potentially infectious materials;-All used linen should be handled using standard precautions (i.e., gloves) and treated as potentially contaminated. Examples of linen that may require special handling include, but are not limited to, visibly soiled with blood or large amounts of body fluids;-Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons;-Used or soiled linen shall be collected at the bedside (or point of use, such as dining room) and placed in a linen bag or designated, lined receptacle. 12. Observation on 04/29/26 at 1:25 P.M., showed the following: -Certified Nurse Assistant (CNA) C and Nurse Assistant (NA) G provided incontinence care for Resident #48;-The resident had been incontinent of bowel and bladder;-The resident's gown, top sheet, cloth incontinence bed pad, and fitted sheet were heavily soiled with urine and/or soiled with feces; -CNA C removed the resident's soiled clothing, soiled linen and sat them directly on the floor by the resident's sink;-CNA C picked the soiled linens off the floor, placed them in a trash bag and removed the soiled linen from the room;-Staff did not sanitize the floor. During an interview on 04/29/26 at 1:25 P.M. and 4/30/26 at 4:13 P.M., CNA C said the following:-He/She knew linens should never touch the floor;-He/She ran out of bags and had nowhere else to put the soiled linens, so he/she made a choice to put them on the floor to continue providing care to the resident that had a large incontinent episode;-Soiled linen should be put in a trash bag;-Soiled linens should not be put on the floor due to infection control and contamination purposes. During an interview on 04/30/26, at 2:50 P.M., the Administrator said the following:-Dirty linens should not be placed on the floor;-If staff put soiled linens on the floor, they should sanitize the floor after the dirty linens were removed. 13. Review of the facility policy, Enhanced Barrier Precautions, revised 5/18/24, showed the following:-It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms;-Enhanced Barrier Precautions (EBP) is a strategy in nursing homes to decrease transmission of CDC-targeted and epidemiologically important multidrug-resistant organisms (MDROs) when contact precautions do not apply. EBP uses personal protective equipment (PPE) and recommends gown and glove use for certain residents during specific high-contact resident care activities associated with MDRO transmission. EBP expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated. EBP uses gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing;-EBP (gown and gloves) must be used for high-contact resident care activities for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO;-High-contact resident care activities include, but are not limited to, dressing, bathing/ showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, indwelling device care or use, or wound care;-Indwelling medical devices include, but are not limited to, central lines, urinary catheters, feeding tubes, and tracheotomies; -Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray. 14. Review of Resident #71's care plan, updated 11/5/25, showed he/she had an indwelling urinary catheter. Observation on 04/30/26 at 7:49 A.M. showed the resident did not have a sign on or near his/her room indicating he/she was on EBP and there was no PPE readily available in the hallway or resident room. Observation on 04/30/26 at 8:29 A.M. showed the following:-NA T wore (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a gown and gloves and emptied urine from the resident's urinary catheter drainage bag. NA T did not wear face protection to protect against splash; -NA S changed the linens on the resident's bed. NA S wore gloves but did not wear a gown. During an interview on 04/30/26 at 9:36 A.M., NA S said the following:-He/She wore EBP when providing care for residents with catheters, wounds, feeding tubes, and certain infections;-Gown and gloves were required when providing care to residents on EBP. A mask may be required depending on the type of infection;-He/She normally only wore gloves when changing the linens for residents on EBP; ?-The charge nurse and the aides told him/her who was on EBP. There was not always a sign on the resident's door, but that would be helpful. 15. Observation on 4/29/26 at 1:07 P.M. showed the following:-LPN F entered Resident #12's room to administer the resident's tube feeding and medications; -LPN F set the necessary supplies on the resident's bedside table, did not perform hand hygiene, and put on gloves;-LPN F opened a capsule and poured the contents into a cup, removed his/her gloves, and did not perform hand hygiene;-LPN F put on shoe covers and a gown and did not perform hand hygiene;-LPN F did not put on gloves. He/She prepared the ordered medications, individually, by adding approximately 10 mL of water to each and stirring with a stir stick; -LPN F did not perform hand hygiene and put on gloves; -LPN F administered the resident's tube feeding, rinsed the supplies, and removed his/her gloves, gown, and shoe covers. LPN F did not perform hand hygiene before leaving the resident's room. During an interview on 04/29/26 at 1:42 P.M., LPN F said he/she should have washed his/her hands before entering the resident's room, starting the medication and tube feeding administration, with glove changes, and after finishing. He/She forgot to do so. 16. Review of Resident #113's physician order sheet (POS), dated April 2026, showed the following:-Insulin lispro subcutaneous solution pen-injector 100 units/milliliter (ml), inject as per sliding scale; 150-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351+ notify physician, give subcutaneously with meals;-Lantus insulin subcutaneous solution 100unit/mL, inject 5 units subcutaneously one time a day. Observation on 04/29/26 at 12:28 P.M. showed the following:-LPN F sat the blood sugar finger stick supplies on the dining room table;-LPN F did not perform hand hygiene and was not wearing gloves;-LPN F completed the resident's blood sugar finger stick;-LPN F sanitized his/her hands, but did not apply gloves;-LPN F administered the insulin into the resident's left arm;-LPN F did not perform hand hygiene. During an interview on 04/29/26 at 1:42 P.M., LPN F said the following:-He/She completed the resident's blood sugar finger stick and insulin administration without wearing gloves;-He/She completed hand hygiene in the medication room before coming out to administer the medication;-He/She did not perform hand hygiene at the table prior to completing the resident's blood sugar finger stick or after administering the resident's insulin;-He/She realized after starting the process that he/she did not have any gloves;-He/She should have stopped to get gloves and restarted, but instead he/she chose to finish the process without gloves.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff placed call lights within the resident's reach for five residents (Residents #48, # 12, #71, #11, and #79), in a review of 30 sampled residents, as directed in the resident's plan of care and per facility policy. The facility census was 116. Review of the facility policy, Call Lights Accessibility and Timely Response, revised on 04/30/24, showed the following:-The purpose of this policy is to ensure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response;-Staff will ensure the call light is within reach of the resident and secured, as needed;-The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. 1. Review of Resident #48's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/29/26, showed the following:-Cognitively intact;-Able to make needs known, made self understood, and understood others;-Independent for transfers. Review of the resident's progress notes, dated 04/18/26, showed the following:-At 8:59 A.M., staff heard the resident yelling. Staff found the resident on the floor face down and complained of left shoulder discomfort. The resident was sent to the local hospital for evaluation and treatment;-At 2:54 P.M., the resident returned to the facility with a left humeral head (upper arm) fracture. Review of the resident's care plan, updated on 04/20/26, showed the following:-The resident was at risk for falls related to psychoactive drug use. The resident fell on [DATE] related to poor balance and unsteady gait;-Be sure the resident's call light is within reach and encourage him/her to use it for assistance as needed. Review of the resident's progress notes, dated 04/25/26 at 3:01 A.M., showed the resident had been stand-by assistance from one staff for ADLs, toileting and when up walking. Staff educated the resident on the importance of using his/her call light when needing assistance. Observation on 04/26/26 at 3:39 P.M., showed the resident lay in bed awake. The call light lay on the recliner out of the resident's reach. During an interview on 04/26/26 at 3:39 P.M., the resident said he/she knew how to use his/her call light, but he/she could not reach it. He/She needed more help, because he/she fell last week. Observation on 04/29/26 at 1:00 P.M., showed the resident lay awake in bed. The resident was incontinent of bowel and bladder. The call light lay on the resident's recliner out of the resident's reach and was covered with a blanket. During an interview on 04/29/26 at 1:00 P.M., the resident said he/she could not go to the bathroom by himself/herself. He/She knew how to use the call light but was unsure where it was. During an interview on 04/29/26 at 1:25 P.M., Certified Nursing Assistant (CNA) C said the resident could use his/her call light if he/she could reach it. 2. Review of Resident #12's admission MDS, dated [DATE], showed the following:-No speech, absence of spoken words;-Usually able to make self understood and to understand others;-Cognitively intact;-Required maximum assistance for bed mobility and transfers. Review of the resident's care plan, revised 3/13/26, showed the following:-The resident was totally dependent on one staff for repositioning and turning in bed;-The resident required one staff to transfer between surfaces;-Encourage the resident to use bell to call for assistance;-The resident had a communication problem;-Ensure/provide a safe environments: call light in reach. Observation on 04/27/26 at 6:28 P.M. showed the following:-Staff found the resident sitting on the ground beside bed;-Licensed Practical Nurse (LPN) BB and Certified Nurse Assistant (CNA) CC arrived to assess the resident and assist the resident back to bed;-LPN BB asked the resident if he/she was comfortable in the bed, placed the wheelchair next to bed, and left the resident's room;-The resident's call light was coiled up around the resident's footboard, at the end of the bed, and was not in the resident's reach. 3. Review of Resident #71's care plan, updated 3/13/26, showed the following:-He/She had an activities of daily living (ADL) self-care performance deficit;-He/She was at risk for falls;-Be sure the resident's call light is within reach and encourage (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident to use it for assistance as needed;-The resident needs prompt response to all requests for assistance. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Independent for all mobility. Observation on 04/26/26 at 3:16 P.M. showed the residents sitting in bed. The resident's call light lay on the ground under the bed and was not in the resident's reach. Observation on 04/30/26 at 7:49 A.M. showed the resident was asleep in bed. The resident's call light lay on the ground under the resident's bed and was not in reach. 4. Review of Resident #11's care plan, revised on 03/18/26, showed the following:-He/She required a mechanical lift for all transfers due to impaired mobility, weakness, and/or inability to safely bear weight;-Keep call light and personal items within reach after transfer;-He/She is at risk for falls related to confusion, gait/balance problems, and use of cardiac and psychoactive medications;-Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Review of the resident's MDS, dated [DATE], showed the resident was dependent on staff for all transfers. Observation on 04/29/26, at 3:25 P.M., showed the lay asleep in bed. The resident's call light was clipped to the light fixture and out of the resident's reach. 5. Observation on 04/30/26, at 2:25 P.M. showed Resident #79 sat in his/her wheelchair next to the bed in his/her room. The resident faced the foot of his/her bed. The resident's call light was attached at the very head of the bed on the side of the mattress far behind the resident (approximately 3 feet behind the resident's wheelchair). During an interview on 04/30/26 at 2:25 P.M., the resident said he/she did know where his/her call light was. He/She asked if his/her call light was on the floor. After telling the resident where his/her call light was, the resident said there was no way he/she could reach his/her call light. He/She hated it when staff put his/her call light there because he/she cannot reach it to call for help. 6. During an interview on 04/30/26 at 4:13 P.M., CNA C said the call lights should always be in the residents' reach. During an interview on 04/30/26 at 4:15 P.M., Nurse Assistant (NA) S said call lights should always be in the resident's reach. During an interview on 04/30/26 at 02:50 P.M., the Administrator said staff should always leave call lights within reach for every resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a homelike environment, keeping the floors, walls, privacy curtains and windows in good repair and working order in the facility. The facility census was 116. Review of the facility's undated policy, Environment, showed the following:-The facility will be maintained in a safe, clean, comfortable and homelike setting;-Housekeeping and maintenance service in the dietary department will maintain a sanitary, orderly and comfortable dining area;-A homelike environment will be maintained with attractive tables, decor, and a pleasant dining area atmosphere. Review of the facility's policy, Safe and Homelike Environment, revised 06/05/24, showed the following:-In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment; -Environment refers to any environment in the facility that is frequented by residents, including but not limited to, the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas;-The facility will create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting;-Housekeeping and maintenance services will be provided as necessary to maintain a sanitary and comfortable environment.-Report any unresolved environmental concerns to the Administrator. 1. Observation in occupied resident room [ROOM NUMBER] on 04/26/26 at 11:44 A.M., showed the following:-Large amounts of dust accumulated on the exhaust fan in the shared bathroom;-A strong urine odor in the shared bathroom;-No toilet paper holder in the bathroom; a roll of toilet paper sat on the handrail;-A large piece of the porcelain sink was missing and exposed the black underlaying of the bowl;-Multiple scraped areas on the door exposing the wood underneath. During an interview on 04/26/26 at 11:44 A.M., the resident, who resided in room [ROOM NUMBER], said it would be nice to have some place to put the toilet paper because the toilet paper fell on the floor frequently. 2. Observation on 04/29/26 at 1:25 P.M., showed the privacy curtain between the two beds in resident room [ROOM NUMBER] was broken and did not completely close around the beds. During an interview on 04/29/26 at 1:25 P.M., Certified Nursing Assistant (CNA) C said he/she was unable to pull the privacy curtain because it was broken. 3. Observation in occupied resident room [ROOM NUMBER] on 04/29/26 at 9:31 A.M. showed the following:-Multiple areas of dry wall on the wall around the television mount was patched and not painted;-Multiple areas of dry wall on the wall by bed A was patched and not painted. During an interview on 04/29/26 at 9:31 A.M., the resident who resided in the room said he/she moved into the room in June or July 2025 and the walls had been like this the entire time. 4. Observation in occupied resident room [ROOM NUMBER] on 04/27/26 at 6:14 P.M., showed the following:-A large area, approximately 2 feet by 3 feet, behind the door to the room had been patched and was not sanded or painted;-A large area on the wall, at the end of the bed, had been patched and was not sanded or painted;-A small area above the resident's bed had been patched and was not sanded or painted;-Areas on the wall were painted, however, the paint did not match;-A board covered the window. During an interview on 04/27/26 at 6:14 P.M., the resident who resided in room [ROOM NUMBER] said the board covered the window since August 2025, and the walls were patched about six months ago. It would be nice to have a nice-looking room. 5. Observation in occupied resident room [ROOM NUMBER] on 04/28/26 at 01:00 P.M., showed the following:-An area of dry wall, approximately the size of a basketball, located in the bathroom, was patched and painted and was dented in and not smooth like the rest of the wall;-An area of dry wall, approximately 30 inches by 24 inches, on the wall by the bathroom, was patched and not painted. During an interview on 04/28/26 at 01:00 P.M., the resident who resided in room [ROOM NUMBER] said the bathroom wall had been like that for two and half years, and the wall outside the bathroom had been like that for a year to year and half. 6. Observation on 04/27/26, at 6:30 P.M. of the Station Two shower room on the 600 hall (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed the following:-Rusted base board heaters on the wall under the window;-Peeling paint on the window frame;-Peeling paint on the floor and at the base of the walls;-A black substance was on the lower part of the wall next to the floor and extended up the wall approximately 8 inches in some areas;-Missing paint on the wall dividing the shower and tub area;-The mirror had lost finish and was dull and had white dots and smears;-A large piece of plastic covered the back of the toilet that did not fit properly. 7. Observation on 04/27/26, at 6:37 P.M., in the Station Two dining room showed a board covered a large window. The curtains covering all the windows were in disrepair; two window curtains were torn into pieces. The curtains were not attached at the top in several areas allowing the curtains sag and looked like they were falling down. 8. Observation on 04/28/26, at 3:12 P.M. of the Station Two shower room on the 500 hall showed the following:-Peeling paint on the shower floor and a black substance on the floor around the base of the shower;-Peeling paint on the shower enclosure walls and a black, mold-like substance around the base of the shower;-Large clumps of hair on the shower floor, on the floor by the tub, and on the floor by the toilet;-The corner wall beside the toilet was discolored around the toilet paper holder, and there was brown build up in the corner between the toilet and the wall. 9. During an interview on 04/28/26, at 2:40 P.M., Certified Medication Technician (CMT) I said the following:-If something needed repaired, the facility has an app for maintenance;-Staff were to put any needed repairs in the app for maintenance staff. During an interview on 04/29/26 at 1:25 P.M., Nursing Assistant (NA) G said staff used an app to report areas that needed repaired to maintenance staff. During an interview on 04/26/26, at 10:00 A.M., Houskeeper FF said the following:-The facility had an app to report needed repairs;-Staff reported anything that was broken or needed fixed. During an interview on 04/29/26, at 3:45 P.M., the Maintenance Supervisor said the following:-The facility had an app employees used to report repairs that needed completed;-The maintenance staff tried to patch holes quickly but had not had time to sand and paint them all;-The shower room floors were an ongoing issue and were painted several times;-The boards on the windows in the dining room and room [ROOM NUMBER] were ordered. The facility was waiting on the vendor. It had been over six months,. He did not know when the windows would be fixed. He was not sure if the Administrator had contacted the vendor recently;-Housekeeping was responsible for cleaning and the curtains;-Department heads completed environmental rounds. During an interview on 04/30/26, at 2:35 P.M., the Administrator said the following:-She expected staff to put in repairs needed to maintenance app;-The program notified the maintenance staff when someone put in a work request, and then notified management if the repairs were not done in 24 hours;-Staff should complete repairs within a couple days;-The Maintenance Director followed up her if he ran into issues getting things completed;-The shower rooms were a work in progress;-Department heads and aides conduct environmental rounds and should put anything needing fixed into the app.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to report a resident-to-resident altercation for two residents (Resident #88 and #23), in a review of 30 sampled residents, to the Administrator when Resident #23 struck Resident #88, per the facility's abuse policy. The facility census was 116.Review of the facility policy, Abuse and Neglect, updated 06/12/24, showed the following:-It is the policy of this facility to ensure all allegations of abuse are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;-Abuse is the willful infliction of injury which can include certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, and physical abuse;-Verbal abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless their age, ability to comprehend, or disability. This includes using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner in a resident's presence.-Physical abuse includes purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner.-When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the licensed nurse will notify the Administrator or designee, notify the attending physician, resident's family/legal representative, and medical director. 1. Review of Resident #88's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 04/18/26, showed the following:-Cognitively intact;-No hallucinations, delusions, or behaviors;-Diagnoses include schizophrenia (Serious mental illness that affects how a person thinks, feels, and behaves), schizoaffective bipolar type (mental health condition that includes features of both schizophrenia and a mood disorder), personality disorder, and anxiety. During an interview on 04/26/26 at 1:51 P.M., Resident #88 said the following:-A staff member was talking about his/her child, and he/she (Resident #88) said the child was probably gay; -He/She didn't understand why, but Resident #23 started punching him/her in the arm and chest;-He/She had to threaten Resident #23 to get him/her to stop punching him/her;-He/She was able to hold himself/herself back from striking Resident #23 back at that time, but he/she felt set up for failure;-He/She could not let people just beat on him/her and not react much longer;-He/She was worried Resident #23 would try it when he/she was having a bad day, and it would get him/her in trouble. 2. Review of Resident #23's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-No hallucinations, delusions, or behaviors;-Diagnoses include traumatic brain injury, anxiety disorder, depression, bipolar, schizophrenia, post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events like abuse or combat), impulse disorder, dysthymic disorder (long term depression). During an interview on 04/26/26 at 11:09 A.M., Resident #23 said the following:-A staff member was talking about his/her child and Resident #88 said the child was gay;-It made him/her mad because Resident #88 was talking about a child, and he/she punched Resident #88 four to five times;-Then Resident #88 threatened he/she was going to kill him/her (Resident #23) or put him/her in the hospital;-He/She was still upset and Resident #88 better not mess with him/her again today. He/She was ready for him/her. 3. During an interview on 04/26/26 at 11:15 A.M., Resident #119 said the following:-He/She saw the whole incident between Resident #23 and Resident #88;-Resident #88 punched Resident #23 a bunch of times;-Resident #88 then called Resident #23 a bitch and kept saying try it one more time, and he/she would kill him/her or put him/her in the hospital;-Certified Medication Technician (CMT) B separated the residents. During an interview on 04/26/26, at 11:45 A.M., CMT B said the following:-That morning (4/26/26) (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	around 9:30 A.M. during smoke break, Resident #88 said something about an employee's child that Resident #23 did not like;-Resident #23 started punching Resident #88 in the arm and yelled at him/her;-He/She stepped between the residents;-Resident #88 called Resident #23 names and yelled at him/her because he/she was upset about being punched;-It took a minute to get the residents calmed down, but staff separated them and then notified the interim Director of Nursing. During an interview on 04/26/26, at 4:15 P.M., the interim Director of Nursing said the following:-She felt the incident between Resident #23 and Resident #88 was reported to him/her this morning, but some details were left out or she missed the details;-She did not realize or did not process that it was a physical altercation;-She thought it was more of an argument;-He/She did not notify the Administrator because he/she did not realize it was a physical altercation. During an interview on 04/26/26, at 4:06 P.M., the Administrator said the following:-Staff did not notify her a resident-to-resident altercation that day (4/26/26),-No one reported to her that Resident #23 struck Resident #88 or that they had a verbal exchange;-She expected staff to report resident-to-resident altercations to her immediately after the residents were separated and safe.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS), a federally mandated assessment completed by staff, according to the Resident Assessment Instrument (RAI) manual for three residents (Residents #2, #70 and #10), in a review of 30 sampled residents. The facility census was 116. Review of the Centers for Medicare and Medicaid Services (CMS), Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.20.1, Chapter 1, revised October 2025, showed the following:-Comprehensive MDSs include admission, annual, significant change in status assessment and significant change in prior assessment;-The Resident Assessment Instrument (RAI) process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that:(1) the assessment accurately reflects the resident's status;(2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals;(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. 1. Review of Resident #2's face sheet showed the resident had a guardian and diagnoses included muscle weakness, unsteadiness on feet, other abnormality of gait and mobility, lack of coordination, and repeated falls. Review of the resident's progress notes, dated 10/7/25 at 3:42 A.M., showed the resident was found on the floor of his/her room, lying next to the bed on his/her stomach. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff, dated 12/8/25, showed no falls since the prior assessment. Review of the resident's progress notes, dated 12/18/25 at 3:10 P.M., showed the resident fell to the floor and landed on his/her buttocks. Review of the resident's progress notes, dated 1/06/26 at 7:55 A.M., showed the resident fell out of his/her wheelchair onto the floor and hit his/her head. Review of the resident's skin issues assessment, dated 2/03/26, showed a new stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough, may also present as an intact or open/ruptured blister) pressure ulcer, in-house acquired, located on the intergluteal cleft (crease between the buttocks). The pressure ulcer measured 1.19 centimeters (cm) long by 1.78 cm wide by 1.52 cm deep. Review of the resident's physician orders, dated 2/10/26, showed an order to apply gauze to the gluteal cleft after cleansing with soap and water or wound cleanser, one time a day for wound care. Review of the resident's progress notes, dated 2/11/26 at 10:47 A.M., showed staff found the resident lying on the fall mat on the floor beside his/her bed. Review of the resident's progress notes, dated 3/06/26 at 8:45 A.M., showed staff witnessed the resident fall and hit the left side of his/her face on the floor. Review of the resident's quarterly MDS, dated [DATE], showed the following:-No falls since last assessment (completed on 12/8/25);-No unhealed pressure ulcers. Review of the resident's physician orders, dated 3/11/26, showed an order to discontinue applying gauze to the gluteal cleft after cleansing with soap and water or wound cleanser, one time a day for wound care. Review of the resident's progress notes dated 3/27/26 at 2:35 P.M. showed staff found the resident on his/her stomach on the fall mat with blankets under him/her. Review of the resident's skin issues assessment, dated 3/27/26, showed stable (previously deteriorating wound characteristics plateaued), stage II pressure ulcer, located on the intergluteal cleft, measuring 0.82 cm long by 1.5 cm wide by 0.1 cm deep. Review of the resident's progress notes, dated 3/29/26 at 2:32 P.M., showed staff found the resident on the fall mat by the bed with the covers under him/her. Review of the resident's progress notes, dated 4/01/26 at 2:41 P.M., showed staff found the resident on the fall mat on the floor, resting on his/her left side, with the covers underneath him/her. Review of the resident's progress notes, dated 4/01/26 at 7:30 P.M., showed staff found the resident face down on his/her floor by the bed. His/Her legs were on the fall mat, but his/her top half of body was on the bare floor. Review of the resident's progress notes, dated 4/06/26 at 7:30 P.M. showed staff found the resident on his/her bedroom floor, face down on the fall (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mat beside the bed with both arms under his/her chest. Review of the resident's significant change MDS, dated [DATE], showed no falls since the last assessment (completed on 3/10/26). 2. Review of Resident #70's face sheet showed the resident's diagnoses included blindness in one eye and low vision in the other eye. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Vision: adequate: sees fine detail, such as regular print in newspapers/books;-Cognitively intact;-Supervision or touching assistance for personal hygiene and wheeling 50 feet with two turns;-Partial/Moderate assistance for eating, oral hygiene, toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear and wheeling wheelchair 150 feet;-Substantial/maximal assistance or upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer;-Frequently incontinent of urine;-Occasionally incontinent of bowel;-Diagnosis of blindness, one eye, low vision other eye. Observations on 04/26/26 through 04/30/26 showed the following;-The resident independently ate multiple meals after staff delivered the resident's tray;-Self-propelled wheelchair short distances;-Independent transfer from wheelchair to bed;-Independent transfer from bed to wheelchair;-Independent bathroom privileges;-No period of incontinence;-Staff assistance with shower only to bring towels and turn water on. During an interview on 04/30/26 at 1:30 P.M., the resident said the following;-He/She was blind in one eye, had impaired vision in the other eye and only saw shadows and could not see fine details;-He/She was independent with eating, transferring, going to the bathroom, wheeling short distances and doing his/her own hygiene/shower after staff turned on the water and brought him/her towels and a washcloth;-He/She rarely had a urine or bowel accident. 3. Review of Resident #10's face sheet showed a diagnosis of schizoaffective disorder, bipolar type (a mental health condition that includes features of both schizophrenia and a mood disorder). Review of the resident's annual MDS, dated [DATE], showed the resident had a diagnosis of schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). The diagnosis triggered an MDS indicator for no Pre-admission Screening and Resident Review (PASARR - a screening assessment used to determine if a resident is suitable for residence in a long-term care facility) and for medication use with a diagnosis of schizophrenia. Review of the resident's medical record showed no documentation the resident had a diagnosis of schizophrenia. 4. During an interview on 04/30/2026 at 3:41 P.M., the MDS coordinator said the following;-Currently, she worked offsite and had not been to the facility;-She just took over the facility's MDSs and planned to go to the facility soon;-A new diagnosis for schizophrenia should be verified before adding it to the MDS;-Staff should include falls and wounds on the MDS if they were present during the look-back period;-Resident #2's MDS should have reflected falls and pressure ulcers if they were present during the look-back period;-She did not complete the MDSs for the residents identified in the citation. During an interview on 04/30/26 at 2:50 P.M., the Administrator said the following:-She expected the MDS to be accurate;-She expected staff to code the MDS according to the RAI manual;-Staff should accurately code wounds and falls on the MDS;-Resident #10 had a diagnosis of schizoaffective disorder and did not have a diagnosis of schizophrenia. Staff incorrectly marked the schizophrenia diagnosis on the MDS.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop a comprehensive, person-centered care plan for four residents (Residents #71, #79, #105, and #2), in a review of 30 sampled residents, when staff did not develop a care plan to address pertinent care areas, including pain, a pressure ulcer, smoking, and a urinary catheter. The facility census was 116. Review of the facility policy, Comprehensive Care Plans, revised 10/31/24, showed the following:-It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment;-The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed;-The comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;-The interdisciplinary team (IDT) will prepare comprehensive care plans;-The IDT will review and revise the comprehensive care plan after each comprehensive and quarterly MDS assessment;-The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed;-Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 1. Review of Resident #71's face sheet showed the resident's diagnoses included chest pain, cervical (neck) radiculopathy (a pinched nerve causing compression or irritation of nerve roots, resulting in pain, numbness, tingling, or weakness), pain in joints of left hand, low back pain, and other chronic pain. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/23/26, showed the following:-The resident did not receive scheduled pain medications;-The resident did receive as needed pain medications;-The resident did not receive non-medication interventions for pain;-The resident received an opioid medication. Review of the resident's April 2026 physician order sheet (POS), showed the following:-Assess for pain every shift;-Biofreeze gel (a topical pain reliever) 4%, apply to lower back/hips topically every four hours as needed for pain;-Tylenol (a medication to relieve pain and reduce temperature) 325 mg, give two tablets by mouth every six hours as need for pain and/or temperature;-Norco (a narcotic pain medication) 7.5-325 mg, give one tablet every six hours as needed for pain;-Consult pain management for low back pain;-Refer resident to pain clinic. Review of the resident's medication administration record (MAR), dated April 2026, showed the following:-The resident received 10 doses of as needed Tylenol;-The resident received four doses of as needed Biofreeze;-The resident received 59 doses of as needed Norco. Review of the resident's progress notes, dated 4/26/26 at 11:02 A.M., showed staff administered Norco. Review of the resident's progress notes, dated 4/26/26 at 1:27 P.M., showed the Norco administration was effective. The resident's follow up pain score was a 3 (on a scale of 1-10 with 10 being the most pain). During an interview on 4/26/26 at 3:16 P.M., the resident said he/she was in pain, and his/her chest was hurting. Review of the resident's progress notes, dated 4/27/26 at 6:39 A.M., showed staff administered Norco for a complaint of back pain. Review of the resident's progress notes, dated 4/27/26 at 5:04 P.M., showed staff administered Norco. Review of the resident's progress notes, dated 4/27/26 at 6:32 P.M., showed the Norco administration was effective with a follow up pain score of 0 (no pain). During an interview on 4/27/26 at 6:56 P.M., the resident said (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he/she was in pain. Review of the resident's progress notes, dated 4/27/26 at 10:36 P.M., showed the resident had complaints of chronic back pain and received Norco, Tylenol, and Biofreeze as requested. During an interview on 4/28/26 at 2:35 P.M., the resident said the following:-His/Her back hurt;-He/She had chronic back pain, but it had been worsening;-He/She received pain medications, but the medications did not seem to work as well. Observation on 4/29/26 at 10:35 A.M. showed the resident walking the hallway and told Licensed Practical Nurse (LPN) F he/she would like a pain pill. Review of the resident's current care plan, dated 3/13/26, showed no documentation the resident had pain, used narcotic pain medications, and no interventions to address the resident's pain. 2. Review of Resident #79's face sheet showed the following:-He/She was his/her own responsible party;-Diagnoses included nicotine dependence. Review of the resident's admission MDS, dated [DATE], showed the following:-Cognitively intact;-No impairment in range of motion to his/her upper extremities;-The resident required maximum assistance for eating;-No tobacco usage. Review of the resident's Smoking and Safety Assessment, dated 4/09/26, showed the following:-The assessment will be utilized for the resident's smoking care plan on admission and as indicated;-The resident used tobacco products;-The resident showed the following: limited or no range of motion (ROM) in arms or hands, insufficient fine motor skills needed to securely hold tobacco or other smoking item, follows the facility's policy on location and time of smoking;-The resident showed the following safety concerns: unable to light tobacco or other smoking products safely, unable to hold tobacco or other smoking products safely, unable to extinguish tobacco or other smoking products safely, unable to use ashtray to extinguish tobacco or other smoking products;-The resident determined today that he/she is going to begin smoking;-The care planning section for tobacco use was left blank;-The clinical suggestions section was left blank. During an interview on 4/27/26 at 5:50 P.M., the resident said the following:-He/She smoked occasionally;-He/She was made to wear a smoking apron yesterday and today, but has not worn one prior;-He/She had neuropathy in their hands. Review of the resident's care plan, dated 3/27/26, showed no documentation the resident smoked, no smoking interventions, or smoking safety concerns as identified on the resident's smoking assessment. 3. Review of Resident #105's annual MDS, dated [DATE], showed the following:-Cognitively intact;-No bladder appliances;-Always continent of bladder. Observation on 4/26/26 at 12:32 P.M. showed the resident had a catheter drainage bag, which contained clear yellow urine, hooked to his/her wheeled walker. During an interview on 4/26/26 at 3:10 P.M., the resident said the following:-He/She had a new catheter placed two days ago while at the hospital due to urine retention;-He/She was told the catheter would stay in place for one to two weeks, then he/she would follow up with urology. Review of the resident's urology consult note, dated 4/28/26, showed the following:-The resident had a catheter in place due to urinary retention;-The resident had possible diabetic cytopathy (a common complications of long-standing diabetes, causing nerve damage that affects bladder control) with recently placed catheter and noted hydronephrosis (swelling of the kidneys caused by a buildup of urine that cannot be drained properly);-The resident was scheduled for urodynamics (a test that evaluates how well the bladder stores and releases urine) and a renal ultrasound;-Order to change catheter monthly. During an interview on 4/29/26 at 9:40 A.M., the resident said he/she saw urology yesterday and he/she still had the catheter. Review of the resident's care plan showed no documentation the resident had a urinary catheter. 4. Review of Resident #2's care plan, revised 7/20/23, showed the following:-He/She had actual skin impairment to skin integrity related to psoriasis (a chronic autoimmune skin disease);-Educate resident/family/caregivers of causative factors and measures to prevent skin injury;-Identify/document potential causative factors and eliminate/resolve where possible. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident was not at risk of developing pressure ulcers;-No unhealed pressure ulcers. Review of the resident's skin issues assessment, dated 2/03/26, showed a new stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough, may also present as an intact or open/ruptured blister), in-house acquired, located on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the intergluteal cleft (the groove between the buttocks). Review of the resident's care plan showed no documentation staff updated the care plan to include the resident's pressure ulcer. Review of the resident's physician orders, dated 2/10/26, showed an order to apply gauze to the gluteal cleft after cleansing with soap and water or wound cleanser, one time a day for wound care. Review of the resident's quarterly MDS, dated [DATE], showed no unhealed pressure ulcers. Review of the resident's physician orders, dated 3/11/26, showed an order to discontinue applying gauze to the gluteal cleft after cleansing with soap and water or wound cleanser, one time a day for wound care. 5. During an interview on 04/30/26 at 2:50 P.M., the Administrator said the following:-The Interdisciplinary Team (IDT) was responsible for completing and updating the care plans at each risk management meeting;-The care plan should be accurate and show the most current level of care for each resident. During an interview on 04/30/26 at 3:41 P.M., the MDS Coordinator said the following:-She just recently took over completing the MDSs for this facility;-She had not been on-site at the facility since taking on this role;-She was responsible for completing the new admission and annual care plans, but she did not know if the facility had a corporate care plan coordinator;-If the facility did not have a corporate care plan coordinator, the facility was responsible for updating the care plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update and revise resident care plans to accurately reflect current care needs for five residents (Residents #10, #13, #70, #2 and #79), in a review of 30 sampled residents. The facility census was 116. Review of the facility's policy, Comprehensive Care Plans, revised on [DATE], showed the following: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment;-The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment;-The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed;-The Individualized Care Service Plan (ICSP), (also called the bedside care plan) will be updated with pertinent information needed for nursing staff on the floor to provide the needed care for residents. 1. Review of Resident #10's annual Minimum Data Set (MDS), a mandatory assessment instrument completed by facility staff, dated [DATE], showed the following:-Cognitively intact;-No hearing or vision issues, made self understood, and understood others;-Required partial/moderate assist of one staff for upper and lower body dressing and putting on/taking off footwear, bathing and personal hygiene;-Supervision or touch assistance only for oral care. Review of the resident's care plan, revised on [DATE], showed the following: -The facility will follow the resident's advanced directive for code status, initiated [DATE]. The resident was a full code (if someone's heart stops beating or they stop breathing, medical staff will use all life-saving measures to resuscitate them, to include cardio-pulmonary resuscitation (CPR);-Risk for impaired communication, initiated on [DATE]. The resident will be able to effectively communicate basic needs; -Intake more than body requirements, initiated on [DATE]. The resident was on a regular diet with large portions;-The resident was on a regular diet, initiated [DATE];-The resident had an activity of daily living (ADL) self-care deficit, initiated on [DATE], and was totally dependent on one staff for dressing, personal hygiene and oral care. Review of the resident's [DATE] physician order sheet (POS) showed the following:-Regular diet, regular texture, thin/regular consistency, large portions, house supplement three times a day with meals with an order date of [DATE];-Code status was DNR (Do Not Resuscitate, indicating CPR would not be started in the event the resident was without pulse or respirations) with an order date of [DATE]. Observation on [DATE], at 2:15 P.M., showed an emergency cart, located inside nursing station one, included a list of residents whose code status was DNR and signed physician orders for DNR status. The resident's name was included on the list with a physician signed Out-of-Hospital purple sheet which indicated the resident was DNR status. During an interview on [DATE], at 11:35 A.M., the resident said the following: -He/She was able to make his/her needs known verbally and could understand staff when they asked questions;-He/She needed assistance of one staff for things like dressing and transfers. He/She was able to assist with dressing and transfers, and staff did not have to do it all;-He/She did not want CPR performed if his/her heart or lungs stopped working and was a DNR. Review of the resident's care plan showed staff failed to update the plan to accurately reflect the resident's code status, diet order, activities of daily living (ADLs) assistance needs and communication status. 2. Review of Resident #13's care plan, revised [DATE], showed the following: -He/She was on a regular diet, initiated [DATE];-The facility will follow the resident's advanced directive for code status. The resident was a full code, initiated [DATE].-Terminal illness related to endˆofˆlife status, as evidenced by hospice enrollment and progressive decline, initiated [DATE]. Review of the resident's (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	POS, dated [DATE], showed the following: -Regular diet, mechanical soft with ground meat texture, thin consistency, use condiments to moisten, ketchup/BBQ sauce, gravy, etc., with an order date of [DATE];-Code status: DNR with an order date of [DATE]. Observation on [DATE], at 2:15 P.M., showed an emergency cart inside nursing station one that included the DNR list and signed physician orders for DNR. The resident's name was included on that list with a physician signed Out-of-Hospital purple sheet which indicated DNR status. Review of the resident's care plan showed staff failed to update the plan to accurately reflect the resident's code status and diet order. 3. Review of Resident #70's undated face sheet showed the resident was his/her own responsible part. The resident's code status was DNR. Review of the resident's care plan, revised [DATE], showed the following: -The resident had a guardian to assist in decision making due to mental illness, initiated [DATE];-The facility would follow the resident's advanced directives for code status. He/She was a full code, initiated [DATE]. Review of the resident's POS, dated [DATE], showed the resident's code status was DNR. Observation on [DATE] at 2:15 P.M., showed an emergency cart, located inside nursing station one, included a list of residents whose code status was DNR and signed physician orders for DNR status. The resident's name was included on the list with a physician signed Out-of-Hospital purple sheet which indicated the resident was DNR status. During an interview on [DATE], at 1:54 P.M., the resident said he/she was his/her own responsible party and decision maker. He/She did not have a guardian. He/She did not want CPR if his/her heart and lungs stopped working. Review of the resident's care plan showed staff failed to update the plan to accurately reflect the appropriate responsible party and the resident's code status. 4. Review of Resident #2's undated face sheet showed the resident's diagnoses included muscle weakness, unsteadiness on feet, other abnormality of gait and mobility, lack of coordination, and repeated falls. Review of the resident's care plan, dated [DATE], showed the following:-The resident was at low risk for falls related to psychoactive drug use;-Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs;-Follow facility fall protocol;-Pharmacist review of medication;-Resident reeducated on situational awareness. Review of the resident's care plan, revised [DATE], showed the following:-The resident had poor safety awareness related to refusing to use a walker or walking away from it;-Encourage use of prescribed assistive devices;-Safety measures, including strategies to reduce the risk of falls and injury, initiated as appropriate. Review of the resident's progress note, dated [DATE] at 3:42 A.M., showed staff found the resident on the floor of his/her room, lying next to the bed on his/her stomach. Review of the resident's progress note, dated [DATE] at 3:10 P.M., showed staff witnessed the resident fall to the floor and land on his/her buttocks. The resident leaned to the left with both legs bent to the right under his/her upper thighs. Review of the resident's progress note, dated [DATE] at 7:55 A.M., showed the resident fell out of his/her wheelchair onto the floor and hit his/her head. Review of the resident's care plan showed the care plan for falls was marked as resolved on [DATE] and there was no active care plan to address falls or fall interventions. Staff did not update or revise the plan of care following the resident's falls on [DATE], [DATE] and [DATE]. Review of the resident's progress note, dated [DATE] at 10:47 A.M., showed staff found the resident on the fall mat on the floor beside his/her bed. Review of the resident's progress note, dated [DATE] at 8:45 A.M., showed staff witnessed the resident fall and hit the left side of his/her face on the floor. Review of the resident's progress note, dated [DATE] at 2:35 P.M., showed staff found the resident on his/her stomach on the fall mat with blankets under him/her. Review of the resident's progress note, dated [DATE] at 2:32 P.M., showed staff found the resident on the fall mat by the bed with covers under him/her. Review of the resident's progress note, dated [DATE] at 2:41 P.M., showed staff found the resident on the fall mat on the floor, resting on his/her left side, with covers underneath him/her. Review of the resident's progress note, dated [DATE] at 7:30 P.M., showed staff found the resident face down on his/her floor by the bed. His/Her legs were on the fall mat but his/her top half of body was on the bare floor. Review of the resident's progress note, dated [DATE] at 7:30 P.M., showed staff found the resident on his/her bedroom floor, face (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	down on the fall mat beside the bed with both arms under his/her chest. During an interview on [DATE] at 6:36 P.M., the resident said he/she was at risk for falls, which is why there was a mat on the floor beside his/her bed. During an interview on [DATE] at 9:36 A.M. and 4:15 P.M., Nurse Aid (NA) S said the resident was a fall risk and had a low bed, fall mat, call light in reach, required 15-minute face checks, and required frequent reminders to use the call light as interventions to prevent falls. During an interview on [DATE] at 4:21 A.M., Licensed Practical Nurse (LPN) U said the resident had a period of time where he/she had multiple falls and was very non-compliant with interventions and education. Review of the resident's care plan showed staff did not update or revise the care plan to address the resident's fall risk and continued falls on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] as well as the interventions put in place to prevent falls, including the fall mat, low bed, and 15 minute checks. 5. Review of Resident #79's undated face sheet showed he/she was his/her own guardian. The resident's diagnoses included lack of coordination, need for assistance with personal cares, muscle weakness, displaced (not in alignment) intertrochanteric fracture of the right femur (upper hip). Review of the resident's care plan, updated [DATE], showed the following:-The resident had an activity of daily living (ADL) self-care performance deficit related to activity intolerance, impaired balance, and limited mobility and fracture of his/her leg;-The resident required assistance from one staff for toileting and to move between surfaces. Review of the resident's progress note, dated [DATE] at 6:30 P.M., showed the resident arrived at the facility in a manual wheelchair. Two staff assisted the resident into bed. Review of the resident's progress note, dated [DATE] at 5:06 A.M., showed the resident required assistance from two staff for activities of daily living (ADLs) and was non-weight bearing on the right leg. Review of the resident's progress note, dated [DATE] at 10:06 A.M., showed the resident required assistance from two staff for all cares and required a hoyer lift (mechanical lift) for transfers. Review of the resident's orthopedic consult note, dated [DATE], showed the following:-Continue therapy as ordered;-Weight bearing as tolerated to the right lower extremity, no restrictions. Observation on [DATE] at 2:37 P.M. showed Nursing Assistant (NA) E, NA S and NA T transferred the resident from his/her wheelchair to the bed with a hoyer lift. During an interview on [DATE] at 4:02 P.M., the Therapy Director said the following:-Orthopedics cleared the resident for weight-bearing as tolerated;-The resident remained a hoyer lift for non-therapy staff due to the resident's fear and neuropathy. During an interview on [DATE] at 4:15 P.M., NA S said the resident used a hoyer lift to transfer. During an interview on [DATE] at 4:21 P.M., Licensed Practical Nurse (LPN) U said the resident was cleared for weight-bearing as tolerated, but therapy had not released him/her, so he/she still transferred with a hoyer lift. Review of the resident's care plan showed staff did not update the plan to adequately reflect the resident's transfer status. 6. During an interview on [DATE], at 2:50 P.M., the Administrator said the following: -The Interdisciplinary Team (IDT) was responsible for completing and updating the care plans at each risk management meeting;-She updated the resident care plans during that meeting;-The care plan should be accurate and show the most current level of care for each resident;-The facility did not have a specific care plan coordinator;-A staff member from corporate had been updating care plans and seemed to be resolving issues that were still current;-The staff member from corporate was not helping with care plan updates anymore.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately complete an assessment to identify the history of trauma, the presence of symptoms related to the trauma, and triggers that may cause re-traumatization and to develop an individualized care plan with interventions to mitigate and eliminate these triggers for three residents (Residents #88, #6 and #23), in a review of 30 sampled residents. The facility census was 116. Review of the facility policy, Trauma Informed Care, revised 05/14/24, showed the following:-It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization;-Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma may include, but are not limited to natural and human caused disasters; accidents; war; physical, sexual, mental, and/or emotional abuse (past or present); rape; violent crime; history of imprisonment; history of homelessness; traumatic life events (death of a loved one, personal illness, etc.);- Trauma-Informed Care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization;-The facility will work to facilitate the principles of trauma informed care which include: A. Safety ensuring residents have a sense of emotional and physical safety; B. Trustworthiness and transparency Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident; C. Peer support and mutual self-help - If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals; D. Collaboration is an emphasis on partnering between residents and/or his/her representative, and all staff and disciplines involved in the resident's care in developing the plan of care; E. Empowerment, voice and choice - Ensuring resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths;-The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his/her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social history/assessment, and others;-The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions;-In some cases, if the facility has more than one trauma survivor, social services will make a good faith effort at establishing a support group that is run by a qualified professional or allow a support group to meet in the facility. If a group cannot be run/meet at facility, social services will assist the resident in locating a support group in the community as appropriate and feasible;-The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to: A. Experiencing a lack of privacy or confinement in a crowded or small space; B. Exposure to loud (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noises, or bright/flashing lights; C. Certain sights, such as objects that are associated with their abuser; D. Sounds, smells, and physical touch;-Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery;-The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified;-In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. 1. Review of Resident #23's Level II Preadmission Screening and Resident Review (PASRR, a screening for serious mental illness, intellectual disability, developmental disability or related conditions that ensures appropriate placement and ensures one receives the necessary specialized services identified)/Level II Evaluations, dated 1/27/25, showed the following:-Diagnoses included post-traumatic stress disorder (PTSD, mental health condition triggered by experiencing or witnessing terrifying events) with nightmare disorder, bipolar disorder (mood disorder that can cause intense mood swings) severe with psychotic features, major depressive disorder, traumatic brain injury (TBI, a disruption in normal brain function caused by an external physical force or a penetrating injury) at age [AGE], dissociative disorder (mental health conditions characterized by an involuntary disconnection between thoughts, memory, identity, or consciousness), mild intellectual disability, borderline personality disorder with psychosis (intense emotional instability combined with short-lived, stress-induced breaks from reality), and personality disorder.-The resident states his/her siblings beat him/her causing 30 percent memory loss;-Onset of psychiatric issues around age [AGE] after a head injury;-History of multiple suicide attempts, anxiety, sadness, confusion, decreased appetite, sleep disturbance, mood swings, hyperactivity, agitation, suspicious, combative behaviors, psychosis and aggression. Impulsive, verbal outburst, command hallucinations, labile, delusional, impulse, depression, problems with concentration, irritability and isolation;-Jailed for hitting people-Crisis intervention: The resident requires a plan to address harm to self or others. Plan should identify clear steps that will be taken to support individual during a crisis situation, specify who to contact for assistance, how staff should work together with individual during the crisis, as well as identify when the physician, emergency medical services and/or law enforcement should be contacted. Review of the resident's care plan, dated 11/04/25, showed the following:-History of PTSD;-PTSD affects resident symptoms and may flare up without any known trigger;-Functional impairment from symptoms, negative alterations in mood and cognitions that began or got worse after the initial event;-Must include two of the following: Inability to recall key features of the event, persistent or negative beliefs, persistent distorted blame, persistent negative emotions, significant lack of interest, feeling of alienation, inability to experience positive emotions;-Goal: The resident will be able to identify triggers and will learn and utilize positive coping strategies. The resident will demonstrate control of emotions and relaxation techniques;-Administer medications appropriately and monitor for side effects or dependance;-Assess anxiety level, determine severity of condition and course of treatment or therapy needs;-Assess resident for suicidal or homicidal ideations to ensure safety of the resident and others;-Assess vitals and assess resident;-Determine baseline for vitals and assess for underlying or accompanying medical conditions;-Encourage the resident to express emotions in a safe environment-Allow residents the freedom to acknowledge their feelings and release any repressed emotions that may be exacerbating their distress. A safe environment should be free from actual or perceived judgement and physical or perceived danger.-Encourage the resident to keep a journal of stressors and emotional reactions to those stressors-Help the resident identify triggers that prompt anxiety or symptoms and evaluate the outcomes of those reactions;-Encourage the resident to verbally identify current (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ineffective coping techniques. Help the resident understand his/her current behaviors that may be preventing effective healing or treatment.(The resident's care plan did not include the type of trauma the resident experienced or specific triggers for the resident.) Review of the resident's quarterly Minimum Data Set (MDS), dated [DATE], showed the following:-Cognitively intact;-Moderate depressive symptoms;-No hallucinations, delusions, or behaviors;-Diagnoses included traumatic brain injury, anxiety disorder, depression, bipolar, schizophrenia, PTSD, impulse disorder, and dysthymic disorder (long term depression);-Medications include antipsychotic, antianxiety, and antidepressant. Review of the resident's Trauma Informed Care Assessment, dated 04/22/26, showed the resident did not experience trauma in the last quarter. (Review of the resident's medical record showed no documentation staff completed a Trauma Informed Care Assessment between admission and 04/22/26.) Observation on 04/30/26 at approximately 9:30 P.M., showed the facility tested the fire alarm. The fire alarm was loud throughout the building. Observation on 04/30/26 at 3:30 P.M. showed the resident sitting in a chair in his/her room. The lights in the room were turned off. During an interview on 04/30/26, at 3:30 P.M., the resident said the following:-He/She had PTSD;-He/She had multiple traumas in his/her life including a bad bike wreck with a head injury, his/her grandparent passed away, abuse by family members, and he/she was injured after an IED exploded while he/she was in the military;-Loud noises like the fire alarm, doors slamming and people arguing and yelling were his/her triggers;-Today, the facility tested the fire alarm, and he/she didn't know it was going to go off. He/She was sitting in his/her room with the light off trying to calm down because the fire alarm triggered him/her;-The tornado siren made him/her feel paralyzed with fear; he/she felt like he/she could not move;-Arguing and yelling gave him/her anxiety;-Doors slamming made him/her feel like he/she needed to run away or get ready to fight someone;-He/She has bad nightmares and took medication to try to prevent the nightmares;-Staff do not do anything to try to prevent him/her from being triggered;-Staff do not warn him/her if they are testing the fire alarm or any other loud noises;-He/She thought they did not warn him/her because they do not care if it triggered anyone;-If he/she knew there was going to be an alarm or a loud noise, he/she could prepare mentally for it so he/she would not be so scared. It takes him/her a long time to calm down. 2. Review of Resident #88's PASRR/Level II Evaluations, completed on 08/26/25, showed the following:-Diagnoses of bipolar disorder, schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder), PTSD, antisocial personality disorder (mental health condition characterized by a lack of regard or remorse for others), psychosis (mental health condition characterized by a disconnection from reality), and substance abuse;-Plan to identify clear steps that will be taken to support individual during crisis. Specify who to contact for assistance, how staff will work together with the individual during a crisis, as well as identify when the physician, emergency medical services, and /or law enforcement will be contacted. Review of the resident's Trauma Informed Care Screen/Assessment, dated 04/24/25, showed the following:-The resident has not experienced a natural disaster, fire/explosion, transportation accident, serious accident, exposure to toxic substances, physical assault, assault with a weapon, sexual assault, combat/war zone, captivity, life-threatening illness/injury; sudden violent death of someone close to you, accidental death of someone close to you; serious injury, harm or death you caused to someone else;-Staff did not identify any symptoms or possible triggers or interventions. Review of the resident's Trauma Informed Care Screen/Assessment, dated 08/27/25, showed the following:-The resident has not experienced a natural disaster, fire/explosion, transportation accident, serious accident, exposure to toxic substances, physical assault, assault with a weapon, sexual assault, combat/war zone, captivity, life-threatening illness/injury; sudden violent death of someone close to you, accidental death of someone close to you; serious injury, harm or death you caused to someone else;-Staff did not identify any symptoms or possible triggers or interventions. Review of the resident's Trauma Informed Care Screen/Assessment, dated 02/10/26, showed the following:-The resident has not experienced a natural disaster, fire/explosion, transportation accident, serious accident, exposure to (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toxic substances, physical assault, assault with a weapon, sexual assault, combat/war zone, captivity, life-threatening illness/injury; sudden violent death of someone close to you, accidental death of someone close to you; serious injury, harm or death you caused to someone else;-Staff did not identify any symptoms or possible triggers or interventions. Review of the resident's care plan, dated 03/17/26, showed the following:-The resident has a history of behavioral challenges that require protective oversight in a secure setting;-Implement plans to change inappropriate behavior-behavior management plan;-Non-pharmaceutical interventions: One-on-one interventions as needed;-Pharmaceutical interventions as needed.(The resident's care plan did not address the resident's diagnosis of PTSD, triggers or interventions to address or prevent re-traumatization.) Review of the resident's comprehensive MDS, dated [DATE], showed the following:-Cognitively intact;-Moderate depression symptoms;-No hallucinations, delusions, or behaviors;-Diagnoses include schizoaffective disorder, hypertension, anxiety and schizophrenia. During an interview on 04/30/26, at 3:50 P.M., the resident said the following:-He/She had traumatic things happen in his/her life;-When he/she was eight years old, he/she saw his/her family member die of a drug overdose. It was scary and awful to witness;-He/She has been bullied, spit on and some worse things he/she didn't want to talk about;- It's hard to think there are children being molested right now as we speak (The resident did not respond when asked if this happened to him/her or someone who was close to him/her. The resident's eyes were teary and his/her voice quivered);-He/She was triggered when he/she felt like someone was trying to manipulate him/her or when they went back on their word;-When he/she tried to meet goals, and the goal post moved farther away, it triggered him/her, and he/she went into fight or flight mode;-It also triggered him/her when people were dishonest or tried to get him/her into trouble. It brought feelings of betrayal to the forefront;- Smoking weed helped him/her stay calm;-He/She was in a drug rehabilitation facility in the past that had physical jobs and responsibilities for everyone;-It was the most peaceful time in his/her life. He/She felt worthy and in control of his/her day-to-day life;-During that time, he/she had jobs like cutting wood or working outside, and it was good for his/her soul;-He/She thought he/she would do better if he/she had goals and felt some self-worth, like a job or something he/she was responsible for and could take pride in; -He/She felt attending real church services would be nice. He/She stayed more grounded when he/she could pray in a structured environment. 3. Review of Resident #6's care plan, dated 11/27/24, showed the following:-The resident had a history of PTSD;-PTSD affected the resident's symptoms and may flare up without any known trigger;-Alterations in reactivity from the traumatic event including aggressiveness and self-destructive behavior, negative alterations in mood and cognitions that began or got worse after the initial event;-Goal: The resident will be able to identify triggers, utilize positive coping strategies and demonstrate control of emotions and relaxation techniques;-Administer medications appropriately and monitor for side effects or dependance;-Assess anxiety level and determine severity of condition and course of treatment or therapy needs;-Encourage the resident to express emotions in a safe environment;-Allow the resident the freedom to acknowledge his/her feelings and release any repressed emotions that may be exacerbating his/her distress;-A safe environment should be free from actual or perceived judgement and physical or perceived danger;-Establish trust with the resident. Listen to what the resident is saying. Behave in a calmmanner;-Establishing trust can help the client calm down and make treatment more effective;-Provide calming and reassuring environment;-Residents with PTSD are often fearful. Provide a calm, relaxing environment can help lessen or relieve anxiety and promote a feeling of safety. Review of the resident's PASRR/ Level II Evaluations, dated 1/27/25, showed the following:-Diagnoses include major depressive disorder, personality disorder (mental health condition characterized by rigid, long-term patterns of thoughts, emotions, and behaviors that differ significantly from cultural expectations), bipolar disorder, generalized anxiety disorder, opioid dependence, PTSD, schizoaffective disorder (mental health condition that includes features of both schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) and a (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mood disorder) and attention-deficit hyperactivity disorder (ADHD, a condition characterized by persistent patterns of inattention, hyperactivity, impulsivity that interfere with daily functioning);-History dates back to 2009 with a diagnosis of bipolar disorder, symptoms have included suicidal ideations, mood lability, increased depression, anxiety, racing thoughts, impulsivity, irritability, distractibility, risk taking behaviors, and manic episodes;-Plan to identify clear steps that will be taken to support individual during crisis, specify who to contact for assistance, how staff will work together with the individual during a crisis, as well as identify when the physician, emergency medical services, and /or law enforcement will be contacted. Review of the resident's Trauma Informed Care Screen/Assessment, dated 06/10/25, showed the following:-Information from the resident;-The resident has not experienced a natural disaster, fire/explosion, transportation accident, serious accident, exposure to toxic substances, physical assault, assault with a weapon, sexual assault, combat/war zone, captivity, life-threatening illness/injury; sudden violent death of someone close to him/her, accidental death of someone close to him/her; serious injury, harm or death he/she caused to someone else;-Staff did not identify any symptoms or possible triggers or interventions. Review of the resident's care plan, dated 08/18/25, showed on 08/18/25, the resident believed he/she heard a motorcycle and thought it was his/her ex coming to get him/her. He/She broke the window in his/her room and went out into the fenced area. He/She then saw it was the lawnmower, and he/she came back into the building and let staff know. Review of the resident's Trauma Informed Care Screen/Assessment, dated 09/10/25, showed the following:-Information from the resident;-The resident has not experienced a natural disaster, fire/explosion, transportation accident, serious accident, exposure to toxic substances, physical assault, assault with a weapon, sexual assault, combat/war zone, captivity, life-threatening illness/injury; sudden violent death of someone close to him/her, accidental death of someone close to him/her; serious injury, harm or death he/she caused to someone else;-Staff did not identify any symptoms or possible triggers or interventions. Review of the resident's care plan, dated 12/04/25, showed the following:-The resident's safety plan with his/her personal goal to go home:-Past crisis moments include rape and drug use.(The resident's care plan did not list any triggers for the resident or direction to staff on how to prevent triggering or re-traumatization of the resident.) Review of the resident's Care Plan, updated 03/05/26, showed the resident had a psychosocial well-being problem related to anxiety and PTSD from past relationships. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Moderate depression symptoms;-No hallucinations, delusions, or behaviors;-Diagnoses included anxiety, depression, bipolar, schizophrenia, and PTSD. During an interview on 04/26/26 at 11:19 A.M., the resident said he/she had severe PTSD. People of the opposite sex are one of his/her triggers. When people of the opposite sex yell or fight, it triggers him/her. He/She wants to get involved and help; he/she has a [NAME] complex but then he/she ends up getting hurt;-He/She has experienced a lot of trauma;-He/She broke out his/her window when he/she was triggered because he/she thought someone was after him/her. During an interview on 04/30/26 at 4:25 P.M., the Administrator said the resident had an episode on 4/30/26 when he/she came to the dining room naked, wrapped in a blanket, and would not speak. He/She was sent to the psychiatric hospital for evaluation. During an interview on 04/30/26, at 4:40 P.M., Certified Nurse Assistant (CNA H) said the resident was sleeping most of the morning, then he/she was in the bathroom a lot. The resident came to the dining room naked wrapped in a blanket and would not speak or respond to staff, so they sent him/her out on 04/30/26. During an interview on 05/05/26 at 2:52 P.M., the resident's guardian's deputy said the following:-The resident was sent to the hospital on [DATE];-He/She was not sure what triggered the resident;-PTSD was on the resident's PASRR but he/she did not know the specifics;-The resident was triggered often and could become violent;-The resident had several violent behaviors and destroyed property when he/she had outburst;-In August, he/she knocked out the window in his/her room and climbed out because he/she thought he/she heard a motorcycle and thought he/she was in danger. The resident went back into the facility when he/she saw the sound (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	came from the lawn [NAME]. 4. During an interview on 04/30/26, at 4:08 P.M., Certified Nurse Assistant (CNA) H said he/she was not sure which residents had PTSD. During an interview on 04/30/26, at 4:12 P.M., Certified Medication Technician (CMT) B said the following:-He/She was the team lead, often, on Station II (locked behavioral unit;-He/She knew Resident #6 had PTSD, but he/she was not sure of the specifics;-There were many residents on Station II who most likely had PTSD;-He/She did not know of any specific triggers for the residents with PTSD;-If he/she had questions, he/she would look at the resident's care plan. During an interview on 04/30/26 at 2:50 P.M., the Administrator said the following:-Staff complete a Trauma Informed Care Assessment for resident with PTSD;-She or the Social Services Director completed the initial Trauma Informed Care Assessments;-She completed the Trauma Informed Care Assessment from the information provided on the residents' PASRR. If the PASRR did not include the specific trauma or triggers, then they may not know them;-She did not interview the residents when completing the assessment;-The staff had not been instructed to call the guardians for information about the residents' traumas.-She was not aware the fire alarm triggered Resident #23;-The facility could not prevent sounding the fire alarm or tell residents in advance staff were sounding the fire alarm because it would make the fire drill useless;-Ideally, the facility would know what caused the residents' trauma and what the residents' triggers were so they were on the care plan for staff to know what to be aware of for each resident.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on observation, interview, and record review, the facility failed to ensure four nurse aides completed a nurse aide (NA) training program within four months of their employment in the facility. The census was 116. Review of the facility's policy, Nurse Aide Training Program, revised 05/18/24, showed the following:-Purpose: This facility maintains an appropriate and effective nurse aide in-service training program for the purpose of ensuring the continuing competence of nurse aides;-The facility, with oversight from the Director of Nursing, shall be responsible for the coordination and/or provision of nurse aide education. Review of the facility's' undated Hospitality Aide Duties, showed the following:-Purpose: The Hospitality Aide position is a way to ensure there is extra support within the facility to help assist with non-nursing duties. To help ensure proper and effective guidelines for the role and tasks of all Hospitality Aides:-Walking rounds;-Intensive monitoring (frequent checks and one-on-one monitoring);-Assisting with smoking breaks for residents;-Cleaning of facility/resident equipment;-Assist with transportation of residents throughout unit, facility, or outings that do not require direct hands-on care;-Attend and assist with Code Greens (behavioral emergencies);-Assist with cardiopulmonary resuscitation (CPR, an emergency, life-saving technique used when a person's heartbeat or breathing has stopped) if the employee has proper certification;-Assist with activities (board games, puzzles, nail painting of residents);- Job Duties that the Hospitality Aides may not assist with on their assigned units include: -Direct patient care; -Bathing; -Dressing; -Grooming; -Turn and repositioning; -Feeding; -Hands on assistance of residents found on floor or witnessed falls; -Activities of Daily Living (ADL) Cares; -Peri-care (Perineal care (peri-care) - Care to the surface area between the thighs, extending from the pubic bone to tail bone.); -Catheter care (Indwelling - A sterile tube inserted into the bladder to drain urine); -Intake and output measuring/documenting (any food or drink intake and any urine output measuring or documenting for the resident). 1. Review of the facility nurse aide report showed NA E's date of hire, for the position of NA, was 02/10/25. Review of NA E's employee file showed no documentation NA E completed a nurse aide training program within four months of his/her hire date. Review of NA E's timecard on 04/29/26 at 3:02 P.M., showed he/she was a hospitality aide and was assigned to the direct care nursing department. During an interview on 04/29/26, at 4:20 P.M., NA E said the following:-He/She had been working as an NA for about a year and had been in classes since December 2025;-He/She would start testing on 05/09/26;-He/She worked as a hospitality aide at a different facility and knew the hospitality aide was not allowed to do any hands on work;-Since working at the facility, his/her title was NA and he/she provided daily care for the residents. Observation on 4/26/26 at 2:37 P.M. showed NA E assisted NA T and NA S to transfer a resident with a hoyer lift (a mechanical lift designed to safely transfer a resident with limited mobility). 2. Review of the facility nurse aide report showed NA X's date of hire, for the position of NA, was 08/01/25. Review of NA X's employee file showed no documentation NA X completed a nurse aide training program within four months of his/her hire date. During an interview on 05/08/26 at 8:30 P.M., NA X said the following:-He/She started working at the facility in August 2025 and was hired as a NA. He/She had never worked in another department and did not know what a hospitality aide was and no one from Human Resources told him/her he/she was a hospitality aide;-He/She started taking classes for certification as a CNA a couple of months ago;-He/She performed care for residents which included peri-care, catheter care, gait belt transfers and Hoyer lift transfers with another staff. 3. Review of the facility nurse aide report showed NA G's date of hire, for the position of NA, was 08/05/25. Review of NA G's employee file showed no documentation NA G completed a nurse aide training program within four months of his/her hire date. Observation on 04/29/26 at 1:25 P.M., showed the following:-NA G assisted Certified Nurse Assistant (CNA) C provide peri-care to Resident #48;-NA G assisted the resident to turn from his/her right side to left side to remove soiled clothing and linens;- NA G assisted the resident to take off his/her soiled shirt (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and assisted the resident to dress;-NA G used a gait belt and assisted the resident to stand During interviews on 04/29/26 at 3:59 P.M. and 05/06/26 at 9:55 A.M., NA G said he/she started working at the facility in August 2025 and was hired as a NA. He/She started taking nurse aide classes one to two months after he/she was hired but had not completed the course. No one told him/her she/he had four months to finish the nurse aide training program. Examples of some of the duties he/she performed included peri care, gait belt transfers, Hoyer lift transfers with other staff members, and resident showers. 4. During an interview on 04/29/26 at 3:20 P.M. and 05/08/26 at 8:01 A.M., Human Resources said the following:-She thought all the NA employees were considered NAs since their hire date. This information was listed on her NA spreadsheet. Corporate called them (the NAs) hospitality aides, but they were listed in the nursing direct care department;-When the facility hired an NA, the NA had 120 days to obtain a certified nurse assistant certification;-She was responsible for tracking the NA progression. She tracked the NA progression by writing their names and cutoff date on a whiteboard in her office. She logged into staffing development and checked the NAs class progression weekly;-If an NA had not completed their certification within four months, the NA was transferred out of the nursing department until they were certified;-She would not expect an NA to be in a position for more than four months without completing their certification. During interviews on 04/30/26 at 2:50 P.M. and 05/05/26 at 11:48 A.M., the Administrator said the following:-An NA was to complete their CNA certification within four months of hire. If they did not, they should be transferred to another department or terminated;-She only knew of one NA who had not completed his/her certification training;-Human Resources and administration were responsible to ensure an NA completed the certified training within four months of their hire date;-Hospitality aides would not provide hands on resident care. An NA was responsible for providing bathing, peri-care, transfers, etc.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure discontinued and course completed medications, stored in the Station One medication storage room, were destroyed within 30 days according to the facility policy, for one resident (Resident #12), in a review of 30 sampled residents, and for three additional residents (Residents #37, #45 and #87). The facility census was 116. Review of the facility's Medication Destruction Policy, revised 6/26/24, showed the following:-Purpose: The purpose of this policy is to ensure medications that cannot be returned to the dispensing pharmacy are destroyed;-Medications should be destroyed weekly if possible but at a minimum of monthly;-The DON is responsible for ensuring that the medications that are no longer needed are being kept securely and destroyed properly. 1. Review of Resident #12's physicians order summary report, dated March 2026, showed the following:-An order, dated 03/02/26, to discontinue atorvastatin calcium (a cholesterol medication) 40 milligrams (mg), give two tablets via peg tube (g-tube, surgical insertion of a tube through the abdominal wall into the stomach) at bedtime. -An order, dated 03/02/26, to discontinue haloperidol (an antipsychotic medication) 5 mg, give one tablet via g-tube every six hours as needed for agitation or aggression for 14 days. -Ibuprofen (pain reliever) 600 mg, give one tablet via g-tube three times a day for right finger pain for three days. This medication was completed on 03/26/26. Observation on 04/28/26 at 4:16 P.M. showed the following medications, labeled for the resident, were stored in an upper cabinet in the Station One medication storage room:-Twenty-four atorvastatin calcium 40 mg tablets;-Twenty haloperidol 5 mg tablets;-Six ibuprofen 600 mg tablets.(Staff failed to destroy the medications within 30 days, per facility policy, after the medications were discontinued.) 2. Review of Resident #37's physician order, dated 12/04/25, showed an order to discontinue hydroxyzine pamoate (anti-anxiety medication) 25 mg, give one capsule at bedtime related to generalized anxiety disorder. Observation on 04/29/26 at 8:17 A.M., showed 21 capsules of hydroxyzine pamoate, labeled for the resident, were stored in the upper cabinet in the Station One medication storage room.(Staff failed to destroy the medication within 30 days, per facility policy, after the medication were discontinued.) 3. Review of Resident #45's physician order for December 2025 showed an order for hydroxyzine hydrochloric acid (HCL) 50 mg, give one tablet by mouth every six hours as needed for anxiety or agitation for 14 days. This medication was completed on 12/22/25. Review of the resident's physician orders for February 2026 showed an order for lactulose oral solution, give 30 milliliters (mL) by mouth every 24 hours as needed for constipation for 14 days. This medication was completed on 02/27/26. Observation on 04/29/26 at 8:17 A.M., showed the following medications, labeled for the resident, were stored in an upper cabinet in the Station One medication storage room:-Nine hydroxyzine hcl 50 mg tablets;-Approximately 328 ml lactulose oral solution.(Staff failed to destroy the medications within 30 days, per facility policy, after the medications were discontinued.) 4. Review of Resident #84's physician order for February 2026 showed an order for hydroxyzine hydrochloric acid (HCL) 50 mg, give one tablet every 24 hours as needed for anxiety or sleep for 14 days. This medication was completed on 02/13/26. Observation on 04/29/26 at 8:17 A.M., showed 11 tablets of hydroxyzine hcl 50 mg, labeled for the resident, were stored in the upper cabinet in the Station One medication storage room.(Staff failed to destroy the medication within 30 days, per facility policy, after the medication were discontinued.) 5. During an interview on 04/28/26 at 8:39 A.M., the Staffing Mentor/Educator said she and the Assistant Director of Nursing (ADON) usually destroyed the medications in the medication storage rooms. She tried to check the storage rooms for medications to be destroyed at least once a week. It had been a week or two since she checked the cabinet for medications to be destroyed. She destroyed medications on 04/23/26 with the Administrator. There were no medications left in the cabinet to be destroyed. Discontinued or completed medications had to be (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	destroyed at least once per month. During an interview on 04/29/26 at 5:21 P.M., the ADON said she usually destroyed medications with the Staffing Mentor/Educator. The Administrator destroyed medications with the Staffing Mentor/Educator last week while he/she was on vacation. Staff usually destroyed medications every week. During an interview on 04/30/26 at 2:50 P.M., the Administrator said staff should destroy medications in a timely manner. During an interview on 04/30/26 at 2:50 P.M., the Corporate Director of Nursing (DON) representative said staff should destroy medications at least monthly.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to provide a nourishing and well-balanced diet to meet dietary needs when staff failed to follow the recipe when preparing the lunch entree on 04/27/26 and failed to ensure staff prepared sufficient food to serve all residents the food items on the lunch menu for 04/27/26. The facility census was 116. Review of the Diet Spreadsheet on 4/27/26 for the lunch meal showed the meal was to include ravioli bake (one slice), cauliflower, breadstick, and apple orchard bar. Observation on 4/27/26 between 12:00 P.M. and 12:45 P.M. during the lunch meal service showed Dietary Staff M served ravioli bake, cauliflower, rolls and canned fruit. Observation on 4/27/26 at 12:46 P.M. during the lunch meal service showed the kitchen ran out of the ravioli bake entree and rolls. Staff served three residents on the 500 Hall the entree. Staff served the remaining residents (approximately 15 residents) on the 500 Hall a ham and cheese sandwich instead of the ravioli bake entree and served biscuits instead of rolls. During interviews on 4/27/26 at 12:49 P.M. and 1:15 P.M., Dietary Staff M said the following:-He/She was probably giving the residents a larger portion of the entree than needed;-He/She served the ravioli bake with a 6-ounce serving scoop. The dietary manager selected the scoop he/she was supposed to utilize for the entree. During an interview on 4/27/26 at 12:50 P.M., the Dietary Manager said the cook who prepared the lunch items should have prepared four pans of ravioli instead of three. She instructed the cook to serve the remaining residents on the 500 Hall (those that did not receive the ravioli bake) a ham and cheese sandwich, cauliflower, creamed corn (alternate vegetable option) and a biscuit (as the facility had run out of rolls). During an interview on 4/27/26 at 5:50 P.M., Resident #79 said the facility ran out food a lot and the only alternative available was a cold-cut sandwich. 2. Review of the recipe for ravioli bake showed the ingredients included spaghetti sauce, cheese ravioli, cottage cheese, mozzarella cheese, and parmesan cheese. During an interview on 4/28/26 at 10:00 A.M., the Dietary Manager said Dietary Staff N did not properly prepare the lunch on 4/27/26. Dietary Staff N should have added cottage cheese and mozzarella cheese to the ravioli bake and did not. She did not watch Dietary Staff N prepare the entree. Dietary Staff N was a newer employee, was young and needed more training. Cooks should follow the recipe when making food items. During an interview on 4/28/26 at 10:15 A.M., Dietary Staff N said staff should follow the recipe when preparing food items. He/She thought the ravioli bake already had the cottage cheese and mozzarella cheese included inside the ravioli, so he did not add these ingredients to the entree. 3. During an interview on 5/5/26 at 2:11 P.M., the Consultant Dietitian said the following:-The facility could have run out of a food item for possibly serving too portions that were too large, or they may not have prepared the item properly;-The facility probably should have served something hot in place of the ravioli bake on 4/27/26, but it would have to be prepared quickly since this occurred near the end of the meal service.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to prepare and serve food items to conserve nutritive value, flavor, appearance and temperature. The facility census was 116. Review of the undated facility policy, Food Temperatures, showed the following:-Foods will be served at proper temperature to ensure food safety;-Take the temperature of each pan of product before serving;-Acceptable serving temperatures are: -Cereal, gravy, casseroles, meat, entrees, potatoes, pasta, soup, pureed foods, hot pureed foods, cold vegetables, coffee: >140 degrees but preferably 160-175 degrees; -Hazardous salads and desserts <41 degrees; -Eggs 140-155 degrees;-If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution and discarded out of temperature range foods. 1. During an interview on 04/26/26 at 11:19 A.M., Resident #6 said the food was not good. The food was fake and rubbery and was very low-quality food. Most of the time, the food had no flavor and was served at room temperature. During an interview on 04/26/26 at 11:26 A.M., Resident #66 said the food was not hot, it was usually room temperature. The facility did not give the residents condiments like ketchup, mustard, or mayo with their meals. During an interview on 04/26/26 at 11:26 A.M., Resident #42 said the food was not good. There is no seasoning. Staff never sent condiments. The food tasted like staff just dumped a can and was barely warmed. Staff served burnt pizza, and the sausage was undercooked. Staff served powdered eggs, and no one liked them. The food was never hot; you are lucky if it was warm. During an interview on 04/26/26 at 11:26 A.M., Resident #55 said the food was always cold. Staff never gave the residents ketchup and mustard. The food was often undercooked or overcooked and mushy. During an interview on 04/26/26 at 11:44 A.M., Resident #15 said a lot of the food was greasy and was not very good. The food did not taste good at all. During an interview on 04/26/26 at 3:04 P.M., Resident #31 said the food was not very good and was often bland. During an interview on 04/26/26 at 3:49 P.M., Resident #107 said the food was not good. Staff boiled everything to the point of mush and it was not good. During an interview on 4/27/26 at 5:50 P.M., Resident #79 said the food was not very good. It rarely was hot, most of the time it was barely warm. During an interview on 4/28/26 at 2:40 P.M., Resident #84 said the food was not great. 2. Record review of the Diet Spreadsheet for lunch on 4/27/26 showed staff were to serve ravioli bake and cauliflower. Observation on 4/27/26 at 12:57 P.M. showed the lunch service ended. Observation on 4/27/26 at 12:58 P.M. showed Dietary Staff M prepared sample test tray. Observation on 4/27/26 at 1:01 P.M. of the sample test tray, showed the following:-Staff did not serve the ravioli bake as the facility ran out of this item during the meal service;-The temperature of the cauliflower was 90.3 degrees Fahrenheit (F). The cauliflower tasted cold;-The temperature of the creamed corn (alternate vegetable) was 109.7 degrees F and tasted cold. 3. Record review of the Diet Spreadsheet for lunch on 4/28/26 showed staff were to serve the following:-Chicken teriyaki;-Broccoli (medley of yellow squash, snow peas, broccoli and carrots was substituted for broccoli). Observation on 4/28/26 at 12:50 P.M. showed the lunch service ended. Observation on 4/28/26 at 12:51 P.M. showed Dietary Staff M prepared the sample test tray. Observation on 4/28/26 at 12:51 P.M. of the sample test tray showed the following:-The temperature of the chicken teriyaki was 108.6 degrees F. The chicken tasted cold;-Vegetable medley of yellow squash, snow peas, broccoli and carrots was 100 degrees F and was cold to taste. During an interview on 4/28/26 at 1:12 P.M., the Dietary Manager said staff should serve hot food items at a temperature of at least 120 degrees F. During an interview on 5/5/26 at 2:11 P.M. the Consultant Dietitian said the following:-Staff should serve hot food items at 120 degrees F;-She was unaware the residents complained of cold food.

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	265526	A. Building B. Wing	04/30/2026

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food that accommodated residents' allergies, intolerances, and preferences, when staff served fish to one resident (Resident #120), who had an allergy to fish and seafood which resulted in an allergic reaction of a rash and itching skin that required medication. The facility failed to provide food/drink items to one resident (Resident #5), in a review of 30 sampled residents, and one additional resident (Resident #55) per their preference. The facility census was 116. Review of the undated facility policy, Diet Identification Card, showed the following:-A diet identification tray card will be completed for each resident by authorized Dietary personnel to ensure residents receive the proper diet as ordered by the physician;-Include information as appropriate, such as beverage and food preferences and food allergies. 1. Review of Resident #120's face sheet showed the resident was admitted to the facility on [DATE]. The resident had an allergy to fish and seafood. Review of the resident's allergy report, dated 04/17/26, showed the resident had an allergy to fish and seafood. Review of the resident's physician's orders sheet, dated 04/17/26, showed the resident had an allergy to fish and seafood. Review of the resident's baseline care plan, dated 04/17/26, showed the resident had an allergy to fish and seafood. Review of the resident's pink dietary order slip, completed by nursing staff on 4/17/26, showed the resident had an allergy to fish and seafood. Review of the Week at a Glance menu for lunch on 4/17/26 showed the menu included oven fried fish. Review of the resident's medication administration record (MAR), dated 04/17/26, showed staff administered 50 milligrams (mg) of Benadryl (antihistamine) at 11:08 P.M. Review of the resident's nurses' notes, dated 04/17/26 at 11:08 P.M., showed staff administered Benadryl for complaints of itching to the resident's abdomen. The staff documented the resident had a rash. Review of the resident's nurses' notes, dated 04/18/26 at 12:35 A.M., showed the resident said the Benadryl helped with the itching. The areas of rash remained red. During an interview on 04/26/26, at 1:09 P.M., the resident said he/she was allergic to fish. Staff served him/her fish about a week ago. He/She didn't eat the fish on his/her plate, but it contaminated his/her noodles. He/She broke out into hives and had to take Benadryl twice for the hives caused by the fish. During interviews on 4/28/26 at 10:00 A.M., 12:21 P.M., and 1:12 P.M., the Dietary Manager said the following:-Nursing staff completed a pink diet slip when the resident was admitted , and she was not aware the resident had an allergy;-She was on vacation when the resident was admitted to the facility. Dietary staff made out the tray ticket for the resident in her absence;-Dietary staff were not aware the resident was allergic to anything;-Staff served fish for the meal on 4/17/26;-The resident did not like fish;-If the resident had an allergy, it would be listed on the tray ticket. The resident did not have any allergies according to the tray ticket;-Staff should not serve a resident fish if the resident had a fish allergy;-She did not complete a formal tray ticket for the resident until 4/27/26. During an interview on 5/5/26 at 2:11 P.M., the Consultant Dietitian said staff should list the resident's allergies on the resident's tray ticket. 2. During an interview on 04/26/26 at 4:25 P.M., Resident #55 said he/she requested milk with his/her lunch, but staff told him/her he/she couldn't have milk and could only have tea or lemonade. Observation and interview on 04/30/26, at 12:10 P.M. showed the resident sat at the dining room table. Staff served him/her a meal tray. Staff did not serve the resident milk with his/her meal. The resident said he/she requested milk, and the staff told him/her to drink tea or lemonade. During an interview on 04/30/26, at 12:25 P.M., Certified Nurse Assistant (CNA) H said the dietary staff was supposed to put milk on the trays for residents who had orders for milk. There was never milk in the refrigerator on the unit for the residents. Staff would have to go to the kitchen to get milk. The other residents would get upset if staff had to stop passing their meal trays to go to the kitchen to get milk. He/She could get milk for the residents after he/she finished passing trays but by then the resident would probably be (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	done eating. If there was milk on the unit or dietary staff sent milk with the meal trays, it would be possible to give the residents milk when requested. During an interview on 4/28/26 at 12:21 P.M., the Dietary Manager said the following:-Staff prepare all the drinks in the kitchen;-Dietary staff served milk with breakfast; -Residents can ask for milk when they want milk;-There should be cartons of milk in the Station One and Station Two nurses stations;-If she was aware a resident wanted milk, staff could add it to the resident's meal tray card;-She was unaware Resident #55 wanted milk with meals. The resident did not require a physician's order for milk. 3. Review of the spreadsheet menu for the evening meal on 4/27/26 showed staff were to serve bean soup, crackers, ham and cheese sandwiches, carrot and raisin salad, pudding parfait and beverage. Observation on 4/27/26 at 5:53 P.M., showed the following:-Staff served Resident #5 a cheese sandwich with one slice of bread, one heel (end piece) of bread and one slice of cheese;-The resident's meal card had a handwritten note stating, no ham sandwich. The resident was on a regular diet, with no restrictions. During an interview on 4/27/26 at 05:54 P.M., Resident #5 said the following:-He/She would like to have a ham and cheese sandwich that was shown on the menu;-He/She received a cheese and bread sandwich;-He/She liked deli ham. During an interview on 4/28/26 at 12:21 P.M., the Dietary Manager said Resident #5 only liked a specific cut of deli ham and not regular ham. The facility did not have the preferred item available to serve. Staff should prepare a sandwich with two slices of bread, two to four slices of deli meat (depending on thickness), and one to two slices of cheese. Staff should not use the heels of the bread.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interview, the facility failed to ensure compliance with the Federal requirement for nurse aide training when the facility charged nurse aides, employed by the facility, for the cost of the nurse aide training program. The facility census was 116.Review of the Code of Federal Regulation, 42 CFR 483.152 Requirements for approval of a nurse aide training and competency evaluation program, showed the following:(c) Prohibition of charges. (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials).Review of the undated facility policy, Agreement Between (the facility corporation) and Employee Regarding Payment for CNA Courses, showed the following: -This agreement (Agreement) is made and entered into by and between (the facility corporation) (hereinafter referred to as the Employer) and the undersigned employee (hereinafter referred to as the Employee);-1. Course Payment and Employment Commitment: The employer agrees to cover the cost of the Certified Nursing Assistant (CNA) training course for the employee in the amount of $700. In exchange, the employee agrees to commit to employment with the employer for a minimum of 12 months starting from the date of course completion;-2. Repayment Terms: The employee agrees to repay the employer the total sum of $700, prorated over the course of 12 months. This repayment will be deducted from the employee's paycheck on a bi-weekly basis in the amount of $26.92 per pay period. The first deduction will occur in the pay period following the Employee's completion of the CNA course;-3. Prorated Payback Clause: If the employee voluntarily resigns or is terminated for cause before completing 12 months of employment, the Employee agrees to repay the remaining balance of the course cost. The outstanding balance will be calculated by multiplying the number of remaining pay periods by the bi-weekly deduction amount. The employer will withhold any outstanding balance from the Employee's final paycheck;-4. Payment Arrangements: In the event the employee's final paycheck does not fully cover the remaining amount owed, the employee agrees to make payment arrangements with the Employer. The terms of such payment arrangements will be mutually agreed upon but must ensure full repayment within a reasonable period;-5. Acknowledgment: By signing this agreement, the employee acknowledges that they have read, understand, and agree to the terms and conditions herein. This agreement shall be binding upon the parties and their respective heirs, legal representatives, successors, and assigns;-This agreement constitutes the full and complete understanding between the parties regarding the matters addressed herein and may not be altered or amended except in writing signed by both parties. 1. Review of the facility provided agreement, between the facility corporation and NA Z, regarding payment for the CNA course showed NA Z and Human Resources (HR) signed the contract on 2/18/26. During an interview on 04/28/26 at 1:56 P.M., NA Z said the facility paid for his/her CNA course but he/she had to pay it back after he/she finished the course. The facility will take money out of each paycheck until he/she has paid them back for the course. 2. Review of the facility provided agreement, between the facility corporation and NA E, regarding payment for the CNA course showed NA E and HR signed the contract on 01/12/26. During an interview on 04/29/26 at 4:20 P.M., NA E said the facility paid for his/her CNA course when he/she started the course. The facility took money from each of his/her paychecks to pay them back for the course. 3. Review of the facility provided agreement, between the facility corporation and NA X, regarding payment for the CNA course showed NA X and HR signed the contract on 01/15/26. During an interview on 05/08/26 at 8:30 P.M., NA X said the following:-He/She started taking CNA classes a couple of months ago;-He/She was in classes when he/she signed a contract with the facility;-He/She did not remember the specifics of the contract, but the facility paid for his/her CNA course and he/she had to pay them back;-If he/she left employment before six months, the facility would take his/her last paycheck. 4. Review of the facility provided agreement between the facility (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	corporation and NA G, regarding payment for the CNA course showed NA G and HR signed the contract on 10/30/25. 5. Review of the facility provided agreement between the facility corporation and NA S, regarding payment for CNA course showed NA S and HR signed the contract on 04/08/26. 6. During an interview on 04/26/26 at 6:00 P.M., the Human Resources Manager said she was instructed to have the NAs sign the contract to take a portion of money out of each paycheck until the NAs had paid the facility back for the CNA course. She was unaware there was a regulation against requiring the NAs to pay the facility for the CNA courses. During an interview on 04/26/26 at 11:15 A.M., the Administrator said the facility paid for NAs to attend the CNA course. The NA sign a contract stating they will pay a small amount from each paycheck to the facility for the CNA course. If the NA ends employment before 12 months, the employee had to pay the remaining sum back to the facility out of their last check.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call system was audible to ensure staff were alerted to the residents' request for assistance. The facility census was 116. Review of the facility policy, Call Lights Accessibility and Timely Response, revised on [DATE], showed the following:-The purpose of this policy is to ensure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response;-Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include: replace call light, provide a bell or whistle, increase frequency of rounding, etc.);-Ensure the call system alerts staff members directly or goes to a centralized staff work area.-All staff members who see or hear an activated call light are responsible for responding 1. Observations from [DATE] to [DATE] showed the call light monitor and audible signal was located in the locked nursing station for Station One (100, 200 and 300 halls). Plexi glass windows enclosed the nursing station. The lights, located above each resident room door, turned on when the residents in the rooms turned on the call lights. The audible signal from the call light monitor could not be heard from outside the Station One nursing station. The audible signal from the call light monitor could not be heard at the entrance to the 100, 200 and 300 hallways. Observations on [DATE] showed the following:-At 1:50 P.M., the call light above the door to room [ROOM NUMBER] was turned on. No staff were in the hallway. -At 2:01 P.M., the call light for room [ROOM NUMBER] was on. No staff walked to the end of the hall where the room was located between 1:50 P.M. and 2:01 P.M.-At 2:06 P.M., the call light for room [ROOM NUMBER] was on. No staff walked to the end of the hall between 2:01 P.M. and 2:06 P.M.-At 2:09 P.M., the call light for room [ROOM NUMBER] was on. No staff walked to the end of the hall between 2:06 P.M. and 2:09 P.M. The light above the room door was not visible from the front of the hall near the nurses' station. There was no audible sound near the nurses' station to indicate the call light in room [ROOM NUMBER] was turned on; -At 2:17 P.M., NA G walked down the hall but did not answer the call light for room [ROOM NUMBER]. The call light over the door was on, however, there was no audible sound at the nurses' station to indicate the call light was on;-At 2:26 P.M., the call light for room [ROOM NUMBER] was on. No staff walked to the end of the hall between 2:17 P.M. and 2:26 P.M. The light above the room door was not visible from the front of the hall near the nurses' station. There was no audible sound near the nurses' station to indicate the call light in room [ROOM NUMBER] was turned on. During an interview on [DATE] at 11:30 A.M., Certified Nurse Assistant (CNA) CC said he/she could hear the call lights for Station One when in the nursing station, but it was difficult to hear the call lights when he/she was outside the nursing station. During an interview on [DATE] at 1:42 P.M., Licensed Practical Nurse (LPN) F said the following:-He/She could only hear the Station One call lights when he/she was inside the nursing station. He/She could not hear the call lights when in the dining room or hallways;-The only way staff knew if call lights were on in the hallways (100, 200, and 300) was to look at the lights above the residents' doors;-Staff could not see the 300 hallway when they were in the dining room or on the 100 and 200 halls. If staff were not in the nursing station or on the 300 hall, they would not know if a resident turned on a call light on the 300 hall;-Staff could not see the call lights above the doors for the last four rooms on the 200 hall (210, 211, 212, and 213) from the dining room or from the Station One nursing station. Staff had to walk a quarter of the way down the hallway or squat to the ground in order to see those lights due to the wall structure.-If staff could not hear and see the call lights, it could cause delays in staff answering the residents' call lights. During an interview on [DATE], at 2:29 P.M., LPN F said the call lights were not audible unless staff were inside the Station One nursing station. The CNAs would not know a call light was on unless they saw the lights above the door to the (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's room. Observation on [DATE] at 2:29 P.M. showed LPN F opened the Station One nursing station door. The call light monitor was on a screen mounted to the wall. A low beep could be heard from the call light monitor when in the nursing station but was not audible outside of the nurses' station. During an interview on [DATE] at 2:30 P.M., CNA C and Nurse Assistant (NA) G said the call lights were not audible unless they went into the nursing station and they did not go in there often. The only way they knew the call lights were on was if they saw the light above the door. They had to walk down the 200 hall to see the lights above the door for the last four rooms. In order to see the call lights for the 300 hall, they had to walk to that hall to see the lights. The lights on the 300 hall were not visible from the nurses desk. NA G said sometimes residents were upset because staff didn't come quickly to answer their call light but the staff did not know the call light was on. During an interview on [DATE] at 4:15 P.M., NA S said the following:-He/She could not hear the call lights in the hallways, only at the Station One nursing station;-When he/she was on the hall, the only way he/she knew if the call light was turned on was to look at the lights above the residents' doors;-Staff could not see the 300 hall call lights from the 100 or 200 halls, which could delay staff's response to the call lights. During an interview on [DATE], at 3:08 P.M., the Administrator said the call lights used to be very loud and no one had reported they were no longer audible outside the nursing station. She expected the call lights to be audible outside the nursing station so the aides could hear them.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. Based on observation and interview, the facility failed to provide sufficient seating in the Station One dining area to accommodate all residents for dining. Fifty-eight residents lived on the 100, 200, and 300 halls and shared the Station One dining area. The facility census was 116. Observation on 04/26/26 at 12:10 P.M., of the Station One dining area showed the following:-Twelve standard height dining room chairs;-Ten tall chairs were placed along the back wall with no tables in front of them and three tall chairs were placed between two shorter dining tables along a half wall. The chairs were taller than the tables;-One resident turned one of the tall chairs around to use at the shorter table for dining service. The was not a standard height dining room chair available for him/her;-Two residents with wheeled walkers sat in tall chairs with no table to eat from. There were no available standard height dining chairs for the two residents to sit in. Observation on 04/26/26 at 12:23 P.M., during the lunch service in the Station One dining room, showed Resident #105 sat on a tall chair against the wall, with no table present. Resident #105 placed his/her meal tray on the seat of a wheeled walker to eat his/her lunch. Resident #107 sat his/her lunch tray on the counter, ate carrots while standing, and took the fruit from the tray back to his/her room. Resident #84 started to eat while standing at a dining room table and took his/her tray back to his/her room. There were no chairs available for the residents to sit in. During an interview on 04/26/26 at 12:37 P.M., Resident #105 said there were not enough chairs to sit at the dining room tables, so he/she had to sit in the chair against the wall. He/She usually put his/her tray on the seat of his/her wheeled walker to eat. During an interview on 04/26/26 at 2:25 P.M., Resident #46 and Resident #56 said they usually ate in their rooms because there were not enough chairs available for them to sit in the dining room and there had not been enough chairs for quite some time.During an interview on 04/26/26 at 3:49 P.M., Resident #107 said he/she only ate the vegetables on the lunch tray and took his/her fruit back to his/her room because there were not enough chairs for the residents to sit at a table and eat lunch. Observation on 04/26/26 at 12:25 P.M., showed Resident #15 entered the dining room during the meal service and walked around looking for an empty chair. No chairs were available, so the resident left the dining room and was heard saying, Guess I will come back. No place to sit, as he/she left the dining room. Observation on 04/28/26 at 5:10 P.M. of the Station One dining area showed the following:-Two residents used the seats of wheeled walkers for a table while they sat in tall chairs with no dining room table to eat from;-Multiple residents took their trays and went to their rooms to eat;-One resident sat on the floor in the dining room while eating his/her meal, and one resident ate his/her meal while standing. Observation on 04/29/26 at 12:00 P.M., of the Station One dining area showed the following:-Two residents with wheeled walkers sat in tall chairs;-All the standard dining room chairs were occupied;-Dining room services began at approximately 12:10 P.M.;-One resident and his/her visitor stood in the dining room as there were no open chairs available to sit in. Observation on 4/29/26 at 12:46 A.M. showed Resident #16 sat in a tall chair against the wall in the dining room, with no table present. The resident placed his/her meal tray on the seat of his/her walker to eat lunch. During an interview on 04/30/26 at 7:50 A.M., Resident #84 said the following:-He/She preferred to eat in the dining room, but there was not always enough room;-He/She could usually find room at a table, but he/she could not find a chair to sit in;-Earlier that week, he/she had to stand at a table to eat because there were not enough chairs to and he/she did not want to take the meal tray back to his/her room;-He/She saw his/her roommate use his/her wheeled walker as a table because there was not enough room at a table;-He/She took his/her meal tray back to his/her room one other day because there was not a spot for him/her in the dining room;-It would be nice to have enough space for everyone to sit in the dining room, if they wanted to. During an interview on 04/27/26 at 5:57 P.M., Licensed Practical Nurse (LPN) F said it got a little full in the dining room at meal service time, but he/she was not sure if there were enough chairs to accommodate the all the residents. (continued on next page)

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	04/30/2026

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.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/30/26, at 6:03 P.M., the Administrator said there should be enough chairs available in the dining room for all residents to sit for meal service if they would like to sit in the dining room.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the facility's abuse and neglect policy to protect two residents (Residents #23 and #88), who were involved in a resident-to-resident altercation, when staff did not implement measures to remove the residents from contact with one another and evaluate and monitor the residents to prevent further incidents. The facility census was 116. Review of the facility policy Abuse and Neglect, updated 06/12/24, showed the following:-It is the policy of this facility to report all allegations of abuse reported immediately to the Administrator of the facility;-Abuse is the willful infliction of injury which can include certain resident-to-resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse and physical abuse;-Verbal Abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. This includes using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner in a resident's presence.-Physical abuse includes purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner.-Protection: The facility will protect residents from harm during an investigation; -When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated the Licensed Nurse will: a. Respond to the needs of the resident and protect him/her from further incident; d. Notify the Administrator or designee; -The Administrator or designee will complete an Administrative Investigation;-Protection of Residents: The Facility will take steps to prevent mistreatment while the investigation is underway;-Residents who allegedly mistreat another resident will be removed from contact with the resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his/her safety, as well as the safety of other residents and employees in the facility. 1. Review of Resident #88's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 04/18/26, showed the following:-Cognitively intact;-No hallucinations, delusions, or behaviors;-Diagnoses include schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), schizoaffective bipolar type (mental health condition that includes features of both schizophrenia and a mood disorder), personality disorder, and anxiety. During an interview on 04/26/26 at 1:51 P.M., Resident #88 said the following:-A staff member was talking about his/her child, and he/she (Resident #88) said the child was probably gay; -He/She didn't understand why, but Resident #23 started punching him/her in the arm and chest;-Staff were there and did not call a Code [NAME] (behavioral emergency);-He/She had to threaten Resident #23 to get him/her to stop punching him/her;-He/She was able to hold himself/herself back from striking Resident #23 back at that time, but he/she felt set up for failure;-He/She could not let people just beat on him/her and not react, much longer;-He/She was worried Resident #23 would try it when he/she was having a bad day, and it would get him/her in trouble.-Staff did not check him/her for injuries or monitor him/her after the altercation;-He/She did not have plans to get back at Resident #23, as long as Resident #23 didn't come at him/her again. 2. Review of Resident #23's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-No hallucinations, delusions, or behaviors;-Diagnoses include traumatic brain injury, anxiety disorder, depression, bipolar disorder, schizophrenia, post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events like abuse or combat), impulse disorder, and dysthymic disorder (long-term depression). Observation on 04/26/26 at 11:09 A.M., showed the resident in his/her room. The resident was calm. There were no staff near the resident. During an interview on 04/26/26 at 11:09 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.M., Resident #23 said the following:-A staff member was talking about his/her child and Resident #88 said the child was gay;-It made him/her mad because Resident #88 was talking about a child, and he/she punched Resident #88 four to five times;-Then Resident #88 threatened he/she was going to kill him/her (Resident #23) or put him/her in the hospital;-Staff did not call a Code Green;-He/She was still upset and Resident #88 better not mess with him/her again today. He/She was ready for him/her;-Staff did not check him/her for injuries or monitor him/her after the altercation. 3. During an interview on 04/26/26 at 11:15 A.M., Resident #119 said the following:-He/She saw the whole incident between Resident #23 and Resident #88;-Resident #88 punched Resident #23 a bunch of times;-Resident #88 then called Resident #23 a bitch and kept saying try it one more time, and he/she would kill him/her or put him/her in the hospital;-Staff did not call a Code Green. Certified Medication Technician (CMT) B separated the residents. During an interview on 04/26/26, at 11:45 A.M., CMT B said the following:-That morning (4/26/26) around 9:30 A.M. during smoke break, Resident #88 said something about an employee's child that Resident #23 did not like;-Resident #23 started punching Resident #88 in the arm and yelled at him/her;-He/She stepped between the residents;-Resident #88 called Resident #23 names and yelled at him/her because he/she was upset about being punched;-It took a minute to get the residents calmed down, but staff separated them and then notified the interim Director of Nursing;-When there was a resident-to-resident altercation, staff were to call a Code Green. CMT B did not know why staff did not call a code green, I guess because we just dealt with it;-Usually after an altercation, a staff provided one-on-one monitoring with the residents;-The residents were not currently on one-on-one supervision. During an interview on 04/26/26, at 4:15 P.M., the interim Director of Nursing said the following:-She felt the incident between Resident #23 and Resident #88 was reported to him/her this morning, but some details were left out or she missed the details;-She did not realize or did not process that it was a physical altercation;-She thought it was more of an argument;-If there was a physical altercation, staff were to call a Code [NAME] and they did not;-If there was a physical altercation, then a nurse would assess for injuries and staff would monitor the residents until they were safe and there was not a threat of further altercations. During an interview on 04/26/26, at 4:06 P.M., the Administrator said the following:-She was not notified of a resident-to-resident altercation that day (4/26/26);-No one reported to her Resident #23 struck Resident #88 or that they had a verbal exchange;-If residents had a physical altercation, staff were to call a Code [NAME] and safely separate the residents to keep them safe;-She expected staff to report resident-to-resident altercations to her immediately after they separated the residents so she could direct an investigation to start and ensure measures were put into place to protect both residents;-If she was notified timely, one or both residents would be on one-on-one monitoring until the residents were calm, depending on the assessment and investigation, to ensure the residents were protected to prevent further altercations.