STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265545	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Memorial Healthcare Facility	1218 West Locust Bolivar, MO 65613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to ensure all residents were treated with dignity and respect when one staff (Nurse Practitioner (NP)) spoke disrespectfully and in a loud tone when interacting with one resident (Resident #1) in a selected sample of 14 residents. The facility census was 94.The Administrator was notified by the Director of Nursing (DON) and Social Service Director (SSD) on 09/23/25 of the incident regarding the resident and the NP. The NP was removed from the facility that day and the facility completed in-servicing of all staff by 09/25/25. The non-compliance was corrected on 09/25/25. Review of the facility's policy titled Patient Rights and Responsibilities, last revised November 2026, showed the following: -Personnel will be oriented and instructed in observing the patient rights and responsibilities within the capabilities and mission of the organization and complying with laws and regulations. Staff will receive a copy of the code of ethics and the facility's guiding principles during general orientation which provide expectations for professional conduct, mission, vision, and values;-Right to dignity and respect. Be treated with consideration, respect, and dignity, recognizing each resident's individuality.1. Review of Resident #1's face sheet (admission data) showed the following:-admission date of 05/21/20;-Diagnoses included nontraumatic intracerebral hemorrhage in hemisphere cortical (ICH - a stroke subtype that often present with sudden neurological deficits, headache, or seizures). Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff), dated 01/19/26, showed the resident had cognitive skills intact.Review of the resident's care plan, revised on 01/20/26, showed the following:-Allow the resident ample time to absorb and respond to information;-Provide a calm, therapeutic environment and structured routine;-The resident had a diagnosis of anxiety. Use a calm reassuring approach, explain all procedures and provide reassurance and comfort. During an interview on 02/09/26, at 2:50 P.M., the resident said the following:-A few months ago, he/she was upset about his/her blood pressure medication;-He/she went to the nurses' desk to talk to the NP regarding his/her concerns;-He/she and the NP got into it and yelled at each other.During an interview on 02/09/26, at 2:39 P.M., Certified Medication Technician (CMT) B said the following:-Over a month ago CMT B was in the medication room next to the nurses' desk;-CMT B heard yelling at the nurses' desk and looked out the window to see who was yelling;-The resident and the NP were in a heated argument about the resident's medication;-The NP yelled at the resident and the resident yelled back;-Staff should not yell and/or raise their voice to residents;-A nurse and a charge nurse were at the desk while the yelling was going on and neither of them tried to intervene;-CMT B reported the incident to the Social Services Director (SSD) and told her the NP yelled at the resident.During an interview on 02/09/26, at 11:03 A.M., CMT C said he/she was in the bathroom by the nurses' station and heard loudness. A staff member told CMT C later that day that the NP and resident were loud with each other.Review of the SSD investigation, dated 09/23/25, showed the following: -The SSD and Director of Nursing (DON) met with the resident after his/her discussion with the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider;-The resident voiced he/she was frustrated because he/she felt the NP was not listening to him/her and understanding what he/she was trying to say to the NP;-He/she repeatedly voiced his/her frustration but did not feel as if the NP listened to him/her and voiced the NP was also frustrated and speaking to the nurse when he/she approached the NP.During an interview on 02/09/26, at 3:10 P.M., SSD said the following: -She heard loudness outside of her office, it was loud enough to get her attention;-The resident and the NP were loud with each other;-She spoke with the resident later who said he/she felt the NP was not understanding him/her;-The SSD expected staff to be respectful of residents. Residents should be comfortable in their own home. Review of the DON's investigation summary, dated 09/23/25, showed the following:-A nurse reported hearing loud voices coming from his/her office. The DON exited his/her office to investigate and observed the resident yelling at the NP;-The NP stood at the nurses' station and faced the nurse on duty;-They appeared to disagree over an order that the resident requested;-Shortly after the DON exited her office, the resident wheeled away, and the NP returned to his office;-The DON reported this interaction to the Administrator at the time of the incident with the SSD present;-The Administrator contacted the NP's supervisor, and NP was sent home for the remainder of the day. During an interview on 02/09/26 at 3:45 P.M. the DON said she was in her office, and the NP was at the nurses' station and his voice was loud. The NP and the resident were loud. She saw the NP facing the nurse when she walked out to the nurses' station. She reported the incident to the Administrator who instructed her to follow up with the resident and NP. The NP went home for the day. She thinks the NP talked to the nurse, the resident yelled at him and the NP got louder and frustrated.During an interview on 02/10/26, at 10:30 A.M., Certified Nurse Aide (CAN) F said the following;-If a resident was yelling or screaming, he/she would try to de-escalate the situation and offer the resident reassurance. If he/she were unable to calm the resident, he/she would notify the charge nurse;-A staff member yelling at a resident was not appropriate, and was an example of not treating a resident in a respectful and dignified manner;-He/she considered the facility to be the resident's home, and staff should treat residents with respect.During an interview on 02/10/26, at 10:23 A.M., Registered Nurse (RN) D said the following: -If he/she observed a staff member yelling or loud with a resident, he/she would ensure the resident's immediate safety and help the resident;-If a resident was yelling, he/she would attempt to intervene and offer the resident a snack and/or an activity;-If a nurse was unable to calm the resident, he/she would notify the DON or the Administrator;-Staff should not yell at any resident.During an interview on 02/10/26, at 10:25 A.M., RN E said the following:-If a resident yelled at a staff member, he/she would try to determine the cause of the yelling and would intervene;-A staff member yelling at a resident would be inappropriate and an example of not treating a resident with dignity/respect.During an interview on 02/09/26, at 3:50 P.M., the Director of Clinical said the following: -The Administrator called her and said the NP was acting out a little and not typical behavior, he got loud with a resident;-She understood that the resident had got after the NP about something, the NP tried to explain, and the resident got louder, and the Administrator said the NP matched the resident's tone;-The Director of Clinical spoke with the NP who said he was frustrated with the scenario. During interviews on 02/09/26, at 2:51 P.M., and 02/10/26, at 12:08 P.M., the Administrator said the following: -She expected staff to remain professional when working with residents;-The NP's tone matched the resident's tone;-She heard this through a third party. The DON heard it outside of her office.Complaint #2706770