STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265547	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Health Care Center	117 Sycamore Street Greenville, MO 63944

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to keep one resident (Resident #1) free from sexual abuse when another resident (Resident #2) intentionally grabbed and squeezed Resident #1's breast twice. The incident upset Resident #1 and the interventions put into place to prevent the incident from happening again caused Resident #1 to feel punished. The facility census was 58. Review of the facility's policy titled, Abuse and Neglect, dated 06/10/24, showed:Abuse is the willful infliction of injury, reasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations;Sexual abuse is non-consensual contact of any type with a resident. Sexual abuse includes, but is not limited to, the following: unwanted intimate touching of any kind especially of breasts or perineal area;Prevention will also include assessment care planning and monitoring of residents with needs or behaviors which may lead to conflict or neglect;As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis. Review of the facility's investigation report, finalized on 07/22/25, showed: The incident occurred on 07/21/25, between Resident #1 and Resident #2;Resident #1 and Resident #2 sat in their wheelchairs in line to go smoke. Resident #1 sat in front of Resident #2. Resident #1 could not move forward due to other residents being in front of him/her. Resident #2 told Resident #1 he/she was slow and to move. Resident #2 then reached over to Resident #1 and grabbed his/her left breast twice. Resident #1 then reacted by slapping Resident #2 in the stomach. Resident #2 left the area with no further interaction between the two residents;The outcome of the investigation concludes that it was substantiated due to witness statements and Resident #1's statement. Resident #2 denied the allegations;Interventions included staff responded immediately and Resident #2 moved away from Resident #1. Staff did a skin assessment on both residents with no injuries noted. Staff monitored Resident #2 the rest of the night with no additional behaviors. Staff contacted the Director of Nursing (DON), Administrator, physician, psychiatry, and the guardian;Care Plan updates included Resident #2 would smoke separately from Resident #1. Resident #2 received education on personal boundaries. Psychiatry to review Resident #2's medication regime. Would encourage Resident #2 to seek counseling for inappropriate behavior and personal space. Staff would continually observe Resident #2 around other residents. Review of Resident #1's medical record showed:Date of admission on [DATE];Diagnosis of lymphoma (a type of cancer that originates in the lymphatic system - a part of the immune system responsible for fighting off infections), pressure ulcer (damage to the skin and/or underlying tissue as a result of pressure), insomnia (difficulty sleeping), and neoplasm (an abnormal mass of tissue resulting from excessive cell division) of bone;Nurse's Note, dated 07/21/25 at 9:35 P.M., showed at approximately 9:30 P. M., Resident #1 was in line to go out for a smoke break. There was a line in front of the resident and in back of the resident. Resident #1's mobility was via a wheelchair. Resident #2 sat behind Resident #1 and yelled at him/her to move and said he/she was slow and to hurry up and move out of the way. Resident #2 then reached over Resident #1 and grabbed Resident#1's left breast. Resident #1 swung his/her arm backwards with his/her hand and slapped Resident #2 in the stomach and told Resident #2 to stop that; Skin assessment dated , 07/22/25, showed no indication of skin issues from the incident on 07/21/25. Review of the resident's Care Plan, last revised 07/14/25, showed:Did not address any behavior issues. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 05/13/25, showed:Cognition intact;No behaviors. During an interview on 07/23/25 at 9:13 A.M., Resident #1 said the resident who smoked were in line to go outside to smoke. Resident #2 told him/her to move and that he/she was going too slow. Resident #2 then intentionally grabbed Resident #1's breast and squeezed it twice. Resident #1 slapped Resident #2 in the stomach, but not hard, and told Resident #1 to stop and not do that. The facility had 15 minute smoke breaks and Resident #1 agreed to go after Resident #2 so the two were separated during smoke breaks. Resident #2 had been quick to smoke but now took his/her time and Resident #1 had to hurry because staff had things to do and had to stay out later for him/her. Resident #1 said he/she didn't get to socialize with the other residents during the smoke break because he/she had to go out alone. Resident #1 said he/she felt safe and he/she could handle