

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2025
NAME OF PROVIDER OR SUPPLIER  Nathan Richard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Highland Avenue Nevada, MO 64772	

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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported to the Department of Health and Senior Services (DHSS) within the required two-hour timeframe when the facility failed to report a verbal altercation/threat involving two residents (Resident #1 and Resident #2 ). Four residents were sampled. The facility census was 60. Review of the facility's policy titled Abuse and Neglect Policy, revised 06/12/24, showed the following:-It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property, immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;-The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences;-Any owner, operator, employee, manager, agent, or contractor of the facility can report an allegation of abuse/neglect/exploitation to the abuse agency hotline without fear of retaliation;-The Administrator/Designee will refer to the State Operations Manual (SOM) for reporting and utilize the Abuse Neglect Reporting Decision Tree to assess the particular incident. Best practice is to include the SOM and Decision Tree with the investigation. Should the incident be a reportable event, notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. Should the event not be reportable continue and complete the investigation with all supporting information and place file with all investigations;-The facility must ensure that all alleged violations involving abuse, neglect, exploitation, mistreatment, or sexual assault, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation in made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency. While specific forms are not required, the DHSS Initial Reporting Form and Follow-up Investigation Form are attached. If the abuse involves alleged suspicion of crime, it must also be reported to local law enforcement within those time frames. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 08/24/23;-Diagnoses included chronic obstructive pulmonary disease (COPD - a progressive lung condition making breathing difficult due to inflamed airways), diabetes, and high blood pressure. Review of the resident's care plan, revised 11/21/25, showed the following:-The resident and facility would use the resident's Functional Behavioral Assessment to ensure the resident's psychosocial needs were met;-The cause of new onset behavior would be evaluated and determined;-The resident would remain safe;-Undesirable behaviors would be monitored and managed;-Encourage participation in self-calming behaviors such as breathing exercises, meditation, or guided imagery;-Ensure the safety of the resident and others;-Monitor for emotional factors that may contribute to new behaviors;-Monitor for environmental factors that may contribute to new behaviors. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/02/25, showed the following:-The resident's cognition was intact;-The resident had no behaviors. Review of the resident's progress notes showed the following: -On 12/26/25, at 3:16 P.M., staff reported to the Director of Nursing (DON) that the resident and his/her significant other broke up. Staff assessed the resident and he/she did not appear upset;-On 12/27/25, at 4:17 P.M., the resident and his/her ex-significant other talked prior to smoke break. He/she requested the ex-significant other not talk to him/her. Staff advised both residents to not communicate unless it was in a nice manner;-On 12/28/25, at 3:20 P.M., the resident continued to make comments related to his/her ex-significant other. He/she was educated to maintain distance and let staff handle any issues that arose;-On 12/29/25, at 2:36 P.M., the Administrator spoke with the resident's guardian about the significant other situation;-On 12/29/25, at 3:00 P.M., received a call from the resident's guardian reporting the resident called him/her and yelled at him/her. He/she reported the resident had never yelled at him/her and that the resident may need to be placed on the unit. The resident had spoken with several staff this day regarding his/her ex-significant other. The resident reported he/she did not cut the TV cord. Staff notified the resident's</p>		