STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265558	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nathan Richard Health Care Center	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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review, facility staff failed to ensure each resident received necessary behavioral health care and services to attain or maintain highest practicable mental and psychosocial well-being when the facility failed to have process in place to monitor repetitive behavior, failed to document new interventions to address repetitive behaviors, and failed to document behavioral services offered to address behaviors of one resident (Resident #1) who had continued behaviors of inappropriate language directed at or around staff and residents. The facility had a census of 62. Review of the facility policy titled, Behavioral Health Services Policy, revised 10/31/24, showed the following: -The facility is to ensure all residents receive necessary behavioral health services to assist in reaching and maintaining their highest level of mental and psychosocial functioning;-Staff are to accurately document changes in behavior, including frequency of occurrence and potential triggers in the resident's medical record;-The plan of care should be discussed for potential modifications;-The resident and care plan should be evaluated routinely to ensure the approaches are meeting the needs of the resident.1. Review of Resident #1's face sheet (basic information sheet) showed the following:-admission date of 11/01/24;-Diagnoses included dementia (decline in mental ability including memory loss, confusion, and behavioral changes impacting daily life) with behavioral disturbance and a traumatic brain injury (TBI - a disruption in brain function caused by an external force resulting in confusion, headaches, memory loss, and mood changes), and anxiety (persistent and excessive fear or worry).Review of the resident's annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff), dated 01/29/26, showed the following:-Cognitively intact;-No verbal or behavioral symptoms directed towards others.Review of the resident's current care plan, as of 03/19/26, showed the following:-Resident had a TBI, psychosocial needs, and behaviors related to mental illness including yelling, repeating himself/herself;-Staff to avoid confrontation, arguing, or getting defensive with the resident;-Staff to maintain routine as much as possible;-Staff to offer as needed medication for anxiety or agitation;-Staff to provide a comforting and homelike environment;-Staff to provide personal space;-Staff to use simple and clear language;-Staff to monitor for signs of agitation;-Staff to work with the resident to reduce impulse feelings of anger;-Staff to encourage participation in self-calming behaviors such as breathing exercises, medication or guided imagery;-Staff to ensure the resident's and other residents' safety;-Staff to monitor for emotional factors that may contribute to new behaviors;-Staff to monitor for environmental factors that may contribute to new behaviors;-Staff to provide emotional support regarding new onset disruptive behavior, and reorientation of the resident to person, place, time, and situation;Review of a resident nurse's note dated 02/06/26, at 1:41 P.M., showed the following: -The resident talked over another resident while waiting for snacks;-Both residents had elevated tones;-Resident #1 used the term, re****, speaking about the secured unit in general, which upset the other resident;-Staff told the residents to refrain from inappropriate language and to talk to each other nicely;-The residents continued arguing back and forth. Staff stepped between the residents and separated them.Review of the resident's current care plan, as of 03/19/26, showed staff did not updated the care plan after the documented behaviors on 02/06/26. Review of (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265558	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nathan Richard Health Care Center	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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's mental status exam, dated 02/10/26, showed the following: -Psychiatrist (a medical doctor specializing in mental health disorders) evaluation of the resident for a verbal altercation;-The symptoms section showed the resident had a minor verbal altercation and used inappropriate language;-Staff redirected the resident;-Psychiatric evaluation showed the resident at his/her baseline;-The psychiatrist did not recommend care or medication changes. Review of the resident's medical records, dated 02/10/26 to 03/10/26, showed staff did not document monitoring the resident's behaviors and the effectiveness of the implemented interventions. Review of the resident's mental status exam, dated 03/10/26, showed the following: -A routine psychiatric follow-up and medication management;-Symptoms section showed no reported behavioral disturbances or psychiatric concerns;-Psychiatric evaluation showed the resident at his/her baseline;-The psychiatrist did not recommend care or medication changes. Review of the resident's medical records, dated 03/10/26 to 03/13/26, showed staff did not document monitoring the resident's behaviors and the effectiveness of the implemented interventions. Review of a resident nurse's note dated 03/14/26, at 2:00 P.M., showed the following: -The resident called another resident a re****;-Resident #1 said he/she called the other resident, re**** and began talking about wanting a copy of divorce papers from his/her ex-partner. Review of the resident's current care plan, as of 03/19/26, showed on 03/14/26, staff added the following: -An addition of resident calling peers names documented on 03/14/26;-Administer medications as ordered;-Provide as needed medications when non-pharmacological interventions are non-effective;-Provide positive feedback for good behavior;-Notify the guardian/physician as needed;-Psychiatric consultation for medication adjustments as needed;-Encourage him/her to go to more private areas to voice concerns/feelings to assist with decreasing episodes of disturbing others.Review of the resident's current Physician's Order Sheet, as of 03/19/26, showed an order, dated 03/14/26, for hydroxyzine (anti-anxiety medication), 50 milligrams (mg) one tablet given once every twelve hours as needed for anxiety. Review of the resident's March 2026 Medication Administration Record (MAR) showed staff did not administer as needed hydroxyzine.Review of the resident's medical records, dated 03/14/26 to 03/19/26, showed staff did not document monitoring the resident's behaviors and the effectiveness of the implemented interventions. Review of a facility assessment signed by the Human Resources (HR) Manager titled, Resident Concerns Questionnaire, dated 03/18/26, showed the services needed section marked as, no.During an interview on 03/17/26, at 2:10 P.M., Certified Nurse Assistant (CNA) A said the following: -He/she documented a behavioral note on 02/02/26 regarding the resident using the word, re****, while talking to another resident;-The resident #1 talked about the secured unit as a whole and did not direct this comment at anyone specific;-The resident says, re****, daily in conversation;-The resident calls staff and residents re****ed and uses the word when speaking in general;-The resident frequently says, I don't belong here with all the re****s;-Staff attempt to redirect by changing the topic of conversation and reminding him/her of appropriate language;-The resident will typically go to his/her room upset when staff attempt redirection;-Residents avoid Resident #1 due to his/her inappropriate language upsetting them;-Staff moved Resident #2 from the secured unit recently following a verbal incident between him/her and Resident #1;-Resident #1's language was disrespectful and has increased in severity over the last two months. The behavior was occasional and is now daily;-Staff should document a behavior note in the medical record for each instance of inappropriate behavior by the nurse;-Staff were not documenting daily behaviors as required for the resident;-He/She did not know of any additional interventions to address the resident's behavior than redirection;-The Administrator and Director of Nursing (DON) have been aware of the resident's inappropriate language;-The current interventions were not adequately addressing the resident's behavior. During an interview on 03/17/26, at 2:31 P.M., Resident #2 said the following: -A few days ago he/she observed Resident #3 moving slowly in the hallway in his/her wheelchair;-Resident #1 approached Resident #3 and called him/her, slow and re****ed;-Resident #3 did not react to the comment by Resident #1;-The comment from Resident #1 upset Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265558	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nathan Richard Health Care Center	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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2;-He/She confronted Resident #1 to defend Resident #3;-Staff separated the residents;-The Administrator came to the facility and spoke with Resident #1 following the incident;-Resident #1 used the word re****ed often both directly toward residents or staff and indirectly when speaking in general;-Resident #1 frequently says, This is a mental hospital and everyone here is re****ed;-He/She said no one should have to hear inappropriate language;-He/She requested placement in another facility due to the inappropriate language used by Resident #1.During an interview on 03/17/26, at 2:49 P.M., CNA B said the following: -Residents on the secured unit curse in general;-The residents do not direct the cursing at anyone usually;-He/She redirected them, discussed usage of appropriate language, and reported to the charge nurse;-He/She did not know what the charge nurse did with the information;-Resident #1 has used the word, re****ed once or twice but did not direct at anyone.During an interview on 03/17/26, at 2:54 P.M., Certified Medication Technician (CMT) C said the following:-Resident #1 used inappropriate language often and said re****, in general conversation;-He/She heard the resident say, You have to be re****ed to live here, and This place is full of re****s, in the past;-The resident does not direct inappropriate language at anyone specifically but says, re****, in front of both residents and staff;-Multiple residents have voiced complaints regarding the resident's language;-He/She and other staff have discussed inappropriate language with the resident, and he/she said it was his/her right to say whatever he/she wanted;-He/She did not know of any interventions than redirection to address the resident's behavior;-He/She reported the resident's language to administrative staff;-He/She had not received new guidance or interventions other than redirection for Resident #1's language;-Administrative staff are responsible for implementing interventions and addressing behaviors.During an interview on 03/19/26, at 10:07 A.M., CNA D said the following: -Previously while passing drinks to other residents he/she overheard Resident #1 loudly calling an unknown person, re****, followed by another resident responding, Don't yell, Quit that;-A nearby CNA responded to the area and separated the residents while he/she continued passing drinks;-CNA E told to him/her, Resident #1 called Resident #3 a, re****, because he/she was taking too long to get in line. Resident #2 stood up for Resident #3 and said he/she was going to call the Administrator;-Cursing had occurred on the unit before from residents when they are upset but he/she could not recall any persistent inappropriate language from residents;-Staff reported the incident to the Administrator aware of the incident;-The Administrator came to the facility and spoke with the residents regarding the incident;-Staff are to report to the charge nurse and Administrator immediately of any inappropriate language;-The charge nurse should document behaviors in the nurses' notes;-He/She did not know of any new interventions to address inappropriate language from Resident #1;-Staff are to redirect the residents from each other and de-escalate;-The administrative staff are responsible for addressing behaviors.During an interview on 03/19/26, at 10:35 A.M., CNA E said the following: -While assisting another resident he/she heard yelling in the hallway;-He/She heard Resident #1 yelling at Resident #3 and called him/her, stupid and re****ed; -Resident #2 started yelling at Resident #1 in defense of Resident #3;-He/she separated the residents and redirected them to de-escalate;-Resident #3 apologized for taking too long while moving down the hall;-Resident #1 said Resident #3 blocked the doorway for 20 to 30 minutes;-CNA E said the doorway was unobstructed when he/she observed Resident #1 yelling at Resident #3;-Resident #1 stands in his/her doorway occasionally and tells people while passing he/she is, practicing to be a re****;-He/She ignored the resident when he/she does this;-He/She reported inappropriate language to the charge nurse and should redirect the resident;-He/She did not know what the charge nurse does with the information;-The charge nurse should document behaviors in the nurses' notes;-The Administrator and DON are responsible for addressing behaviors;-He/She was unaware of any interventions than verbal redirection for Resident #1 regarding inappropriate language. During an interview on 03/19/26, at 10:52 P.M., Licensed Practical Nurse (LPN) F said the following: -CNA D said Resident #1 called Resident #3 a, re****, due to Resident #3 blocking the hallway and not moving quickly;-It was not uncommon for residents on the secured unit to get mad at each other and call one (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265558	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nathan Richard Health Care Center	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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another stupid;-He/She had not heard residents calling one another re****;-He/She had not heard Resident #1 using that language before until this incident;-Staff were to notify the nurse immediately, separate the residents, and ensure resident safety;-Staff should create a nurses' note for behaviors;-Staff reported the incident to the Administrator;-Resident #3 moved from the unit following the incident to limit potential interactions with Resident #1;-He/She did not know of any interventions put in place to address Resident #1's behavior. During an interview on 03/19/26, at 11:38 A.M., Resident #3 said the following: -He/she moved from the secured unit a few days ago following a run in with another resident;-He/She could not recall who the other resident was;-The resident called him/her names and picked on him/her;-He/She could not recall what the other resident said, but it was upsetting at the time;- Staff separated the other resident and addressed the situation.During an interview on 03/19/26, at 1:41 P.M., CMT G said the following: -Resident #1 was usually non-confrontational but opinionated;-The resident said, We are all re****ed, on a weekly basis;-Staff verbally redirected the resident when the behavior occurs;-The resident had ups and downs in mood but was stable;-He/She did not know of any interventions related to behavior for the resident other than redirection;-Staff are to step between residents during altercations, de-escalate, assess, calm, ensure separation, and report to the charge nurse immediately;-The nurse should document any behaviors in the nurses' notes;-He/She did not know what the charge nurse does with the information;-Administrative staff are responsible for addressing behaviors. During an interview on 03/19/26, at 2:50 P.M., the Director of Nursing (DON) said the following: -The resident is normally calm but when agitated voices frustrations with residing in a facility and issues regarding his/her ex-partner;-She had not heard the resident calling anyone names;-The resident was redirectable;-Staff have reported the resident said he/she felt he/she was in the facility with re****s on one occasion. She could not recall when this occurred. Staff redirected the resident at that time;-He/She did not know of further issues;-Staff should report Inappropriate behaviors to him/her and the psychiatrist who sees residents monthly;-He/She did not know if the resident received additional services to address inappropriate behavior;-Nursing staff should document behaviors in the nurses' notes and revise the care plan as needed;-The resident had maintained his/her baseline mental ability;-The Social Services Director (SSD) was responsible for addressing behaviors.During an interview on 03/19/26, at 3:13 P.M., the SSD said the following: -The resident had repetitive verbal behaviors;-He/She had offered counseling to the resident in the past;- The resident has declined counseling;-He/She did not document offers of additional counseling;-He/She sees the psychiatrist monthly;-He/She was unaware of additional interventions or changes from the psychiatrist;-Staff should notify him/her of ongoing behaviors;-He/She had not heard the resident using the word re****, but has heard him/her voice he/she doesn't feel he/she belongs in the facility.During an interview on 03/19/26, at 3:24 P.M., the Administrator said the following:-The resident had some agitation at baseline and was easily agitated;-He had talked to the resident regarding counseling which agitated him/her;-He spoke to the resident one week ago regarding counseling and it he/she declined. He/She did not document offering;-The resident fixated on his/her past and issues with his/her ex-partner and guardian;-Staff walk with him/her, redirect, provide sodas, but he/she maintains agitation with fixation. He has talked to the resident about not calling residents and staff re****s. The resident denies and immediately begins fixating on his ex-partner. The resident calms himself/herself by staying in his/her room and watching TV or checking his/her phone, but nothing has been completely effective. Staff report he/she says re****, but does not direct at anyone;-He/She will say, he/she is around a bunch of re****s;-The resident has had increased agitation since his/her guardian visited recently;-The psychiatrist is aware of increased agitation and inappropriate language use. He could not recall when the psychiatrist became aware;-He said staff notified the psychiatrist of the resident's behavior on multiple notifications;-The notifications should be documented in the nurses' notes; -Staff are to redirect, report to administration, and document behaviors;-No additional measures were implemented as redirection was typically successful and the behavior was not daily. Complaint 2804265 and 2804279