

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/02/2025
NAME OF PROVIDER OR SUPPLIER  Pleasant Hill Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 Broadway Pleasant Hill, MO 64080	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21003</p> <p>Based on observation, interview and record review, the facility failed to protect one sampled resident (Resident #69) when on 12/27/24 Resident #387 grabbed Resident #69 in the hallway resulting in him/her twisting and causing bruising to the resident's left forearm out of 17 sampled residents. The facility census was 76 residents.</p> <p>On 1/2/25 the Administrator was notified of Past Non-Compliance which occurred on 12/27/24. Facility training for abuse, neglect, dignity and customer services was completed for all staff 12/28/24 prior to the start of their shift. The deficiency was corrected 12/28/24.</p> <p>Review of the facility Resident Rights Policy dated 5/1/23 showed:</p> <p>-Purpose:</p> <p>--This policy is concerned with all incidents and accidents involving residents.</p> <p>--All of our residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident property.</p> <p>--Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.</p> <p>1. Review of Resident #387's Face Sheet showed the resident was admitted on [DATE], with diagnoses including cerebral palsy (a congenital disorder of movement, muscle tone or posture), seizures, intellectual disabilities, and brain disorder.</p> <p>Review of Resident #387's admission Minimum Data Set (MDS- a federally mandated assessment tool to be completed by facility staff for care planning) dated 10/25/24, showed the resident:</p> <p>-Had memory problems with severe cognitive incapacity.</p> <p>-Did not have any behavioral symptoms, mood, depression or anxiety.</p> <p>-Needed moderate to maximum assistance with bathing, dressing, toileting, mobility and used a wheelchair for ambulation.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #387's Care Plan dated 11/21/24, showed the resident had an intellectual disability, memory and recall problems and difficulty making himself/herself understood. There was no documentation showing the resident had any aggressive behaviors. Interventions showed staff would:</p> <ul style="list-style-type: none"> <li>-Maintain a structured environment and provide instruction at the resident's level of understanding.</li> <li>-Provide personal space.</li> <li>-Provide a daily tasks activity schedule.</li> <li>-Develop personal supports, family is very supportive.</li> <li>-Redirect the resident when entering unsafe areas.</li> <li>-Follow up with facility representatives to ensure recommendations are fully implemented.</li> </ul> <p>Review of Resident #69's Face Sheet showed the resident was admitted on [DATE] with diagnoses including dementia with behavioral disturbance, depression, anxiety, pain and respiratory disease.</p> <p>Review of Resident #69's quarterly MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-He/she had significant cognitive impairment.</li> <li>-He/she had no behavioral issues during the look back period but showed signs/symptoms of depression.</li> <li>-He/she needed partial to moderate assistance with bathing, dressing, toileting, mobility and used a wheelchair for ambulation.</li> </ul> <p>Review of Resident #387's Nursing Notes dated 12/27/24 at 3:10 P.M. showed he/she had an altercation which was witnessed by staff involving this resident reaching out and grabbing another resident's arm causing bruising to occur.</p> <p>Review of Resident #69's Nursing Notes dated 12/27/24 showed:</p> <ul style="list-style-type: none"> <li>-He/she had a resident to resident incident where he/she was not the aggressor. A skin assessment was completed on the resident and the resident sustained two dark purple bruises to his/her left forearm that measured 6 centimeters (cm) length by 6.5 cm width, and 1.5 cm length by 2 cm width. The resident denied any complaint of pain or discomfort.</li> </ul> <p>Review of the facility investigation report dated 12/27/24 showed:</p> <ul style="list-style-type: none"> <li>-Staff reported Resident #387 was seen holding Resident #69's arm. Staff immediately separated the residents and the resident was placed on one to one monitoring.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident interview summary showed the facility staff was unable to successfully interview the residents to find out what occurred due to both of the resident's dementia and ability to recall the incident.</p> <p>-Resident #69 said they were friends and it was all in good fun.</p> <p>Observation and interview on 12/31/24 at 9:35 A.M., showed Resident #69's was laying in his/her bed awake and wearing oxygen. On the resident's left forearm were two fading purplish bruises. The resident said:</p> <p>-He/She felt safe in the facility and was not afraid of any residents.</p> <p>-He/She was not in any pain or discomfort.</p> <p>During an interview on 12/31/24 at 11:44 A.M. Certified Medication Technician (CMT) A said:</p> <p>-He/She was working and observed the resident incident on 12/27/24 that was after breakfast when residents were exiting the dining area.</p> <p>-Resident #387 was sitting in his/her wheelchair in the hallway and was tapping residents on the arm or shoulder as they went by.</p> <p>-Resident #387 was swinging his/her arms so he/she told the resident he/she was going to move him/her over since he/she was blocking the entryway to the dining area, and moved the resident over out of the middle of the entryway.</p> <p>-The resident continued to swing his/her arms and hit a resident. The resident became agitated, so he/she moved Resident #387 down the hallway toward his/her room, but the resident did not want to go into his/her room and stayed outside of his/her room.</p> <p>-A few minutes later he/she saw the resident by the nursing station where Resident #69 was sitting and he/she heard Resident #69 yell, stop that hurt and he/she went to see what occurred and saw Resident #387 twisting Resident #69's left forearm.</p> <p>During an interview on 12/31/24 at 2:35 P.M., showed Licensed Practical Nurse (LPN) A said:</p> <p>-He/She was working on 12/27/24 and both residents were outside of the 200 hall when he/she heard Resident #67 say ouch, you're hurting me.</p> <p>-He/She looked up and saw Resident #387 was holding Resident #69's left arm.</p> <p>-There was another nursing staff that was already separating the residents and had Resident #69 at the nursing station.</p> <p>-Resident #387 was headed back down the 200 hallway.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She completed a skin assessment on Resident #67 and saw the bruising on his/her left forearm and documented it in his/her medical record. The Nursing Assistant (NA) went to inform the Administrator and DON.</p> <p>During an interview on 1/2/25 at 9:03 A.M., NA A said:</p> <p>-Usually Resident #387 does not become aggressive unless residents or staff, are trying to pass him/her in the hall or in the dining area (anywhere there is a group of people).</p> <p>-Resident #387 will deliberately sit in the pathway so that residents cannot get around him/her and will refuse to move when they ask him/her to move.</p> <p>-Staff will then have to assist and move Resident #387 and if the residents or staff try to move him to get around him/her, Resident #387 will become physically aggressive.</p> <p>-Resident #387 has hit at him/her when he/she has tried to get him/her to move to the side so that a resident could pass in the hallway.</p> <p>During an interview on 12/31/24 at 1:50 P.M., the Director of Nursing (DON) said:</p> <p>-On 12/27/24 he/she was working and received a report that Resident #387 and Resident #69 were passing each other in the hall and they were tapping each other on the arm and Resident #387 grabbed Resident #69's arm and twisted it.</p> <p>-Nursing staff stepped in and separated the residents and a skin assessment was performed on Resident #69 and showed bruising on his/her arm.</p> <p>-Resident #387 does not like for people to be in his/her space and does not like to be in groups of people.</p> <p>-Resident #387 will place himself/herself in the middle of the hallway when other residents and staff have to try to get by him/her.</p> <p>-Resident #387 does not like to be moved.</p> <p>-After the incident occurred, he/she tried to interview Resident #387 and he/she did not think he/she understood what he/she was asking. He/She also interviewed Resident #69 and he/she said that it was all in good fun and that he/she did not think Resident #387 was trying to harm him/her.</p> <p>-Since this incident, Resident #387 has had physical aggression towards staff and another resident.</p> <p>During an interview on 12/31/24 at 2:52 P.M., the Administrator said:</p> <p>-He/She was in the facility on 12/27/24 and the DON told him/her about the incident between Resident #387 and Resident #67.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She thought that the nursing staff that initially moved Resident #387 out of the hallway was what made Resident #387 agitated initially. He/She said he/she tried to speak with Resident #387 and he/she did not respond at that time.</p> <p>-A couple hours later, the DON said the residents were on the 200 hall and staff saw Resident #387 grab Resident #69's arm causing bruising. Staff separated the residents.</p> <p>MO00247157</p>		