STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265573	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Care Center for Rehab and Healthcare	202 East Mill Street Humansville, MO 65674

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 1. Please refer to Event ID NXM312, exit 03/27/25. Based on observation, interview, and record review, the facility staff failed to fully implement their abuse and neglect policies and procedures when staff failed to report an allegation of abuse made by one resident (Resident #1), who reported to the charge nurse that another resident (Resident #2) kissed him/her on the mouth, immediately to facility Administrator and within two hours to the state survey agency (Department of Health and Senior Services - DHSS). A sample of four residents was selected for review. The facility census was 46. Review of the facility's policy titled Abuse and Neglect Policy, revised September 2024, showed the following: -It was the policy of the home to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare had been or may be adversely affected by abuse or neglect caused by another person; -If there was any allegation of abuse, then the facility must report immediately to the administrator and to State Survey Agency, no later than two hours; -Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident. This includes financial, verbal, sexual, mental/psychological, or physical abuse, including corporal punishment, involuntary seclusion, or any other actions within this definition; -Sexual abuse was the non-consensual sexual contact of any type with a resident and the individual acts deliberately; not that the individual has intended to inflict injury or harm. Any touching or exposure of the anus, breast or any part of the genitals of a resident without the voluntary, informed consent of the resident and with the intent to arouse or gratify the sexual desire of any person and includes but is not limited to sexual harassment, sexual coercion or sexual assault. 1. Review of Resident #1's face sheet (admission data) showed the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted [DATE]; -Diagnoses included depression, obesity, and panic disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/17/24, showed the resident's cognitive skills were intact and resident had no behaviors. Review of the resident's care plan, dated 06/26/24, showed the resident was at risk for mood problems as evidenced by his/her mood interview score. Staff to allow the resident to have control over situations, if possible. During an interview on 03/27/25, at 11:24 A.M., the resident said the following: -One evening, he/she played games in the main dining room and Resident #2 came into the dining room and came to him/her like he/she was going to kiss him/her; -He/she moved Resident #2 back and the resident came and gave him/her a quick kiss on the lips; -Resident #2 did hand gestures referring to his/her chest area. Resident #2 did not touch him/her; -He/she thought the kiss was gross and creepy; -He/she reported this to Licensed Practical Nurse (LPN) D. 2. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included Alzheimer's disease, cognitive communication deficit, and depression. Review of the resident's care plan, dated 12/05/24, showed the following: -The resident has a serious mental illness, intellectual disabilities, and a related condition; -Staff to address emotional issues; -The resident had cognitive loss and dementia; -Staff to provide cues and supervision to resident. Review of the resident's significant change in status MDS, dated [DATE], showed the following: -Cognitive skills severely impaired; -Rejection of care one to three days. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note dated 03/21/25, at 9:08 P.M., showed LPN D documented a resident (Resident #1) reported that Resident #2 made him/her uncomfortable. Resident #1 reported that Resident #2 came up to him/her in front of another resident and kissed him/her on the mouth. Resident #1 said he/she pushed Resident #2 and said no that is not ok. Resident #2 laughed as if it was funny. Resident #1 also reported that Resident #2 made gestures to him/her when he/she passes by. Resident #1 reports he/she felt uncomfortable and unsafe. 3. Review of DHSS records showed the facility reported the allegation of abuse to the state on 03/24/25 at 11:43 A.M. (three days after the allegation of abuse was made by Resident #1). 4. During an interview on 03/27/25, at 2:18 P.M., LPN D said the following: -On 03/21/25, Resident #1 came up to him/her and said Resident #2 came up and kissed him/her on his/her lips. Resident #1 said it made him/her feel weird; -LPN D texted the Director of Nursing (DON) on 03/21/25 of the incident; -Staff monitored Resident #2 with 15-minute checks; -The DON educated him/her the next time he/she was at the facility to report that Resident #1 said this incident made him/her feel unsafe; -LPN D considered the unwanted kiss as sexual abuse. During interviews on 03/27/25, at 1:30 P.M. and 02:30 P.M., the DON said the following: -LPN D reported to her that the resident said the kiss was unwanted and not to do it again; -LPN D texted her on Friday, 03/21/25, that Resident #1 said Resident #2 walked right up to him/her and kissed Resident #1 on his/her lips. Resident #1 said it was fast and it made him/her feel weird. Resident #1 told Resident #2 that it was not ok; -The DON said she did not know why she (the DON) did not call the allegation of abuse into the state; -LPN D reported that the resident went up and kissed Resident #1; -Resident #1 did not report Resident #2 made inappropriate gestures toward him/her. During interviews on 03/27/25, at 2:00 P.M. and 2:30 P.M., the Administrator said the following: -The allegation of abuse should have been reported to her and the state timely; -She found out about the incident on Saturday (03/22/25) and did not have all the information until Monday (03/24/25) when she talked to Resident #1; -On Sunday, 03/23/25, the DON reported that LPN D called her and said Resident #2 tried to kiss Resident #1; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-After she talked to Resident #1 on Monday morning (03/24/25), it was a different story. Resident #1 said Resident #2 came up to tried to kiss him/her and he/she pushed Resident #2 away and said no, Resident #2 came back and forcibly kissed him/her on the lips and made a motion with his/her hands towards him/her; -Staff should had reported the incident immediately and reported to the state sooner. During an interview on 03/27/25, at 10:00 A.M., Certified Medication Technician (CMT) E said the following: -Examples of sexual abuse include touching inappropriate, kissing and fondling; -Staff should report immediately an allegation of abuse to the supervisor; -The facility should notify the state of any allegation of abuse within two hours. During an interview on 03/27/25, at 10:09 A.M., the Housekeeping Supervisor said the following: -Staff should report immediately an allegation of abuse to the supervisor; -The facility should notify the state of any allegation of abuse within two hours. During an interview on 03/27/25, at 10:47 A.M., Certified Nurse Aide (CNA)/CMT F said the following: -Staff should report immediately an allegation of abuse to the supervisor, charge nurse, DON or the administrator; -The facility should notify the state of any allegation of abuse within two hours. During an interview on 03/27/25, at 1:30 P.M., the DON said the following: -She considers an unwanted kiss as sexual abuse; -Staff should report immediately an allegation of abuse to the supervisor; -Staff should notify the state of any allegation of abuse within two hours. During an interview on 03/27/25, at 2:00 P.M., the Administrator said the following: -She considers an unwanted kiss as sexual abuse; -Staff should report immediately an allegation of abuse to the supervisor and the supervisor reports to the administrator; -Staff should notify the state of any allegation of abuse within two hours. MO00251591