STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265656	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strafford Care Center	505 West Evergreen Strafford, MO 65757

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. Based on interviews and record review, the facility failed to protect one resident's (Resident #1) right to be free from verbal and physical abuse by staff when one staff (Certified Nursing Assistant (CNA) C) yelled at and physically forced a resident to receive incontinent care. The facility census was 64. Review of facility policy titled Abuse, Prevention, and Prohibition Policy, dated March 2025, showed the following: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion; -Residents must not be subjected to abuse by anyone; -The facility prohibits mistreatment, neglect, or abuse of residents. Review of the facility Abuse Investigative Guidelines, dated May 2024, showed the following: -A nursing progress note should be entered after an allegation of abuse; -Nurse progress note should include a description of the situation, who reported, what was reported, involved parties, where it took place, what the allegation is, and could the resident identify the person named in the allegation; -Documentation should be factual and not subjective; -Head to toe assessment, including documentation of any noted skin issues or concerns. 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 09/01/22; -Diagnoses included venous hypertension (abnormally high pressure within the veins causing blood to pool and impair circulation), anxiety disorder, and fibromyalgia (condition that involves widespread body pain and tiredness). (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 03/10/25, showed the following: -Moderate cognitive impairment; -No behavioral symptoms; -Dependent with showers, dressing, and hygiene; -Partial to moderate assistance from staff with bed mobility and transfers; -Independent with wheelchair mobility. Review of the resident's care plan, revised 04/11/25, showed the resident was at risk for falls due to confusion and balance problems and had impaired cognitive function. Review of the resident's electronic medical record (EMR) showed staff did not document related to report of abuse. Review of the facility's investigative summary, undated, showed the following: -On 05/17/25, at 7:30 A.M., the Administrator was notified Certified Nurse Assistant (CNA) C reported a rough roll while assisting the resident to Registered Nurse (RN) D. CNA C reported the resident became combative, hitting, and cussing during cares and he/she rolled resident a little rough. Written statements were collected from witnesses. Required notifications made and assessment was completed on the resident and no issues were noted. -During an interview conducted by the Administrator, CNA C reported he/she did not leave the room when the resident became agitated and continued to change the resident. The facility determined that CNA C was rough with the resident and the allegation did occur. Review of a written statement by CNA C, dated 05/17/25, showed the resident became very angry and was yelling and cursing while the CNA tried to change him/her. The CNA made several attempts to deescalate the situation but had to use some elbow grease to get him/her turned over, all while the resident was hitting, scratching, and slapping the CNA. Staff did finally get the resident changed. During interview on 05/21/25, at 3:15 P.M., CNA C said the following: -He/she and CNA A approached the resident to provide incontinence care; -The resident advised the aides he/she did not want to be changed or messed with; -The resident began hitting him/her and told the aides to leave the room; -CNA C attempted to educate resident about needing to be changed to prevent skin breakdown; -The resident was hitting, smacking, and punching him/her while attempting to provide care; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident then reported his/her shoulder hurt so CNA C grabbed the resident's hip and pulled him/her to the side a little hard; -The resident legs were hanging off the bed as he/she was attempting to kick CNA C; -CNA C scooped resident's legs up and placed them back in bed, but not forcefully; -CNA C then held resident towards him/her so the resident could be changed; -He/she went to report this to the nurse after resident was changed due to the feeling he/she might have turned resident too hard; -CNA C reported elbow grease meant he/she had to put a little more force into it; -The resident is combative during incontinence care nine times out of ten and he/she tries to be gentle and calm; -He/she felt that he/she should report to the nurse this time due to using too much force when pulling resident towards him/her; -He/she would get another aide or nurse and would not change a combative resident if this occurred again. Review of a written statement by CNA A, undated, showed the resident reported pain to his/her shoulder when staff went to roll him/her over and began hitting and said you are hurting my shoulder. CNA C got smacked and scratched and at that point went to the end of the bed and grabbed the resident's legs and slammed them down on bed and said, god damn. Then CNA C grabbed the resident's sore shoulder and flung him/her into the bed rail saying, fucking bitch. CNA A then told CNA C to leave three times, but he/she finished care and then reported to the nurse. During an interview on 05/20/25. at 10:39 A.M., CNA A said the following: -He/she and CNA C were changing the resident when the resident reported his/her right shoulder was hurting; -CNA C started turning the resident towards him/her and had one hand on resident's right shoulder and one hand on the right hip when the resident began to hit CNA C and scratched one of his/her arms; -CNA C released the resident and grabbed both of his/her ankles and picked them up and slammed them on the bed while stating God damn it; -CNA C then went back to turn the resident towards him/her by pulling on the right shoulder and hip; -CNA C held resident down with force on the right side and said Fuck you, fucking bitch; -Resident appeared upset and CNA A requested CNA C leave the room three times; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA C eventually left the room and CNA A finished up with resident care; -CNA A immediately left the resident room to report to RN D, but CNA C had already reported incident to him/her; -CNA C was at the end of his/her shift and left the building. Review of a written statement by RN D, dated 05/17/25, showed on 05/17/25, at approximately 5:30 A.M., CNA C reported that while changing the resident, the resident became combative and was hitting and scratching CNA C. CNA C reported when he/she attempted to turn the resident to change him/her, the roll was a little rough. Resident was assessed and reported pain to the left shoulder due to arthritis. Resident stated Oh that fat hog when asked about any problems. When asked what about the hog, resident stated I don't remember. Skin assessment showed bruising (purple) to left hand and right forearm. Resident unable to state how this occurred. Statements requested and Administrator contacted. During an interview on 05/20/25, at 1:56 P.M., RN D said the following: -On 05/17/25, at approximately 5:35 A.M., CNA C reported the resident was slapping and combative during incontinence care; -CNA C reported it was a rough roll when turning the resident; -He/she had CNA C write a statement of what occurred; -He/she assessed the resident and no new injuries were noted; -The resident did have some older discolorations to his/her arms, but no fresh bruising or other injuries noted; -The Administrator was contacted after the resident was assessed; -He/she did not complete a progress note related to the incident or assessment; -The resident did not remember the incident during initial interview but did report Oh that fat hog and I don't know or can't remember. Review of an interview conducted on 05/17/25, at 9:20 A.M., with the resident by the Director of Nursing (DON) showed the resident reported Everything is good except that big old fat gal, he/she is stupid and rude, and I don't want him/her around anymore. DON then asked resident if he/she was mean or rough with the resident and resident responded, No he/she is just stupid and fat. During an interview on 05/20/25, at 12:25 P.M., CNA G said the following: -He/she would report any abuse to the charge nurse as soon as possible; -A resident should not be forced to do something they do not want to do; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a resident refused care he/she would report it to the nurse, have another aide try, and reapproach the resident at a different time. During an interview on 05/20/25, at 12:35 P.M., Licensed Practical Nurse (LPN) F said the following: -He/she would notify the administrator and DON immediately of any abuse; -He/she would assess the resident for injuries, obtain vital signs, provide first aid if needed, notify family, and document all information in a nursing note if a resident was involved in an allegation of abuse; -A skin assessment would be conducted on the form in the electronic medical record if a resident involved in physical abuse; -Aides should advise a nurse if a resident refuses care; -He/she would document occurrence, notify the physician, try to reapproach a resident that had refused care; -Residents should not be forced to do anything they do not want to do. During an interview on 05/20/25, at 1:30 P.M., RN E said the following: -He/she would immediately remove a resident from the abusive situation and contact the DON and Administrator immediately; -He/she would immediately remove the accused abuser of the property, call the police, notify the physician and family; -He/she would assess resident, obtain vital signs, perform a skin assessment and a mental evaluation, and interview the resident and staff; -All information and assessments would be documented in the resident's electronic health record. During interview on 05/20/25, at 2:25 P.M., the DON said the following: -Staff should ensure resident is safe, escort staff member out of facility, and notify the DON and administrator immediately if there is an allegation of abuse; -Alleged staff member should be suspended pending an investigation; -The resident's family, physician, police, and the Department of Health and Senior Services (DHSS) should be notified; -CNA C will not be returning to the facility. (continued on next page)

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