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	01/05/2026

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 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. 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 hours timeframe when the facility did not report one resident's (Resident #1) statement of abuse. The facility census was 68.Review of the facility's policy titled Abuse, Prevention and Prohibition Policy, dated November 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, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals;-The facility administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report or cause a report to be made to the mandated state agency per reporting criteria. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the administrator. The person made aware of allegations of abuse or neglect, or the administrator will report the allegation of abuse and neglect to the mandated state agency and law enforcement. The allegation will be reported no later than two hours, or per state regulations, after the allegation is made. 1. Review of Resident #1"s face sheet (admission data) showed the following:-admission date of 12/27/25;-Diagnoses included major depressive disorder, other chronic pain, and congestive heart failure (CHF - a long-term condition that happens when the heart can't pump blood well enough to give the body a normal supply). Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/30/25, showed the resident's cognitive skills intact.Review of the facility grievance form dated 12/31/25, no time, showed the Social Service Director (SSD) documented the resident stated that Certified Nurse Aide (CNA) A comes in and is hateful and verbally abusive towards him/her. The resident said the CNA gets mad when he/she asked for stuff and asked to get up and the CNA refused. Review of DHSS records showed the facility did not report the allegation of possible abuse on 12/31/25. Review of the resident's care plan, revised 01/05/26, showed the following:-The resident had a mood problem;-The resident needs time to talk;-The resident had a behavior problem;-The resident refused to get out of bed and refused therapy. During an interview on 01/05/26, at 9:29 A.M., CNA A said the following:-Staff should report to the charge nurse and Administrator immediately any allegation of abuse; -The facility should call the state within two hours with an allegation of abuse; -Last week the Director of Nursing (DON) called him/her into the office and said staff said he/she threw down the resident's meal tray, the resident's food was cold, stated to the resident you get what you get and did not assist the resident up in his/her bed;-The DON said this was borderline abuse due to an allegation of stating to the resident to butt out of his/her roommate's care.During an interview on 01/05/26, at 10:46 A.M., CNA B said the following:-Staff should report to the charge nurse immediately any (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	allegation of abuse;-Staff should report an allegation of abuse to the state within two hours. During an interview on 01/05/26, at 10:54 A.M., the DON said the following:-On 12/31/25, the SSD said the resident was mad about the eggs and later said the resident said CNA A and another aide was rough with his/her roommate; -She spoke with the resident who said the aide was rude;-She did not tell CNA A it was borderline abuse of the statement of butt out of roommate's business;-The resident did not state abuse to her;-Staff should report an allegation of abuse to the administrator immediately;-Staff should report an allegation of abuse to the state within two hours;-Observation showed the DON reviewed the grievance report, dated 12/31/25, and said it stated verbal abuse. During interviews on 01/05/26, at 11:24 A.M. and 1:00 P.M., the SSD said the following: -For abuse allegations, SSD called the state first then told the Administrator;-If a resident was in immediate danger, he made sure the resident was safe and then notified the administrator;-On 12/31/25, he spoke with the resident in his/her room. CNA A came into the resident's room and said the resident said he/she thought CNA A was getting him/her up. CNA A said he/she tried to get him/her up and he/she refused. The resident stated to SSD every time CNA A came in, he/she was mean to him/her;-SSD informed the Administrator on 12/31/25 the resident said CNA A was rude, disrespectful, and mean;-SSD said the resident said mean, meaning CNA refused to warm up his/her food and pull him/her up in bed;-The Administrator informed him to speak to the DON. He informed the DON that he witnessed CNA A be disrespectful to the resident and refuse to pull up the resident in bed. CNA A was mean in the way he/she spoke to the resident and dismissed the resident;-The DON informed him to bring her a grievance form;-He did not remember what he put on the grievance form;-On 1/05/26, at 1:00 P.M., the SSD reviewed the grievance form dated 12/31/25 and said he handed the form to the DON and the resident did state verbal abuse. He did not receive the grievance form back.During an interview on 01/05/26, at 1:00 P.M., the SSD said he emailed the grievance form to the Administrator and on 12/31/25 he informed the Administrator that the resident said verbal abuse. He did not hear anything else until today. The DON said she did not have the grievance form when he requested it from her.During an interview on 01/05/26, at 2:50 P.M., the ADON said the following:-Staff should notify the Administrator immediately of any allegation of abuse;-She did not know of the allegation of abuse. During an interview on 01/05/26, at 12:47 P.M., the DON said staff should report an allegation of abuse to the supervisor immediately and to the state within two hours. She did not think she understood the word abuse was on the grievance form. The SSD said the resident was upset with the eggs. She was not sure if she saw verbally abusive on the form.During an interview on 01/05/26, at 11:50 A.M., and the Administrator said the following:-Staff should report to the charge nurse or her immediately of an allegation of abuse; -The facility should report to the state within two hours of an allegation of abuse;-The SSD took the grievance form to the DON on 12/31/25;-She did not think the SSD informed her of what he wrote on the grievance form;-The Administrator did not know of the allegation of abuse on the grievance form dated 12/31/25 until today;-She considered the statement of verbal abuse an allegation of abuse. During an interview on 01/05/26, at 1:49 P.M., the Administrator said she had to leave on 12/31/25 and was in the facility for a little while on 01/01/26 and 01/02/26. She did not check her email. She expected staff to inform her of the allegation of abuse and notify DHSS timely. Complaint 2705749

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all allegations of possible abuse were thoroughly investigated in a timely manner and that steps were taken to protect all residents during the investigation when staff failed to document an investigation and steps to protect all resident during the investigation after an allegation of abuse involving one resident (Resident #1). The facility census was 68. Review of the facility's policy titled Abuse, Prevention and Prohibition Policy, dated November 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, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals;-Resident abuse must be reported immediately to the administrator. The facility administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action;-While a facility investigation is under way, steps will be taken to prevent further abuse. If a person is identified in the allegation of abuse, that person will not be allowed access to the facility while the investigation is in progress, except to meet with the administrator as part of the investigation. The person identified in the allegation of abuse will have no contact with residents or other employees during the investigation process;-When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be barred from any further contact with residents through suspension, pending the outcome of the facility investigation, prosecution, or disciplinary action against the employee. The administrator and/or the Director of Nursing (DON) will relay this suspension. At that time, the alleged staff member will be advised of the allegation and encouraged to assist in completing a statement relevant to the facts. The employee shall be instructed that the suspension is without pay and will be in effect while the investigation is ongoing. 1. Review of Resident #1''s face sheet (admission data) showed the following:-admission date of 12/27/25;-Diagnoses included major depressive disorder, other chronic pain, and congestive heart failure (CHF - a long-term condition that happens when the heart can't pump blood well enough to give the body a normal supply). Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/30/25, showed the resident's cognitive skills intact.Review of the facility grievance form dated 12/31/25, no time, showed the Social Service Director (SSD) documented the resident stated that Certified Nurse Aide (CNA) A comes in and is hateful and verbally abusive towards him/her. The resident said the CNA gets mad when he/she asked for stuff and asked to get up and the CNA refused. Review of the resident's care plan, revised 01/05/26, showed the following:-The resident had a mood problem;-The resident needed time to talk;-The resident had a behavior problem;-The resident refused to get out of bed and refused therapy.Review showed the facility did not provide a previously completed written investigation or documentation of steps taken to protect all residents during the investigation. During an interview on 01/05/26. at 9:29 A.M., CNA A said the following:-Last week the DON called him/her into the office and said staff said he/she threw down the resident's meal tray, the resident's food was cold, stated to the resident you get what you get and did not assist the resident up in his/her bed;-The DON said this was borderline abuse due to an allegation of stating to the resident to butt out of his/her roommate's care;-CNA A worked with another CNA the rest of the day with the resident. CNA A worked with other residents on his/her own. During an interview on 01/05/26, at 10:54 A.M., the DON said the following:-Observation showed she reviewed the grievance report dated 12/31/25 and said it stated verbal abuse;-She was responsible for investigating an allegation of abuse;-Staff (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have suspended CNA A pending the abuse investigation. During an interview on 01/5/26, at 11:24 A.M., the SSD the following: -When an allegation of abuse is received, if a resident is in immediate danger, he makes sure the resident is safe and then notified the Administrator;-On 12/31/25, he informed the Administrator the resident said CNA A was rude, disrespectful, and mean. SSD said the resident said mean, meaning CNA refused to warm up his/her food and pull him/her up in bed;-The Administrator informed him to speak to the DON. He informed the DON that he witnessed CNA A disrespectful to the resident and refused to pull up the resident in bed. CNA A was mean in the way he/she spoke to the resident and dismissed the resident. -The DON informed him to bring her a grievance form. He did not remember what he put on the grievance form;-On 01/05/26, at 1:00 P.M., the SSD reviewed the grievance form, dated 12/31/25, and said he handed the form to the DON. The resident did state verbal abuse.During an interview on 01/05/26, at 2:50 P.M., the Assistant Director of Nursing (ADON) said staff should notify the Administrator immediately of an allegation of abuse. Staff should speak with the residents, staff, and obtain statements during an abuse investigation. She did not know of the allegation of abuse.During an interview on 01/05/26, at 11:50 A.M., the Administrator said the following:-The SSD took the grievance form to the DON on 12/31/25;-She did not think the SSD informed her of what he wrote on the grievance form;-The Administrator did not know of the allegation of abuse on the grievance form dated 12/31/25 until today;-She considered the statement of verbal abuse an allegation of abuse;-Staff should protect the residents immediately of an allegation of abuse and suspend the named employee pending the investigation;-The DON is responsible for investigating an allegation of abuse with the help of the ADON. During an interview on 01/05/26, at 12:47 P.M., the DON said she did not think she understood the word abuse was on the grievance form. She was not sure if she saw verbally abusive on the form. Staff should had suspended CNA A immediately until the allegation of abuse was investigated by staff.During an interview on 01/05/26, at 1:49 P.M., the Administrator said she left the faciity on [DATE] and was in the facility for a little while on 01/01/26 and 01/02/26. She did not check her email. She expected staff to inform her of the allegation of abuse, call DHSS timely, and suspend CNA A pending the abuse investigation. Complaint 2705749