

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265698	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Nick's Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 253 East Highway 116 Plattsburg, MO 64477	

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 - 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. (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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one resident (Resident #2) from physical abuse when Resident #1 punched Resident #2 in the face to the extent hospitalization was required. The facility census was 66. The Administrator was notified on 10/20/2025 at 5:05 PM of the past noncompliance which began on 10/20/2025. The facility administration immediately separated and protected the residents from further abuse by Resident #1. Residents #1 and #2 were sent to separate hospitals for medical assessment and treatment, staff updated regarding each resident's plan of care, and all residents were interviewed and provided updated abuse and neglect information. All staff were In-serviced on the abuse and neglect policy and procedure by 10/23/25. The noncompliance was corrected on 10/23/2025. Review of the facility's Abuse and Neglect Policy dated 6/12/24., showed:- The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences;- Alleged violation is defined as a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse;- Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse;- Physical Abuse is defined as purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or mistreating a resident in a brutal or inhumane manner. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking;- Protection of Residents: Residents who allegedly mistreat another resident will be removed from contact with the resident during the course of the investigation. The accused residents shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety, as well as the safety of other residents;- The facility will identify, correct, and intervene in situations where abuse is likely to occur;- The facility will identify patterns, behaviors, and trends of behaviors that could result in harm to others;- The facility will protect all residents from harm;- The Administrator will complete an administrative investigation and notify the appropriate agencies no later than 24 hours after discovery of the incident;- The Administrator will follow up with appropriate agencies, during business hours, to confirm the report was received. 1. Review of Resident #1's Discharge MDS (Minimum Data Set), a federally mandated assessment tool completed by facility staff, dated 10/20/25., showed:- Mild cognitive impairment;- Diagnoses included: schizophrenia (a mental health condition characterized by a distorted perception of reality, leading to symptoms like hallucinations, delusions, disorganized thinking, and a loss of motivation), antisocial personality disorder (a mental health condition characterized by persistent disregard of the rights of other people, failure to comply with laws and social customs, and irresponsible and reckless behavior), anxiety, depression, intermittent explosive disorder (a mental health condition characterized by repeated, sudden bouts of impulsive, aggressive, violent behavior or angry verbal outbursts), and heart disease;- Independent with ambulation and all mobility. Review of the resident's care plan, dated 10/21/25, showed:- The resident had the potential to be physically or verbally aggressive related to diagnoses;- The resident was at risk for delusions (fixed false beliefs that can't be reasoned with), hallucinations (hearing, seeing, feeling, smelling things that are not there), or irritability;- The resident was at risk for cursing, hollering, moving around in or frequently getting up and down from the chair, nervousness, pacing on the unit, or restlessness;- The resident required nursing staff to be aware of body stance and facial expressions when approached; - The resident would be provided the lowest restrictive environment while maintaining protective oversight. Review of the resident's nursing progress notes for the month of October 2025 showed:- On 10/20/25 at 3:50 A.M., Resident #1 came to staff and reported he/she had stabbed Resident #2. Resident #1 was calm and cooperative and placed on immediate one on one with facility staff for protective oversight of all residents and staff. Appropriate personnel were notified;- On 10/20/25 at 5:57 A.M., Chlorpromazine (antipsychotic medication) 50 milligrams (mg) administered to the resident for related to increased delusions and voiced hallucinations per psychiatric physician order. The resident reported to staff they are telling me to</p>		