STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265702	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Manor	200 Thompson Drive Troy, MO 63379

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on interview and record review, the facility failed to ensure staff treated one resident (Resident #4), in a review of seven sampled residents, and one additional resident (Resident #8) with dignity and respect. Without saying anything, staff pulled back the covers and yanked on Resident #4's arm and it hurt and scared him/her. Staff yelled Resident #8's name and spoke angrily toward the resident, frightening the resident. The census was 85. Review of Resident Rights, found in the employee handbook, last revised 10/01/17, showed treating residents with dignity and respect was not only the facility's policy, but also the law. Treat all residents with consideration, respect and dignity at all times. Your behavior must reflect your beliefs in this right in your daily interactions with the residents, families and visitors to our facility. Review of the undated facility policy, Resident Rights, showed the resident has a right to a dignified existence. The resident had the right to privacy and respect. 1. Review of Resident #4's face sheet showed his/her diagnoses included legal blindness and dementia. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 09/11/24, showed the following: -Mildly impaired cognition; -Severely impaired vision (no vision or only sees light, color or shapes); -No corrective lenses; -No delirium, behaviors, mood or rejection of cares. During an interview on 10/02/24 at 12:40 P.M., the resident said an unknown staff member entered his/her room early in the morning, and without saying anything, pulled back the covers and yanked on his/her arm. It hurt and scared him/her. It could have pulled his/her arm out of socket. He/She could not describe the staff as he/she could not see. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Care Plan, last revised 10/03/24, showed the resident's vision was highly impaired and to provide verbal and physical cues to enhance independence. During an interview on 10/03/24 at 11:51 A.M., Certified Medication Technician (CMT) B said he/she was in the dining room on 09/30/24 around 6:30 A.M. when Resident #4 and his/her roommate (Resident #12) were upset. Resident #4 was crying and too upset to speak, so his/her roommate told him/her (CMT B) that a staff member had been rough and mean with Resident #4 when getting him/her out of bed that morning. The residents described the staff. The two residents asked if he/she could help and he/she reported it first to the Assistant Director of Nursing (ADON) when she arrived at work between 7:30 A.M. and 8:00 A.M. and then the Director of Nursing (DON) when she arrived around 15 minutes later. 2. Review of Resident #8's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Adequate hearing and vision; -Physical (kicking, hitting, grabbing) and verbal (threatening, screaming and cursing) behavior directed at others one to three days of the seven day look back period; -Supervision or touch assist for bed mobility. During an interview on 10/03/24 at 12:05 P.M., Nurse Assistant (NA) G said the following: -He/She went to relieve an aide on the 300 hall early on 09/30/24; -The other aide and Certified Nurse Assistant (CNA) F had been helping to get Resident #8 out of bed when he/she entered the room to take over; -The resident was not wanting to cooperate and roll over; -CNA F yelled the resident's name and said angrily, We're not doing this!; -CNA F's face was bright red; -He/She told CNA F to leave and he/she would finish cares; -The resident was quiet after that and told him/her that CNA F had been coming into his/her room causing problems; -He/She told had told a medication technician or a nurse. During an interview 10/03/24 at 4:00 P.M., the resident said CNA F yelled at him/her and it scared him/her. 3. During an interview on 10/02/24 at 1:30 P.M., the ADON said the following: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On the morning of 9/30/24, CMT B reported the incident involving Resident #4; -She visited with the resident and his/her roommate and filled out their statements; -He/She was not aware of CNA F yelling at Resident #8. During an interview on 10/03/24 at 8:25 A.M. and 4:15 P.M., the DON said the following: -She was aware of a staff being rough with Resident #4; -Staff should not yell at a resident; -Staff should announce their presence, explain the cares they are going to provide and be patient with the resident; -Residents were to be treated with dignity and respect. During interview on 10/03/24 at 12:15 P.M. and 4:30 P.M., the Administrator said it was a resident's right to be treated with dignity and respect at all times. MO239725

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview and record review, the facility failed to ensure residents on the 200 hall (Room #'s 211, 212 and 200) had access to hot water in their rooms, including two residents (Resident #9 and #13) in a review of seven sampled residents. The census was 85. During an interview on 10/17/24 at 12:55 P.M. the Administrator said she could not locate a policy on hot water temperatures but the temperature range should be between 105-120 degrees Fahrenheit. 1. Review of Resident #9's care plan, last revised 08/14/24, showed the following: -Incontinent of bladder and bowel; -Provide peri-care routinely and as needed. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 09/20/24, showed the following: -Partial to moderate assist with bed mobility; -Always incontinent of bladder and bowel. Observation on 10/03/24 at 8:38 A.M., showed the following: -Certified Nurse Assistant (CNA) C entered the room and prepared to perform incontinent care on the resident; -Before beginning perineal care, CNA C told the resident there was no hot water and warned the resident it was going to be cold. During an interview on 10/03/24 at 9:00 A.M., CNA C said the 200 hall had not had hot water for two or three months. The water was cold. If he/she had to give a bed bath, he/she would fill a basin with warm water from the 100 hall. Observation on 10/03/24 at 10:33 A.M., showed the hot water temperature from the faucet in the resident's room (room [ROOM NUMBER]), measured with an electronic thermometer, was 90.1 degrees Fahrenheit. During an interview on 10/03/24 at 10:33 A.M., the resident said he/she had gotten used to the water being cold, but it was a shock. 2. Review of Resident #13's care plan, last revised 04/11/24, showed to provide incontinence care after each incontinent episode. Review of the resident's annual MDS, dated [DATE], showed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Always incontinent of bladder and bowel; -Dependent for toileting and perineal care. Observation on 10/02/24 at 5:15 P.M. showed CNA L and Nurse Assistant (NA) E entered room [ROOM NUMBER] and performed incontinent care on the resident. Staff informed the resident the cloths would be cold. During an interview on 10/03/24 at 10:35 A.M., the resident said the water was cold and it bothered him/her when staff cleaned him/her up. Observation on 10/03/24 at 10:43 A.M. showed the hot water temperature from the faucet in the resident's room was 97.1 degrees Fahrenheit. 3. Observation on 10/03/24 at 10:35 A.M. showed the hot water temperature from the faucet in room [ROOM NUMBER] (a resident occupied room) was 69.4 degrees Fahrenheit. During an interview on 10/03/24 at 2:00 P.M., the maintenance director said the following: -Halls 300 and 400 each had their own water heaters; -Halls 100 and 200 share a water heater; -He had had complaints from staff about not having hot water; -This had been an issue for a long time, at least two- three months; -The 100 hall had adequate hot water but if turned up enough to allow 200 hall the same temperatures, it would make the water on 100 hall too hot; -He had spoken with corporate at some point, but had not informed the administrator; -He did take water temperatures bi-weekly and it could take up to five minutes to get hot water; -He had measured temperatures of up to 100 degrees Fahrenheit in room [ROOM NUMBER]. During an interview on 10/03/24 at 4:15 P.M., the Director of Nursing (DON) said the following: -Residents should have access to hot water; -She was not aware of the 200 hall did not have hot water; -She had had complaints from staff that it could take up to 30 seconds to get water but thought it then got warm. During an interview on 10/03/24 at 4:30 P.M., the Administrator said the following: -She had not had any reports of 200 hall not having hot water; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She had heard it took a long time to get hot water on the 200 hall. -She had not looked into it or inquired with maintenance until today.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on interview and record review, the facility failed to ensure three residents (Residents #3, #5 and Resident #11), in a review of seven sampled residents, were free from abuse when Resident #1 caused physical harm to Resident #5 when he/she pulled him/her out of his/her wheelchair, resulting in a left shoulder fracture, and when he/she hit an additional resident, Resident #11, in the face and grabbed Resident #3's arm, causing the resident pain. The census was 85. Review of the facility policy, Abuse Prohibition, dated 11/2016, showed the following: -The purpose of the facility policy is to prohibit mistreatment, neglect or abuse of any resident; -Abuse is the willful infliction of injury with resulting physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Review of the undated facility policy, Resident Rights, showed residents have the right to be free from abuse. 1. Review of Resident #1's progress notes, dated 05/29/24 at 6:30 A.M., showed staff documented the nurse was called to the main dining room related to an incident where this resident punched another resident (Resident #11) in the face. Resident #1 said Resident #11 was cussing and would not stop so he/she hit Resident #11. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 08/28/24 showed the following: -Severely impaired cognition; -No hearing impairment; -Able to understand others and make self understood; -No psychosis; -Verbal behavioral symptoms occurred one to three days of look back period; -No behaviors impacting residents or others; -Independent with transfers and ambulating ten feet; -Used a manual wheelchair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress notes, dated 09/19/24 at 2:44 A.M., showed staff documented the resident hit another resident (his/her roommate, Resident #3) at the 100 nurse station saying Resident #3 took his/her money. Review of the resident's progress notes, dated 09/22/24, showed staff documented the following: -At 2:00 A.M., the resident was walking up the hallway yelling at staff and when approached, stated don't you touch me! and started swinging his/her fists at staff threatening to hit them. Resident sat in a wheelchair and propelled his/herself in the hallway, pulled the alarm on the 100 hall and pushed on the door; -At 2:28 A.M., new order received for Haldol (antipsychotic) five milligram (mg) intramuscularly (IM). Three staff stabilized the resident and injection administered; -At 3:06 A.M., resident a little calmer but made threats at anyone that approached him/her; -At 4:27 A.M., resident grabbed another resident (Resident #5) by the arm and pulled him/her out of his/her chair in the dining room. New order obtained to send Resident #1 to the emergency room for evaluation. Review of the resident's care plan, last revised 09/25/24, showed the following: -Behavioral symptoms: Potential for reoccurrence of agitation/physical aggression. Resident will not harm self or others. Assess whether the behavior endangers resident or others. Intervene if necessary and report to nurse. Redirected by staff and 15 minute checks done as needed at nurse's discretion if he/she becomes agitated or aggressive towards others; -On 09/19/24, the resident grabbed/hit another resident's forearm and accused him/her of stealing money; -On 09/22/24 the resident pulled another resident out of his/her chair by the arm in the dining room. The other resident was sent to the emergency room (ER) and found to have a left shoulder fracture. Review of the resident's Physician Order Sheet, dated 10/2024, showed the following: -Diagnoses included vascular dementia (memory loss) with other behavioral disturbances and Alzheimer's disease (memory loss and confusion) with late onset; -Behavior monitoring every shift (06/23/23). 2. Review of Resident #5's significant change MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Independent with transfers and ambulation. Review of the resident's care plan, last revised 09/25/24, showed the following: (continued on next page)

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(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	-Diagnoses included pain in left arm, shoulder and hand; -Resident to resident altercation on 09/22/24 at 4:40 A.M. when another resident (Resident #1) pulled the resident out of his/her chair onto the floor in the dining room. Resident complained of pain and found to have a left shoulder fracture. Observation on 10/02/24 at 12:35 P.M., showed the resident lay in his/her bed and wore a sling to his/her left arm. During an interview on 10/02/24 at 12:35 P.M., the resident said he/she remembered when (Resident #1) pulled him/her out of his/her chair and that it had hurt. His/Her arm was painful, but pain medicine helped. 3. Review of Resident #3's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -No behaviors; -Independent with transfers/ambulation; -Used a manual wheelchair. During an interview on 10/02/24 at 11:09 A.M., the resident said the following: -Resident #1 used to be his/her roommate; -He/She recalled an altercation with Resident #1 which occurred about two weeks ago in the evening; -He/She was going down the hall and said hello to Resident #1 who grabbed his/her (Resident #3's) forearm with one hand, balled up his/her fist and drew it back in an attempt to hit him/her in the face and said, You son-of-a-bitch, you stole my money; -He/She had just had abdominal hernia surgery and had a plate in the arm the resident grabbed, so it hurt when Resident #1 did this. His/Her arm was sore from the wrist half-way up to the elbow. During an interview on 10/09/24 at 3:24 P.M., Nurse Assistant (NA) E said the following: -He/She had worked on 09/19/24 when Resident #1 had grabbed Resident #3's arm and attempted to hit him/her. He/She and another staff separated the two residents; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She worked on 09/22/24 when Resident #1 had multiple behaviors. Around 1:15 A.M., he/she went to perform the (already in place) 15 minute check on the resident and the resident came running towards him/her and swung at him/her multiple times. He/She yelled for help, kept his/her distance and watched the resident. The resident went down the hall and chased another co-worker around the table in the conference room. He/She hit another co-worker who was working 600 hall and a nurse who was working the lower 300 hall. He/She (NA E) saw the resident go towards the dining room in his/her wheelchair and then heard Resident #5 scream and found Resident #5 on the floor. He/She did not see Resident #1 pull Resident #5 out of his/her chair. During an interview on 10/10/24 at 11:52 A.M., NA H said the following: -He/She had worked 10:30 P.M. to 6:30 A.M. starting on 09/21/24 into 09/22/24; -Resident #1 was sitting in his/her usual spot in the dining room and he/she saw Resident #1 get up as he/she went to answer a call light. As he/she was returning to the area, he/she saw Resident #1 grab Resident #5's chair and pull him/her over. During an interview on 10/03/24 at 9:40 A.M., Licensed Practical Nurse (LPN) I said the following: -He/She was called in around 12:30 A.M. the morning of 09/22/24; -Resident #1 was really agitated, trying to get into rooms and chasing around an aide; -Around 3:30 A.M., staff felt the resident was calming down and took their eyes off of him/her for a minute or two; that was when he/she (Resident #1) got to Resident #5. During an interview on 10/03/24 at 12:29 P.M., LPN A said the following: -He/She was the charge nurse for Residents #1 and #5 the early morning of 09/22/24; -He/She was in the middle of passing medications when the altercation between Resident #1 and Resident #5 occurred, about 4:05 A.M.; -Resident #1 had been in and out of bed all night. He/She had had quite a few incidents with other residents in the past; -Resident #5 sits up at night in the dining room and colors. He/She did not have behaviors; -NA E came down the hall and said Resident #1 had pulled Resident #5 out of his/her chair; -NA H was already present in the dining room with the residents when he/she arrived. Resident #5 had already been assisted back into his/her chair. During an interview on 10/03/24 at 4:15 P.M., the Director of Nursing (DON) said the following: -Residents should be free from abuse; -The incidents with Resident #1 constituted resident to resident abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/03/24 at 4:30 P.M., the Administrator said the following: -Residents should be free of abuse; -Resident #1's actions toward Residents #3, #5, and #11 constituted abuse. MO242564

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(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** 32899 Based on interview and record review, the facility failed to report a staff to resident allegation of abuse to the state agency for one resident (Resident #4), in a review of seven sampled residents. Resident #4 alleged, and Resident #12 witnessed and reported, an allegation of abuse by a staff member that occurred on 9/30/24 to the Assistant Director of Nursing (ADON) on 9/30/24. Certified Medication Technician (CMT) B reported the allegation of abuse to the Director of Nursing (DON) on 9/30/24. Neither the ADON or the DON reported this allegation to the administrator or state agency per facility policy. The census was 85. Review of the undated facility policy, Abuse Reporting Guidelines, showed all alleged violations involving abuse or mistreatment are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the state survey agency). Investigation guidelines: At such time that the Administrator and/or Director of Nursing believe that abuse occurred, the Administrator or DON will notify the appropriate personnel. These may include the appropriate state agencies. Review of the facility policy, Abuse Prohibition, dated 11/2016, showed the following: -The purpose of the facility policy is to prohibit mistreatment, neglect or abuse of any resident; -Abuse is the willful infliction of injury with resulting physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm; -Examples of abuse include rough handling during care or when moving a resident. 1. Review of Resident #4's face sheet showed he/she had diagnoses that included legal blindness and unspecified dementia. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 09/11/24, showed the following: -Mildly impaired cognition; -Severely impaired vision-(no vision or only sees light, color or shapes); -No corrective lenses; -No delirium, behaviors, mood or rejection of cares; (continued on next page)

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(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	-Independent with transfers; -Supervision or touch assist to ambulate. Review of a statement written by an unknown staff member and dated 9/30/24 at 7:30 A.M. read, They yanked me out of my chair and rushed me around. No one likes to be yanked around. The statement was initialed by the resident. During an interview on 10/02/24 at 12:40 P.M., the resident said an unknown staff member entered the room early in the morning and without saying anything, pulled back the covers and yanked on his/her arm. It hurt and scared him/her. It could have pulled his/her arm out of socket. He/She could not describe the staff as he/she could not see and he/she did not know if the staff member had ever provided care to him/her before or not. Review of the resident's care plan, last revised 10/03/24 showed the following: -Vision highly impaired, provide verbal and physical cues to enhance independence; -On 09/30/24, resident reported a Certified Nurse Assistant (CNA) pulled on his/her arm and was disrespectful with rushing him/her around early in the morning. 2. Review of Resident #12's significant change MDS, dated [DATE] showed the following: -Mildly impaired cognition; -Adequate hearing, vision and wore glasses; -Understood others. Review of the a written statement, dated 9/30/24 7:40 A.M. and documented by an unknown staff showed, Girl came in and said I'm running late. Went to Resident #4, grabbed his/her arm and pulled him/her up. The document was signed by Resident #12. During an interview on 10/02/24 at 12:40 P.M., Resident #4's roommate, Resident # 12 said that on Monday, (9/30/24), he/she was in the room when a short, blonde haired staff member, who wore a ponytail, entered their dark room. The staff member said, I'm behind, and without saying a word to his/her roommate, he/she yanked the resident by the arm to get him/her out of bed and walked the resident to the bathroom. He/She reported this to the Assistant Director of Nursing (ADON) that morning who wrote it down and interviewed him/her and Resident #4. During an interview on 10/03/24 at 11:51 A.M., Certified Medication Technician (CMT) B said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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(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	He/She was in the dining room on 9/30/24 around 6:30 A.M., when Resident #4 and his/her roommate were upset. Resident #4 was crying and too upset to speak, so the roommate told him/her a staff member had been rough and mean with Resident #4 when getting him/her out of bed that morning. The residents described the staff member appearance and voice. The two residents asked if he/she could help and he/she reported it first to the ADON when she arrived to work between 7:30 and 8:00 A.M. and then to the Director of Nursing (DON) when she arrived around 15 minutes later. During an interview on 10/2/24 at 1:30 P.M. the ADON said the following: -The incident was reported to her by CMT B the morning of 09/30/24; -She visited with the resident and his/her roommate and filled out their statements, turning them in to the DON; -She gave the DON the description of the staff that the roommate had reported to her; -They were looking at staffing to see who fit the description; -She had not reported it to the state agency as she had been told by the Administrator in the past that the DON or Administrator were responsible for reporting. During an interview on 10/03/24 at 8:25 A.M. and 4:15 P.M., the DON said the following: -She said she was made aware on 9/30/24 between 7:30 and 8:30 A.M. upon arriving at work. There were two written statements under her door; -She did not report this concern of an incident involving staff being rough with Resident #4, as the resident's statement said she had been rushed. She did not know about the yanking on the arm; -She had not spoken with Resident #4 or Resident #12; -She had not reported it to the administrator; -She said the allegation should have been reported to the state agency within two hours. During interview on 10/03/24 at 12:15 P.M. and 4:30 P.M., the Administrator said the following: -She said she was not aware of any staff to resident roughness and she felt staff would have reported it to her if there was an issue; -The DON had not reported it to her but she would have expected her to; -Staff should follow their policy on reporting abuse allegations; -The DON or Administrator was responsible for reporting to the state agency; -An allegation of yanking on a resident's arm would be considered abuse; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265702	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Manor	200 Thompson Drive Troy, MO 63379

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(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	-An allegation of abuse should be reported within two hours; MO242564

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 32899 Based on interview and record review, the facility failed to investigate an allegation of abuse for one resident (Resident #4) in a review of seven sampled residents. The census was 85. Review of the facility policy, Abuse Prohibition Protocol Manual, dated 03/2012 showed the following: Investigation Guidelines: -It is the purpose of this facility to investigate events that may indicate abuse; -All events listed under the Identification section of this manual will be initially investigated on the facility's incident report forms. This is done by the charge nurse, Assistant Director of Nursing (ADON), Director of Nursing (DON) and the Administrator; -Review of an investigation form, that was to be completed with an investigation, showed it was to include: date and time of incident, person and title conducting the investigation, type of abuse, injury, medical attention, names of witnesses and alleged perpetrator, what happened, list of statements, resident physical condition report, review of physician order sheet (POS), medication administration record (MAR), behaviors, nurses notes for last 14 days, summary of interviews with staff members, resident's roommate(s), resident family members and investigators findings, including if it indicated abuse, corrective action taken and dates and times of findings and corrective actions. Review of the facility policy, Abuse Prohibition, dated 11/2016, showed the following: -The purpose of the facility policy is to prohibit mistreatment, neglect or abuse of any resident; -Abuse is the willful infliction of injury with resulting physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm; -Examples of abuse include rough handling during care or when moving a resident. 1. Review of Resident #4's face sheet showed he/she had diagnoses that included legal blindness and unspecified dementia. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 09/11/24, showed the following: -Mildly impaired cognition; -Severely impaired vision-(no vision or only sees light, color or shapes); -No corrective lenses; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No delirium, behaviors, mood or rejection of cares; -Independent with transfers; -Supervision or touch assist to ambulate. Review of a statement written by an unknown staff member and dated 9/30/24 at 7:30 A.M. read, They yanked me out of my chair and rushed me around. No one likes to be yanked around. The statement was initialed by the resident. During an interview on 10/02/24 at 12:40 P.M., the resident said an unknown staff member entered the room early in the morning and without saying anything, pulled back the covers and yanked on his/her arm. It hurt and scared him/her. It could have pulled his/her arm out of socket. He/She could not describe the staff as he/she could not see and he/she did not know if the staff member had ever provided care to him/her before or not. Review of the resident's care plan, last revised 10/03/24 showed the following: -Vision highly impaired, provide verbal and physical cues to enhance independence; -On 09/30/24, resident reported a Certified Nurse Assistant (CNA) pulled on his/her arm and was disrespectful with rushing him/her around early in the morning. 2. Review of Resident #12's significant change MDS, dated [DATE] showed the following: -Mildly impaired cognition; -Adequate hearing, vision and wore glasses; -Understood others. Review of the a written statement, dated 9/30/24 7:40 A.M. and documented by an unknown staff showed, Girl came in and said I'm running late. Went to Resident #4, grabbed his/her arm and pulled him/her up. The document was signed by Resident #12. During an interview on 10/02/24 at 12:40 P.M., Resident #4's roommate, Resident # 12 said that on Monday, (9/30/24), he/she was in the room when a short, blonde haired staff member, who wore a ponytail, entered their dark room. The staff member said, I'm behind, and without saying a word to his/her roommate, he/she yanked the resident by the arm to get him/her out of bed and walked the resident to the bathroom. He/She reported this to the Assistant Director of Nursing (ADON) that morning who wrote it down and interviewed him/her and Resident #4. During an interview on 10/03/24 at 11:51 A.M., Certified Medication Technician (CMT) B said the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He/She was in the dining room on 9/30/24 around 6:30 A.M., when Resident #4 and his/her roommate were upset. Resident #4 was crying and too upset to speak, so the roommate told him/her a staff member had been rough and mean with Resident #4 when getting him/her out of bed that morning. The residents described the staff member appearance and voice. The two residents asked if he/she could help and he/she reported it first to the ADON when she arrived to work between 7:30 and 8:00 A.M. and then to the Director of Nursing (DON) when she arrived around 15 minutes later. 3. Request for a facility investigation regarding this incident was made of the facility on 10/03/24. They provided two statements (from the two residents). An interview with CNA F was received from the facility on 10/04/24. As of 10/07/24, the facility had not provided the state agency with an investigation within five working days of the incident and did not provide evidence that the alleged violation had been thoroughly investigated. The facility had not provided a completed investigation form with the required elements per their policy. During an interview on 10/2/24 at 1:30 P.M. the ADON said the following: -The incident was reported to her by CMT B the morning of 09/30/24; -She visited with the resident and his/her roommate and filled out their statements, turning them into the DON; -She gave the DON the description of the staff that the roommate had reported to her; -The facility typically suspend staff pending an investigation but they had not suspended anyone yet; -They were looking at staffing to see who fit the description, even though CMT B identified the staff member Resident #12 identified. During an interview on 10/03/24 at 8:25 A.M. and 4:15 P.M. and on 10/17/24 at 1:35 P.M. the DON said the following: -She was made aware of an incident between a staff being rough with Resident #4 upon arrival to work on 09/30/24 after discovering two written statements under her door; -She was not aware that CMT B knew anything about the incident and had not questioned him/her. CMT B did not report the incident to her; -She and the Administrator were responsible for investigating allegations of abuse; -She had not interviewed the night aides who had worked; -She was not sure if she interviewed the night nurse; -The only interviews documented were those of the resident and his/her roommate; -She did not fill out the investigation forms as per the policy. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/03/24 at 12:15 P.M. and 4:30 P.M., the Administrator said the following: -She was not aware of any staff to resident roughness and she felt staff would have reported it to her if there was an issue; -It is a residents' right to be free from abuse and the facility should follow their policy on abuse allegations and investigating; -She and the DON would be responsible for investigating an allegation of abuse. MO242564

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Manor	200 Thompson Drive Troy, MO 63379

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32899 Based on observation, interview and record review, the facility failed to ensure staff repositioned one resident appropriately (Resident #9), in a review of seven sampled residents. The census was 85. Review of the facility policy, Positioning the Resident, dated 03/2015, showed the following: -To move the resident up in bed when a resident is helpless with two staff lifting: -A nurse stands on each side of the bed or both on the same side; - Flex the residents' knees; -One nurse supports the head, shoulders and back by placing one arm across the back to the opposite axilla (arm pit). With the nurse's free hand, he/she lifts and arranges the resident's head so that it rests comfortably on his/her arm. Nurse places his/her arm across the small of the resident's back; -The second nurse places one arm across the back, the other under the thighs. If nurses are on the opposite sides of the bed, head and shoulders may be supported with a pillow; -Both nurses lift the resident into position desired; -When using a pull sheet under the resident use two staff with one staff on each side of the bed. Grasp the firmly at the shoulder and hips; on signal, move the resident up to the head of the bed. 1. Review of Resident #9's care plan, last revised 08/14/24 showed the following: -Diagnoses included pain in the right arm and Alzheimer's disease; -Resident has a U-bar placed on both sides of his/her bed to aid with positioning. Encourage and re-educate resident on properly utilizing the U-bar for repositioning self; -Use assist of one staff for bed mobility and a mechanical lift with two staff assist with transfers. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 09/20/24, showed the following: -Severely impaired cognition; -No range of motion impairment; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Partial to moderate assist with rolling in bed, sit to lying and lying to sitting transfers (helper did more than half of the effort). Observation on 10/03/24 at 8:38 A.M. showed the following: -Resident #9 lay on his/her back on a a disposable, absorbent pad in bed; -Certified Nurse Assistant (CNA) C and Nurse Assistant (NA) D entered the room, put the head of the bed down and prepared to move the resident up in the bed; -CNA C and NA D stood on opposite sides of the bed, placed their arms under the resident's axilla area (armpits), and pulled the resident up in bed. During an interview on 10/03/24 at 10:33 A.M., the resident said the following: -His/Her shoulders always hurt; -It pulled his/her arms and did not feel good when staff pulled him/her up in bed by pulling under his/her arms. During an interview on 10/3/24 at 2:25 P.M., CNA C said the following: -He/She repositioned the resident by placing his/her arms under the resident's, locking his/her arms with the resident's and then pulled the resident up in the bed; -He/She used the cloth pads to reposition residents when they had them; -No one had educated him/her to reposition a resident by hooking pulling them up under their arms, that was just the way he/she did it. During an interview on 10/03/24 at 2:30 P.M., NA D said the following: -He/She was taught to put his/her arm under the resident's arm to reposition a resident in bed but could not recall who taught him/her this. He/She was told if it was done a certain way, it would not hurt the resident; -He/She was not sure what a draw sheet was; -He/She should reposition a resident up in bed with a pad. During an interview on 10/03/24 at 11:35 A.M., the Director of Therapy said the following: -He/She would expect staff to reposition residents up in bed using a pad; -He/She would not recommend pulling a resident up in bed by lifting under the resident's arms; -There were a lot of nerves under the arms and it could hurt the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/03/24 at 4:15 P.M., the Director of Nursing said she had not educated any staff to reposition a resident by pulling the resident under the arms. Staff should stand on either side of the bed, communicate with each other, count and lift the resident with a pad. During an interview on 10/03/24 at 4:30 P.M., the Administrator said she would not expect staff to lift a resident up in bed by locking their arms under a resident's arms and pulling the resident up in bed. She would expect staff to use a draw sheet to reposition a resident up in the bed. MO239725

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47246 Based on observation, interview and record review, the facility failed to provide food items at a safe and appetizing temperature. The facility census was 87. Review of the facility policy, Food Temperatures, dated April 2011, showed the following: -The Dietary Services Manager (DSM) or designee is responsible for seeing that all food is the proper temperature before trays are assembled; -Hot food should be at least 120 degrees Fahrenheit (F) when served to the resident; -Hot/cold foods should not be placed together on the same plate. During an interview on 11/18/24 at 11:40 A.M., Resident #5 said he/she always eats in his/her room and the food was never hot. During an interview on 11/18/24 at 2:10 P.M., Resident #6 said he/she always eats in his/her room and the food was not always hot when it should be, he/she just figured it was cold because the facility had so many people to feed. During an interview on 11/19/24 at 9:30 A.M., Resident #8 said he/she always eats in his/her room and the food was always cold. Review of the Dietary Manager's, food temperatures-hall trays, showed she documented the following temperatures: -On 09/10/24 200 hall tray, protein temperature 94 degrees F; -On 09/27/24 200 hall tray, protein temperature 98 degrees F; -On 10/21/24 200 hall tray, protein temperature 94 degrees F; -On 10/30/24 300 hall tray, soup temperature 86 degrees F; -On 11/14/24 200 hall tray, protein temperature 97 degrees F. Review of the facility lunch menu for 11/19/24, showed the lunch meal included chili, hot dogs, and a lettuce salad. Review of the facility's temperature log, dated 11/19/24, showed staff documented the holding temperature of the lunch meat (protein) at 175 degrees F. Observation on 11/19/24 at 1:00 P.M., of the test tray obtained after staff served the last resident on the 200 Hall, showed the following: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The test tray showed a plate with a cold salad (lettuce), a hot dog on a hot dog bun, and a bowl of chili; -The temperature of the hot dog was 90 degrees F, and the temperature of the chili 110 degrees F. During an interview on 11/19/24 at 2:00 P.M., the Dietary Manager said the following: -She was not aware that any residents had complained that their food was cold; -She realized the temperature of food would decrease the minute it was plated and sent to the residents who ate in their rooms; -She will temp test one tray each week from each hallway in the facility where staff served residents meals in their rooms; -The plate warmer will hold the heat of the plate to 125 degrees F; she would like to see it at 135 degrees F, but the kitchen staff complained the plates were too hot to hold; -The cold salad (lettuce) plated with the hot dog probably reduced the temperature of the hot dog; -Food should be served at an appropriate and appetizing temperature. During an interview on 11/19/24 at 3:15 P.M., the administrator said the following: -She was not aware any resident had complained of their food being cold; -Food should be served at an appropriate and appetizing temperature. MO00243111

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview and record review, the facility failed to ensure staff used appropriate infection control procedures, including handwashing and gloving, while providing resident care for two additional residents (Residents #9 and #10). The census was 85. Review of the facility policy, Implementing the Body Substance Precautions, dated 06/2006, showed the following: -Handwashing remains the single most effective means of preventing disease transmission. Wash hands often and well, paying particular attention to around and under the fingernails and between fingers. Wash hands whenever they are soiled with body substances, after using the toilet, before performing invasive procedures and when each resident's care is completed; -Dirty gloves are worse than dirty hands because microorganisms adhere to the surface of a glove easier than to the skin on your hands. Handling medical equipment and devices with contaminated gloves is not acceptable; -Change gloves between contacts with different residents or with different body sites of the same resident. 1. Review of Resident #9's care plan, last revised 08/14/24 showed the following: -Bladder incontinence at times; -Provide toileting assistance and peri-care routinely and as needed. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 09/20/24, showed the following: -Partial to moderate assist with bed mobility; -Always incontinent of bladder and bowel. Observation on 10/03/24 at 8:38 A.M., showed the following: -The resident lay on his/her back in the bed; -Certified Nurse Assistant (CNA) C entered the room and prepared to perform incontinent care on the resident; -Nurse Assistant (NA) D entered the room and without washing his/her hands, donned gloves; -CNA C untaped and pulled down the urine soiled incontinent brief, sprayed a washcloth with perineal wash, cleaned the resident's front perineum and tucked the soiled incontinent brief and pad under the resident; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-NA D rolled the resident and CNA C used two more cloths wiping feces from the resident's buttocks. Without changing gloves, CNA C placed a clean disposable, absorbent pad under the resident and an incontinent brief with his/her soiled gloves; -NA D rolled the resident to his/her right side, while CNA C held the resident, touching the resident's left hip and buttock with soiled gloves, as NA D pulled the soiled brief and pad out followed by the clean pad and brief; -NA D and CNA C, without changing soiled gloves, assisted the resident to his/her back and secured the brief; -CNA C removed his/her gloves and without washing his/her hands lowered the head of the resident's bed. NA D removed his/her gloves; -CNA C and NA D, without washing their hands, positioned the resident up in bed; -Without washing hands, CNA D exited the room with a trash bag that held the soiled brief and wipes; -Without washing hands, NA D picked up a bag holding linens, covered the resident, raised the head of the resident's bed, and exited the room. During an interview on 10/03/24 at 2:25 P.M., CNA C said hands should be washed before cares, after cares and before exiting a resident room. Gloves should be changed if they become soiled with feces or urine. During an interview on 10/03/24 at 2:30 P.M., NA D said hands should be washed before and after cares and with glove changes. Gloves should be changed when they become soiled and hands washed or sanitized. Staff should not touch anything clean with soiled hands or gloves. 2. Review of Resident #10's care plan, last revised 08/14/24, showed the following: -Bladder incontinence at times; -Provide toileting assistance and peri-care routinely and as needed. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Partial to moderate assist with toileting and hygiene; -Independent with bed mobility; -Always incontinent of bowel and bladder. Observation on 10/02/24 at 1:12 P.M., showed the following: -The resident sat in a wheelchair in his/her room. NA J and CNA K entered the room, transferred the resident to bed and prepared to perform incontinent care on the resident; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA K untaped the resident's urine soiled incontinence brief and used a washcloth to clean the resident's front peri area, placed the washcloth in a bag, and with the same soiled gloves, tucked the soiled brief under the resident and assisted the resident to roll again, touching the resident's back and hip area with his/her soiled gloves; -NA J wiped soft feces from the resident's anal area, folded the cloth and wiped again. He/She picked up a clean towel, sprayed it with perineal spray and wiped the resident's buttocks; -Without washing hands or changing gloves, NA J assisted the resident to roll, touching the resident's back and leg with his/her soiled gloves, and removed the soiled brief; -NA J and CNA K, without changing gloves and washing hands, placed their arms under the resident's arms and lifted the resident up in bed. Using soiled gloves, CNA A handed the resident his/her call light. During an interview on 10/03/24 at 1:10 P.M., NA J said the following: -Hands should be washed before gloving and when removing gloves; -Gloves should be changed when they become soiled; -Clean items and areas should only be touched after gloves are removed and hands are cleaned. During an interview on 10/03/24 at 4:15 P.M., the Director of Nursing said the following: -Staff should wash their hands before and after perineal care and when going from a dirty to clean tasks; She would expect staff to change gloves and wash hands after cleaning feces, even if no feces were visible on gloves; -Gloves should be changed after perineal care and anytime they are soiled; -Clean areas/items should not be touched with soiled hands. MO239725 MO241048