STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265739	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holden Manor Health & Rehabilitation	2005 South Lexington Holden, MO 64040

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. Based on interview and record review, the facility failed to ensure residents were treated with dignity when one resident (Resident #1) alleged that Certified Nursing Assistant (CNA) A put his/her hands on the resident and pushed him/her in the shoulders, causing the resident to be scared and angry. The facility census was 34 residents.The Administrator and the Regional Nurse Consultant were notified on 1/22/26 of the past noncompliance which began on 1/11/26. The facility immediately completed an all-staff education for Abuse and Neglect and customer service. The deficiency was corrected on 1/19/26. Review of the facility's Dignity Policy, undated, showed:-Each resident was cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.-Residents were treated with dignity and respect at all times.-When assisting with care, residents are supported in exercising their rights.-Staff speak respectfully to residents at all times.-Demeaning practices and standards of care that compromised dignity were prohibited. -Staff were expected to promote dignity and assist residents:--Promptly responding to a resident's request for toileting assistance. Review of the facility's Abuse Prevention Program policy, undated, showed:-Residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. -This included but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. 1. Review of Resident #1's Face Sheet, undated, showed the resident was diagnosed with:--Anxiety disorder (a feeling of worry, fear, or unease about future events).--Legal Blindness.--Muscle weakness. Review of the resident's quarterly Minimum Data Set (MDS-a health status screening and assessment tool used for all residents of long-term care nursing facilities) dated 12/16/25, showed:-The resident was severely cognitively impaired.-The resident required maximal assistance with toileting. Review of the resident's Care Plan (an individualized plan that summarized the resident's health conditions, specific care needs, and current treatments), dated 1/12/26, showed the resident had an Activities of Daily Living (ADL- fundamental self-care tasks essential for independent living) self-care performance deficit related to blindness. During an interview on 1/22/26 at 9:16 A.M. the resident said:-He/She was sitting on the side the bed with his/her legs dangling down.-He/She could not remember when it was, but stated CNA A came in his/her room.-He/She told CNA A he/she needed to use the restroom.-CNA A said to him/her, I have better things to do and pushed the resident on his/her shoulders causing him/her to lean back on his/her bed. -He/she did not fall off or out of the bed.-CNA A had an attitude in the past but had never been physical with him/her.-He/She was scared at first then he/she got mad.-Another aide came to his/her room and helped him/her to use the restroom. During an interview on 1/22/26 at 9:54 A.M. CNA B said:-The resident complained about CNA A to him/her.-Another resident also complained to him/her that CNA A always seemed to be in a hurry. During an interview on 1/22/26 at 10:26 A.M. Licensed Practical Nurse (LPN) A said:-He/She reported the incident when he/she overheard the resident (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tell a family member that CNA A pushed him/her last night.-He/She got the Registered Nurse (RN) on duty, and they went in the resident's s room and interviewed the resident with the family member present.-The resident told them CNA A pushed him/her last night. -An assessment was completed, and no marks, bruising, edema, or inflammation was noted.-The resident pointed to his/her upper chest when asked where CNA A made contact with him/her.-No marks noted. During an interview on 1/22/26 at 10:55 A.M. Resident #2 said:-CNA A was not the best aide. -CNA A always seemed to be in a hurry.-He/She felt like CNA A ignored him/her. -He/She heard CNA A yelling at Resident #1.-CNA A's tone sounded gruff.-He/She could not understand what CNA A was saying to Resident #1, but his/her tone was gruff. During an interview on 1/22/26 at 11:40 A.M. CNA A said:-He/She started his/her shift at 6:00 P.M.-The resident wanted to call his/her family member every night around midnight.-The family asked the staff not to allow the resident to call that late.-When he/she told the resident he/she cannot call his/her family member, the resident alleged things about him/her. -Sometimes the resident got verbally aggressive and cussed at him/her.-Residents have asked him/her to slow down a little bit but sometimes he/she did not have time to spend that extra time with the residents. -He/She had a conversation with the Administrator regarding his/her tone of voice and he/she was working on it. -He/She did not put his/her hands on the resident. -The resident was hard of hearing and sometimes when he/she goes in the resident's room he/she will tap the resident on the shoulder to him/her know he/she was in the room. During an interview on 1/22/26 at 11:57 A.M. the Administrator said:-The incident was reported to him/her as soon as LPN A was informed.-He/She started the investigation.-CNA A was told not to return to work until the investigation was complete.-His/Her investigation concluded that CNA A was a little quick in providing cares.-The resident was upset that CNA A didn't let him/her call his/her family member. -All staff were trained on Abuse and Neglect within 24 hours of the alleged incident.-CNA A had one-on-one training.-All residents who were able to be interviewed were interviewed and showed no issues with CNA A other than he/she needed to slow down his/her cares. -His/Her investigation showed the allegation to be unsubstantiated for abuse and/or neglect. -He/She would expect staff to be patient with residents and provide them with dignity and respect. 2713443