STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265762	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Manor Health & Rehabilitation	1317 North 36th Street Saint Joseph, MO 64506

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 Note: The nursing home is disputing this citation.	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** Based on observations, interviews and record review, the facility failed to keep four residents (Residents #1, #2, #3, and #4) free from resident-to-resident physical abuse, resulting in injury when Resident #1 scratched Resident #2 on the neck and Resident #2 hit Resident #1 on the cheek causing redness. On a separate occasion Resident #3 scratched Resident #4's fingers. Facility census was 68.Review of the facility's Abuse Prevention Program policy, dated 2001, showed:-Our residents have the right to be free from abuse;-This includes but is not limited to freedom from verbal, mental, or physical abuse;-As part of the resident abuse preventions, the administration will protect residents from abuse by anyone, including, but not necessarily limited to other residents; -Develop and implement policies and procedures to aid our facility in preventing abuse or mistreatment of the residents. 1. Review of Resident #1's electronic medical records on 05/12/26 showed:-Diagnoses included: Dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing a significant impairment in daily life), and mood disorder (a mental health condition characterized by persistent and pervasive change in a person's emotional state). Review of the annual Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 03/08/36,showed:-The resident had adequate hearing, clear speech, and was able to make self understood;-He/She scored 12 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents), indicating moderately impaired cognitive skills;-He/She displayed no behaviors during the assessment period. Review of the resident's comprehensive care plan, dated 04/20/26, showed interventions related to the resident had potential for aggression toward others related to dementia, impaired cognitive function, and depression and mood disorder. Review of Resident #2's electronic medical record on 05/12/26 showed:-Diagnoses included: Chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath), bipolar disorder (a mental health condition characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area, stroke), and major depressive disorder. Review of the admission MDS, dated [DATE], showed:-He/She had adequate hearing, clear speech, made self-understood, and understood others;-He/She scored 15 on the BIMS indicating no cognitive impairment;-He/She displayed no behaviors during the assessment period. Review of the comprehensive care plan, dated 05/06/26, showed interventions related to potential for aggression toward other residents, elopement risk, anxiety/bipolar disorder, depression, mood, and COPD. Review of the facility investigation, dated 05/08/26, showed:-On 05/02/26 at 6:30 P.M., the nurse was alerted by staff in the dining room that Resident #1 and Resident #2 were involved in an altercation;-When the nurse entered the dining room, Resident #1 was sitting at the dining table, and three scratches were visible on the resident's neck;-Resident #1 said that another resident came into the dining room and said he/she hated it at the facility and no one wanted to help him/her;-Resident #1 said he/she told the resident 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265762	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Manor Health & Rehabilitation	1317 North 36th Street Saint Joseph, MO 64506

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 Note: The nursing home is disputing this citation.	could leave the facility;-The other resident then left the dining room;-Resident #2 then approached Resident #1 and told Resident #1 to quit talking about the other resident;-The two residents then got into a verbal altercation;-Resident #2 then scratched Resident #1 on the neck, and Resident #1 hit Resident #2 in the face; -Resident #2 had redness and swelling to the right cheek; -The staff separated the residents;-The residents were assessed and no other injuries were noted; -When interviewed, both residents said they felt safe at the facility;- No documentation that abuse education was provided to the staff after the resident to resident altercation. During an interview on 05/12/26 at 3:01 P.M., Resident #1 said:-He/She felt safe at the facility;-He/She told the resident who complained about the facility that they didn't have to live there, and Resident #2 didn't like that;-The two residents yelled at each other until Resident #2 reached out and scratched Resident #1, so Resident #1 hit Resident #2;-He/She has been avoiding Resident #2 since the incident and has had no other issues. During an interview on 05/12/26 at 3:10 P.M., Resident #2 said:-He/She felt safe at the facility;-He/She overheard Resident #1 tell the other resident he/she could leave if he/she didn't like the facility;-Resident #2 said Resident #1 didn't have the right to talk to anyone that way and went over and told Resident #1 that; -Resident #1 yelled at Resident #2 and Resident #2 rolled his/her wheelchair closer to Resident #1;-Resident #2 thought Resident #1 was going to hit him/her, so he/she put his/her hand out and scratched Resident #1's neck;-Resident #1 then hit Resident #2 on the right side of the face;-Resident #2's right cheek was red for a bit but he/she had no other injuries. During an interview on 05/12/26 at 2:40 P.M., the Social Services Designee (SSD) said: -He/She was aware of the altercation involving Residents #1 and #2; -The resident who said he/she didn't like living at the facility and Resident #1 told him/her could leave is Resident #2's relative;-Resident #2 had lived at the facility for approximately a month, but his/her relative lived at the facility for much longer;-There have been no issues with Residents #1 and #2 prior to this altercation. 2. Review of Resident #3's electronic medical records on 05/12/26 showed:-Diagnoses included: Cerebral infarction, hemiplegia/hemiparesis following cerebral infarction affecting left side (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), dysphagia (difficulty swallowing), history of traumatic brain injury (a disruption in normal brain function caused by an external physical force), anxiety disorder (a mental health disorder characterized by severe, ongoing anxiety that interferes with daily activities), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms) and major depressive disorder. Review of the quarterly MDS, dated [DATE], showed:-He/She had adequate hearing, unclear speech, usually made self-understood and understood others;-He/She scored 15 on the BIMS;-He/She displayed rejection of care and wandering during the assessment period. Review of the comprehensive care plan, dated 05/12/26, showed interventions related to potential for aggression towards others, behaviors related to alcohol and cannabis use in facility, schizoaffective disorder, depression, mood, anxiety, and chronic pain. Review of Resident #4's electronic medical record, dated 05/12/26, showed:-Diagnoses included: Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), cerebral infarction, cognitive communication deficit (a difficulty with communication that's caused by an underlying issue with cognition), restlessness and agitation, and major depressive disorder. Review of the annual MDS, dated [DATE], showed:-He/She had minimal difficulty hearing, clear speech, made self-understood and understood others;-He/She scored 15 on the BIMS;-He/She displayed no behaviors during the assessment period. Review of the comprehensive care plan, dated 05/12/26, showed interventions related to potential to be physically and verbally aggressive toward others, daily complaints about food, restlessness and agitation, attention seeking behaviors, hoarding, depression, Parkinson's disease, and impaired vision and hearing. Review of the facility investigation, dated 05/12/26, showed:-On 05/11/26 during dinner, Licensed Practical Nurse (LPN) A was notified there was an altercation in the small dining room;-Resident #3 entered the small dining room, rolled his/her wheelchair up to Resident #4's table and pushed Resident #4's plate to the floor;-Resident #4 stood (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265762	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Manor Health & Rehabilitation	1317 North 36th Street Saint Joseph, MO 64506

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 Note: The nursing home is disputing this citation.	up, grabbed Resident #3's reacher and proceeded to hit Resident #3 in the upper thigh six or seven times;-Resident #3 grabbed Resident #4's hand and dug his/her fingernails in the top of Resident #4's hand;-Resident #4 turned and walked away but turned back around and threw his/her drink on Resident #3;-The residents were separated; -The nurse assessed each resident and provided treatment to Resident #4's hand;-Resident #3 had no injuries;-The Administer arrived at the facility at 6:15 P.M. and Resident #3 was sitting out front and was holding a full urinal;-When asked why he/she had the urinal, Resident #3 responded it was to throw on Resident #4;-LPN A took the urinal from Resident #3 and disposed of it;-Both residents were interviewed and educated on appropriate behaviors, being courteous to one another and avoiding each other.-On 05/12/26, the residents were placed on 15-minute checks for safety;-On 05/12/26 Resident #3 was moved to a different hall on the other side of the facility. During an interview on 05/12/26 at 2:40 P.M., the Social Services Designee (SSD) said:-Resident #3 has had problems in the past following rules and being aggressive with other residents and staff;-SSD has met with Resident #4 and discussed this behavior. During an interview on 05/12/26 at 2:50 P.M., LPN A said:-There was an incident on 05/10/26;-Both residents were outside of the facility;-Resident #4 was using the hose to water the flowers and sprayed Resident #3;-Resident #4 said it was an accident, Resident #3 felt it was done on purpose; -LPN A intervened during the altercation in the small dining room on 05/11/26;-Resident #3 told LPN A that he/she was still mad about being sprayed with the hose the day before and went to find Resident #4. During an interview on 05/12/26 at 2:35 P.M., Resident #3 said:-He/She felt safe in the facility;-He/She did not have an altercation with another resident in the dining room;-He/She did not know why staff would say that or why it would be documented in his/her medical record;-He/She had no issues with Resident #4.-If he/she had issues with another resident or did not feel safe, he/she would go to the social worker, nurse or administrator. During an interview on 05/12/26 at 3:07 P.M., Resident #4 said:-He/She felt safe at the facility;-He/She had a fight with Resident #3 in the small dining room on 05/11/26;-He/She thought Resident #3 was still mad that Resident #4 accidently sprayed him/her with the water hose a couple days ago;-Resident #3 came up to Resident #4's table during dinner and pushed Resident #4's plate to the floor;-Resident #4 stood up and Resident #3 tried to hit Resident #4 with a reacher;-Resident #4 tried to grab the reacher from Resident #3 and Resident #3 grabbed Resident #4's hand and dug his/her fingernails in, causing cuts; -Resident #4 got his/her hand away and turned to walk away;-However, he/she felt that Resident #3 was still coming at him/her and Resident #4 threw his/her drink on Resident #3;-The nurse came and got between the residents; -Resident #3 left the dining room and the nurse attended to the cuts on Resident #4's hand; -They eat in different dining rooms;-If Resident #4 sees Resident #3, he/she goes the other way. During an interview on 05/12/26 at 1:30 P.M., the Administrator said:-He/She expected residents to be respectful and polite to each other;-He/She expected staff to be aware of resident's behaviors and needed interventions and care planned interventions used to keep residents safe;-Resident #3 was placed on 15 minutes checks on 05/12/26;-Resident #3 was moved to a different hall on the opposite side of the facility from Resident #4 on 05/12/26;-Staff received education on abuse and neglect, and monitoring all residents involved in the altercations to assist them in avoiding each other on 05/12/26.Intake 3009620Intake 3010826