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	06/25/2026

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

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on record review and interviews, the facility failed to obtain written authorization from one resident (Resident #2) to deposit pension personal funds into the facility operating account. The facility census was 65.Review of facility policy, Deposit of Residents' Personal Funds, revised March 2021, showed:- Residents are not required to deposit personal funds with the facility;- If a resident chooses for the facility to hold, safeguard, and manage his or her personal funds, the facility will deposit the funds in an interest-bearing account that is separate from facility operating accounts;- A copy of the resident's or representative's authorization designating the facility as the agency to manage the resident's funds I filed in the resident's financial record;1. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 3/30/26, showed:- Resident was cognitively intact;- Diagnoses: obstructive uropathy (blockage of the urinary tract), diabetes, dementia, and chronic obstructive pulmonary disease;During an interview on 6/25/26 at 11:15 A.M., the Resident said:- A letter with his/her pension check was not delivered to him/her. Instead it was delivered to the Business Office Manager (BOM). The BOM called the Resident to her office and showed him/her the letter which the BOM had opened. The letter was addressed to the Resident but the BOM said she had opened it by mistake. Since the Resident owed the facility money the BOM deposited it into the facility bank account without getting permission from the resident or a signature on the check. - The Resident was very upset that his/her mail was not delivered and money was taken from him/her without authorization. The Resident knows he/she owed the facility money and would have given them most of the amount from the check but needed some of that money for his/her personal expenses. He/she had not given authorization to the facility to handle his/her pension fund check. Record Review of the facility operating fund, showed:- 5/31/26 a deposit of $283.59 was made into the operating account with a scanned check, #03782267. The scanned check was made out to Resident #2, there was no endorsement signature on the check or receipt on file for the money reflecting a payment from the Resident.Record Review of Resident #2's Resident Trust Fund Authorizations showed no authorizations in place on 5/31/26 for the facility to manage the Resident's pension check. During an interview on 6/25/26 at 1:25 P.M., the BOM said:- On 5/31/26 she was presented by the Resident with a pension check #03782267 and told to deposit the whole check amount, $283.59, into the operating account to counter what he/she owed the facility.- She did not have a signed receipt from the Resident for the funds given to the Business Office and she did not have a signed endorsement on the back of the check since the bank would accept it without a signature. She did not have a signed authorization from the Resident giving the facility permission to manage the Resident's pension check as of 5/31/26. During an interview on 6/25/26 at 2:15 P.M., the Administrator said:- The facility should obtain signed receipts for deposits given to the Business Office and whenever money changes hands between the facility and the residents.- Purchases on behalf of the residents require receipts and residents need to sign when they have received materials purchased for them. - Checks turned over to the Business Office should be endorsed on the back of the check by the person who the check is made out to. - Mail addressed to a resident is never opened by facility staff unless requested by the resident. Intake 3017541

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 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. Based on interview and record review, the facility failed to protect one resident's (Resident #1) right to be free from physical abuse when a facility staff member physically forced the resident into his/her room. Upon assessment, the resident was had burst blood vessel on his/her left thumb. The facility census was 65.On 6/25/26, the Administrator was notified of the past noncompliance incident which occurred on 6/18/26. On 6/18/26, facility administration was notified of an allegation of staff to resident abuse, an investigation immediately began and corrective actions were implemented to include: Assessment of the Resident, suspension of the accused staff member, interviews with other residents for indications of abuse, and mandatory in-service training for all staff on abuse, dignity and safe resident handling. The noncompliance was corrected on 6/19/26. Review of facility policy, Abuse Prevention Program, revised December 2016, showed:- Residents have the right to be free from abuse, neglect, and misappropriation of resident property;- The administration will protect residents from abuse by facility staff;- Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior;- The facility will identify and assess all possible incidents of abuse, investigate and report any allegations of abuse, and protect resident during abuse investigations. 1. Review of Resident #1's Face Sheet, dated 6/19/26, showed:-The resident was not their own person and had two Designated Power of Attorneys for his/her healthcare;- Diagnosis: stroke, aphasia (neurological disorder that impairs a person's ability to speak, write, and understand spoken and written language), dysphagia (difficulty in swallowing food or liquids), diabetes, GERD (acid reflux), anxiety disorder, and dementia;Review of the resident's Care Plan, undated, showed:- The resident had potential to be physically aggressive due to anger, pain, and frustration. Staff should provide physical and verbal cues to alleviate anxiety and give positive feedback and guide away from source of distress.- The resident had a communication problem. Staff should allow adequate time to respond and repeat as necessary. Do not rush and request clarification from the resident to ensure understanding. - The resident had potential for impairment to skin integrity. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.Review of the resident's Progress notes, dated 6/18/26 at 3:30 P.M., showed a Late Entry 6/25/26 at 11:54 A.M. note that said CNA (A) pushed the resident down the hall in a wheelchair while resident was expressing audible anger. The resident tried to prevent entry into their room by placing his/her hand on the door frame to stop the wheelchair. CNA (A) forcibly grabbed the resident's hand and removed it from the door frame. CNA (A) then pushed the resident's wheelchair into the room and began to argue with the resident. LPN (A) entered the room and confronted CNA (A) about the incident, CNA (A) left the room without a response. LPN (A) assessed the resident and noted a nickel size bruise to the left hand with no other injuries. LPN (A) calmed the resident down and reported the incident to Human Resources and the Administrator. Record Review of resident Skin Assessment, dated 6/18/26 at 3:30 P.M., showed bruising on the back of the left hand. Review of Follow-up Investigation Form, dated 6/18/26, showed:- Facility staff witnessed CNA (A) pulling the resident's hand from a door frame and speaking to the resident in an abusive manor. Multiple facility staff gave statements of improper behavior by CNA (A). The resident had an area on his/her left thumb with a burst blood vessel. - Incident was reported to physician's office.- CNA (A) was suspended pending investigation.- CNA (A) admitted to Human Resources (HR) and the Administrator that he/she forcefully made the resident return to his/her room. He/she removed the resident from the dining room because he/she was messing with the cabinets and the sugar stored in them. - The resident BIMS score of zero showing the resident had severe cognitive impairment. Trauma screening showed some symptom indicators and resident had mild depression.- Conclusion of investigation by facility showed CNA (A) was aggressive both physically and verbally with the resident per witness (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	statements. CNA (A) was terminated from his/her position. Record review of interviews and statements collected during the facility investigation showed:- Human Resources Manager (HRM) statement showed she interviewed Resident #1, (all dates/times unknown) who said his/her hand did not hurt but it hurt when CNA (A) grabbed his/her hand. The resident had a small bruise on his/her left thumb from this incident. HRM interviewed Resident #4 who said CNA (A) makes him/her feel uncomfortable. HRM interviewed Resident #5 who said CNA (A) speaks very loudly to all of the residents as if each resident required a hearing aid. HRM interviewed Resident #6 who said CNA (A) doesn't listen to the residents and is very negative. HRM interviewed Resident #7 who said CNA (A) is very aggressive and would not listen to the resident when being changed. The whole process with CNA (A) was rough handling by CNA (A). CNA (A) did apologize to the resident several days later. When the HRM and Administrator interviewed CNA (A) he/she said he/she tried to keep Resident #1 from interfering with an activity that was going on in the dining room. The resident was not happy about going back to his/her room and he/she remembers yanking the resident's hand away from the door frame. - CNA (A) statement showed he/she noticed Resident #1 playing with sugar packets in the dining room and he/she needed to go back to his/her room due to his/her behaviors. The resident was being combative all the way back to his/her room. CNA (A) just left the resident at his/her room since he/she was being so combative. - CNA (C) statement showed an incident while working with CNA (A) on 6/17/26. CNA (A) was in Resident #6's room removing trash. CNA (C) entered the room and requested CNA (A) assist him/her in getting the resident ready for bed. CNA (A) was briefed by CNA (C) on the resident's routine for going to bed. CNA (A) turned to the resident and said, We are going to get this done and we're not going to have problems. CNA (C) considered the interaction with the resident rude and unprofessional. The resident looked at CNA (C) with a confused look on his/her face. CNA (C) checked on the resident later to make sure he/her was okay and he/she had no concerns. - LPN (A) statement showed on 6/19/26 at 3:30 P.M. that he/she sat at the North Hall nurses' station when CNA (A) stood up abruptly and went down the hall towards the dining room. CNA (A) came back towards him/her pushing Resident #1's wheelchair. The resident was yelling and CNA (A) attempted to push the resident into his/her room but the resident grabbed the door frame. CNA (A) forcibly grabbed the resident's had and removed it from the door frame and then pushed the resident's wheelchair into the room. CNA (A) told the resident he/she was going to go to bed and the resident was yelling at CNA (A). LPN (A) entered the room and asked CNA (A) what the issue was with the resident and CNA (A) left the room without providing an answer. LPN (A) calmed the resident down and assessed the resident and noted a small bruise to the left hand between the thumb and index finger. Administrator was immediately notified. Record review of Trauma/Abuse/Neglect screening, dated 6/19/26 at 2:25 P.M., showed no concerns.Review of Corrective Action Form, dated 6/22/26, showed:- CNA (A) was terminated for performance/behavioral conduct;- Reason for Action: Speaking and acting aggressively towards a resident, not adhering to resident rights and admitted to performing the aforementioned actions. Observation of the resident on 6/25/26 at 9:45 A.M. at the Nurses' station showed:- The resident was quiet and calm with no anxiety or distress noted;- The resident was unable to communicate when asked questions due to cognitive ability;- No bruises or marks were observed on the resident's hands. During an interview on 6/25/26 at 9:20 A.M., LPN (A) said:- He/She sat at the nurse's station charting and CNA (A) sat at another computer station nearby. CNA (A) abruptly stood up and quickly went to the dining hall. He/She then saw CNA (A) pushing the resident down the hall in their wheelchair. The resident's ability to communicate was very limited but he/she could tell that the resident was extremely distressed since he/she had been taking care of the resident for the last four years. CNA (A) was verbally aggressive with the resident and his/her actions were not calming the resident down at all.- CNA (A) got the resident to their room but before they could enter, the resident grabbed the door frame to resist entering the room. CNA (A) then forcibly removed the resident's hand from the door frame. LPN (A) then approached CNA (A) and asked what caused him/her to react towards the resident in an aggressive manor. CNA (A) did not (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	have an explanation and exited the room and walked away from LPN (A) instead of answering the question. From what he/she observed CNA (A) was trying to put the resident into bed and the resident didn't want to go to his/her room or bed but was forcibly made to by CNA (A). - LPN (A) calmed the resident down and did a skin assessment. The resident appeared to have a small bruise forming between the thumb and index finger which was the location that CNA (A) had grabbed the resident. - LPN (A) then informed HR and the Administrator of the incident. Since the incident the resident has been at baseline behavior with no indications that the incident had any negative effect on him/her. During an interview on 6/25/26 at 2:45 P.M., the Administrator said:- She would expect an abuse incident with a resident to be documented in the resident's progress notes.- She would expect skin assessments for the resident in a physical abuse incident to be recorded in the resident's medical record. - Based on her investigative findings, the incident between CNA (A) and the resident was physical and mental abuse. Residents have the right to be free from abuse. During an interview on 6/29/26 at 9:10 A.M., CNA (A) said he/she admitted that he/she was just trying to get the resident to calm down and putting the resident to bed was how he/she decided it should be handled. During an interview on 6/29/26 at 1:34 P.M., CNA (A) said:- The resident was in the dining room around lunch time and messing around with the dietary supplies and based on the Business Manager's reaction to the resident playing with the sugar packets he/she needed to remove the resident from the dining room and put him/her into bed.- He/She took the resident by wheelchair to his/her room but the resident was being combative about leaving the dining room. CNA (A) doesn't remember if the resident put his/her hands on the door frame to prevent entrance to the room. If he/she removed the resident's hand from the door frame he/she was certain it was done gently and would not leave any bruising. Bruising would indicate a level of abuse in his/her opinion. He/She was very nice to the resident and spoke to him/her with respect during the altercation. Rather than leaving the resident alone at the front of his/her room he/she forced the resident into his/her room because it would be safer than leaving the resident in the hallway Intake 3048841

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observation, interview and record review, the facility failed to implement the Resident Smoking Policy when one sampled resident (Resident #3) out of 5 sampled residents was observed smoking cannabis, a federally illegal substance, 10 feet from the building in a non-designated smoking area. The facility census was 65.Record review of the facility's policy, Smoking Policy, dated 10/2/24, showed:- Smoking will only be allowed in designated area(s) at designated times in the facility that are not near flammable substances or where oxygen is in use. - The Smoking Policy outlines the designated areas, notices, education and requirements for smoking on the facility property to ensure precautions are taken for the resident's individual safety as well as the safety of others in the facility. - Individualized approaches and directions for safety and assistance will be documented in the resident plan of care and communicated to direct care staff. Documentation will detail situations when residents are not allowed to smoke.- Education about the Smoking Policy will be provided to the resident/resident representative. - Residents who can sign out per responsible party, may ask for their smoking materials after signing out and must leave the property to smoke at will. - All residents who smoke need to be supervised by a facility staff member or personal family member at the designated locations.- The smoking of other federally illegal substances is never permitted, and violators may be issued a discharge. Record review of the facility's policy, THC Policy & Procedure, undated, showed:- THC (cannabis or marijuana) smoking is not permitted at the facility due to conflict between state and federal laws regarding cannabis.- Directly allowing smoking is problematic due to broader clean-air and healthcare setting regulations, as well as the risks associated with cannabis smoke. - Consuming THC, in any manner or form, in a nursing home environment is not permitted due to current federal regulations and associated risks.- THC remains a Schedule 3 substance under federal law, considered to have no accepted medical use and a high potential for abuse. 1. Review of Resident #3's face sheet, dated 6/25/26, showed:- Resident was a Medicaid/Medicare recipient;- Resident was their own responsible person;- Diagnoses: neuropathy, gastric ulcer, GERD (acid reflux), stage 3 kidney disease, major depressive disorder, and edema;Review of Resident's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 5/24/26, showed:- Resident was cognitively intact;- Resident had no mood or behavioral concerns;Review of Resident's Care Plan, undated, showed:- Resident receives Norco medication daily and the use of this drug with other depressants may result in profound sedation, coma, and death;- Resident was dependent on tobacco and was instructed on the facility smoking policy (locations, times, rules, safe smoking practices);- Resident can smoke unsupervised;- Resident had a behavior problem using cannabis products while on facility grounds;- Intervene as necessary to protect the rights and safety of others. Remove from cannabis smoking situation and take to alternate location as needed;Observation outside the facility at the front lobby door on 6/25/26 at 11:15 A.M., showed:- Resident was smoking a small rolled cigarette 10 feet in front of the side entrance lobby doors to the facility which was not a designated smoking area.- The smell of cannabis was strongly noticeable from 50 feet away from Resident #3.During an interview on 6/25/26 at 11:22 A.M., Resident #3 said:- He/she was smoking marijuana while being observed by the surveyor.- He/she gets the marijuana from an outside source and the staff does not help him/her obtain it or condone him/her smoking it. He/she smokes it to feel relaxed and is not going to stop using it. During an interview on 6/25/26 at 11:55 A.M., CMT (A) said:- The designated smoking areas are located on the patio for independent smokers and they can smoke anytime they want. There is an inside smoke room that is monitored and the dependent smokers have designated times they can go there to smoke. During an interview on 6/25/26 at 12:10 P.M., CNA (B) said: - Residents can smoke in the courtyard or in the smoking room that is set aside for smokers;- Independent smokers are supposed to smoke away from the facility if they go outside but usually they go out in the front of the building which is near the front entrance;- He/she has observed one of the residents, who has since (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharged , a few weeks ago to strongly smell of marijuana;- He/she has never seen or heard of staff providing marijuana to residents;During an interview on 6/25/26 at 2:25 P.M., the Administrator said:- She would not expect or condone residents smoking 10 feet from a building entrance and definitely not marijuana;- She has had issues with Resident #3 in the past with regards to smoking illegal substances and has documented it in his/her care plan. She is considering enforcing a no tolerance policy that results in immediate discharge of the resident after the first warning due to the difficulty in enforcing the smoking policy with marijuana at the facility. - Residents who are independent and want to smoke outside the facility must move to at least 100 feet away from the buildings or they are in violation of the Smoking Policy. During an interview on 6/29/26 at 12:53 P.M., the Nurse Practitioner said:- The Resident has not been prescribed, nor would he/she ever be prescribed cannabis while at a skilled nursing facility. The Resident has the potential for an adverse effect by using cannabis when combined with his/her current medication regimen. Narcan (a lifesaving medication designed to rapidly reverse an opioid overdose) should be added to his/her orders based on him/her using cannabis. Intake 3034148