STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265843	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appleton City Manor	600 North Ohio Appleton City, MO 64724

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 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** 48534 Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported to the Department of Health and Senior Services (DHSS) within the required two hours timeframe when the facility did not report one resident's (Resident #1) statement threatening physical violence towards other residents. The facility census was 28. Review of facility policy titled, Abuse Prohibition, Prevention, Investigation, Reporting and Response, updated 09/26/16, showed the following: -It is the policy of the facility to take all reasonable and responsible measurements to prevent the occurrence of abuse, including mental abuse, neglect, injuries of unknown sources, and misappropriation of resident property, and to ensure that all alleged, reported, and suspected violations of Federal or State laws which involve mistreatment, abuse, neglect, injuries of unknown origin and misappropriation of resident property are reported to State agencies within twenty-four (24) hours after receiving said report. The facility will investigate each alleged violation thoroughly and report the results of all investigations to the appropriate State agency or individuals within five working days of the alleged violation; -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulted in physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain, or maintain, physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents cause physical harm or pain or mental anguish; -Mental abuse includes, but is not limited to verbal or nonverbal humiliation, harassment, threats or punishment or deprivation. This includes conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. -Verbal abuse is any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. 1. Review of Resident #1's face sheet (resident's information at a quick glance) showed the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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	-admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a lung disease that makes it difficult to breathe), suicidal ideation's, and hypomagnesemia (condition in which the level of magnesium in the blood is lower than normal). Review of the Resident Incident Report dated 11/16/24, at 7:00 P.M., and completed by LPN E showed the following: -Certified nurse aide (CNA) reported resident out at smoke break at 7:00 P.M. The resident became verbally aggressive with peers and stated you're in my fucking spot. Staff immediately intervened and redirected, when resident came in from smoke he/she stated I'm gonna bash somebody's fucking head with a hammer. Staff redirected resident immediately, all parties separated, staff assisted resident to room and to bed. No harm to any parties. Staff notified Medical Director, interim Director of Nursing (DON). Staff completed 72 hour incident report and 15-minute checks initiated. Medical Director issued new orders for labs. Review of the resident's nurses' notes showed Licensed Practical Nurse (LPN) E wrote the following: -On 11/16/24, at 8:00 P.M., the resident was outside for smoke break at 7:00 P.M. with staff and other residents. The resident became aggressive and stated to peer you're sitting in my fucking spot. Staff immediately intervened. Resident continued cussing and yelling at two peers. The resident mumbled as residents were coming back inside, I'm gonna bash somebody fucking head with a hammer. Staff redirected and immediately residents were separated and taken to room away from other residents. Staff assisted the resident to bed. No harm done to any of residents involved. Staff notified Interim DON notified and Medical Director called at 8:10 P.M. with new orders for labs. Resident is his/her own responsible part and aware of new orders. (Staff did not document reporting the allegation of possible abuse to DHSS.) Review of a witness statement provided by CNA F, dated 11/16/24, showed the following: -At approximately 7:00 P.M., CNA F took the residents out to smoke for their scheduled smoke break. The resident stated, Resident #3 do not sit in my spot! Resident #3 began to switch seats, but the other CNA and CNA F told Resident #3 that he/she did not have to move. Resident #3 remained seated and Resident #1 began cussing. Resident #2 began to stick up for Resident #3. Resident #2 and Resident #1 began a heated verbal dispute. The other CNA spoke up and stated that if the arguing did not stop, the smoke break would not occur. The resident calmed down and smoke break ensued with no further arguing. -Upon entering the facility, post smoke break Resident #1 was asked by CNA F if he/she wanted to get ready for bed. Resident #1 stated that he wanted to bash somebody's fucking head in with a hammer. -Resident #1 was taken to his room and put to bed. Charge nurse notified immediately. No further occurrences at the time of this statement, involving resident. Review of a witness statement by CNA G, dated 11/16/24, showed the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At approximately 7:00 P.M., CNA G, another CNA and three residents outside to smoke. Resident #1 said Resident #3, Do no sit in my spot. Resident #3 began to get up, but CNA G told him/her that he/she could sit back down and CNA G directed Resident #1 to the opposite end of the table, where he/she had sat at every other smoke break that day; -Resident #2 and Resident #1 began to argue and CNA G stated that if the arguing continued, the smoke break would be over. Residents stopped arguing. Review of a witness statement by CNA H, dated 11/16/24, showed the following: -At around 7:00 P.M., when the residents came inside from smoke break CNA H heard Resident #1 say I'm gonna bash somebody's fucking head in with a hammer. The other CNA's and CNA H immediately redirected, and the resident went in room and went to bed. The resident continued to be hateful and completely disrespectful. The patient's room was searched for any kind of hammer or weapon. The patient is getting checked every 15-minutes. During an interview on 11/18/24, at 1:37 P.M., Resident #1 said the following: -Resident #1 was involved in an incident over the weekend with Resident #2; -Resident #1 said there was a confrontation with another smoker in the smoking area that was verbal and nearly physical; -Resident #1 said staff calmed them down and there have been no other issues since; -Resident #1 said he/she only sees Resident #2 when smoking. Record review of DHSS records showed the facility did not complete a self-report to DHSS regarding the allegation of possible abuse. 2. Review of Resident #2's face sheet showed admitted [DATE]. Review of the resident's care plan, updated 11/12/24, showed the resident was a smoker. Review of the resident's nurse's note dated 11/16/24, at 3:00 P.M., showed LPN E wrote the resident was out at smoke break with other residents. Resident #1 was aggressive and cussing at Resident #3. The resident intervened and asked Resident #1 to stop yelling at Resident #3. Resident #1 said to the resident fuck you. The resident said no fuck you. Resident #1 said to the resident he/she would kick his/her ass and the resident replied bring it. Staff immediately redirected both residents and separated them. No further issues this shift. (Staff did not document reporting the allegation of possible abuse to DHSS.) During an interview on 11/18/24 at 1:21 P.M., Resident #2 said the following: -Resident #2 said Resident #1 was being mean to Resident #3. Resident #1 thinks he/she owns the bench and started cussing and calling Resident #3 names. Resident #2 told Resident #1 that he/she needed to leave Resident #3 alone and quit being mean; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #2 said that was the first time he/she had any issue with Resident #1; -Resident #2 said that he and Resident #1 have talked since the incident on Saturday; -Resident #2 said staff intervened in the incident and told both residents to quit arguing and staff wrote a report on it; -Resident #2 said staff told Resident #1 if he didn't stop the cops would be called. Record review of DHSS records showed the facility did not complete a self-report to DHSS regarding the allegation of possible abuse. 3. Review of Resident #3's face sheet showed the following: -admitted [DATE]; -Diagnoses included COPD, major depressive disorder (mood disorder that is characterized by a low mood and negative emotions), and hypokalemia (a condition where the level of potassium in your blood is lower than normal). Review of the residents' nurses notes show no documentation on 11/16/24 by staff. 4. During interviews on 11/18/24, at 12:35 P.M. and 3:15 P.M., the Social Services Director (SSD) said the following: -The social service worker from hospice contacted the police department today (11/18/24) regarding the incident over the weekend with Resident #1 and a police report was made; -He/she did not know what occurred over the weekend, but he/she had a note taped to her door this morning. The note was from LPN E and said the following: Resident #1 needs cigarettes ASAP - completely out. Please get ASAP. Resident has been having behaviors this weekend, is on 72 hour charting and 15-minute checks per interim DON due to this. Don't want to add to it with no cigs. -The SSD said he/she talked with the hospice nurse about the situation and the hospice social worker called the police. -If staff received an allegation of abuse, staff should call her and the Administrator. The Administrator would conduct the investigation. -She found out about the incident today (11/18/24) and did not call the police or DHSS because she thought everyone else took care of it. 5. During an interview on 11/18/24, at 2:24 P.M., CNA A said the following: -CNA A said Resident #1 can get loud and cuss at staff when he/she doesn't get what he/she wants or if he/she misses a smoke break; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA A said that verbal abuse and threats is a form of abuse and should be investigated by the facility; -The state required allegations of abuse, neglect, or misappropriation to be reported to the state within two hours. 6. During an interview on 11/18/24, at 4:40 P.M., LPN I said if he/she witnessed a resident to resident altercation, he/she separated the residents first, then talked to them about the events that led to the altercation. He/she contacted the DON and completed an incident report. He/she thought the DON contacted the state agency to report abuse allegations. If a resident threatened another resident, he/she would consider that abuse. 7. During an interview conducted on 11/20/24, at 12:30 P.M., LPN C said if someone reported to him/her an allegation of abuse, he/she would investigate the situation, document what happened in the nurses' notes, and notify the DON who would report the allegation to the state agency within two hours. The DON would complete the investigation. A resident threatening another resident was an allegation of abuse. 8. During an interview on 11/18/24, at 2:25 P.M., the Assistant Director of Nursing (ADON) said if she observed a resident-to-resident altercation, she would separate the residents, then ask the residents what happened, obtain vital signs and complete a physical, if applicable and emotional assessment. She would also interview and obtain staff/witness statements, document the altercation/incident in the residents' nurses' notes, complete an incident report, notify the DON, physician, and resident's family. The DON notified the state agency. The ADON said she heard from the DON this morning, that Resident #1 and Resident #2 got into an argument around smoke break, sometime this last weekend. Resident #2 said Resident #1 was verbally aggressive because he/she did not have any cigarettes. Staff thought the weekend charge nurse notified hospice of the incident but hospice staff did not know about it until they visited the facility today. They called the police. 9. During an interview on 11/20/24, at 12:35 P.M., the DON said the following: -The incident over the weekend between Resident #1 and Resident #2 was not an allegation of abuse; -The residents were separated, put on 15-minute checks, the doctor was notified and new orders were given.

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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. 48534 Based on observation, interview, and record review, the facility failed to ensure an environment that remained as free of possible hazards as possible when one resident (Resident #4) was found to have marijuana and unknown pills on their person and in their room. The facility also failed to educate staff and implement interventions to prevent future occurrences for the resident. The facility census was 28. Review of the facility's policy titled Incident/Accident Policy, dated 07/15/99, showed the following: -Document any incident occurring out of the normal, to any resident, employee, or visitor. When an incident occurs with a resident, employee or visitor, there should be an incident report made out as to name, what occurred, and if any injury was noted. If the incident occurred with a resident, be sure to put on the incident report exactly how staff found the resident, what injury staff found on the resident, and who staff notified such as physician, family, or any other responsible party; -Take the white copy to the Director of Nursing (DON) and the yellow copy to the Administrator's desk; -Note incident on charge sheet and pass it on to the other shifts; -Notify physician and family within 24 hours unless life threatening injury, then notify immediately. Review of the facility's policy titled Smoking Policy, dated 03/21/22, showed the following: -All residents who smoke must sign an agreement with the facility stating that they understand the risk and agree with this policy; -Staff are to report any unsafe practices by the resident; -If smoking materials are found in the resident's room, they will be placed behind the nurses' station. Explaining the importance of following these policies that are set out for their safety at this time; -These policies are a guideline to keep the staff and the residents in a safe environment and reduce the number of harmful outcomes. Residents may have a care plan meeting with staff to accommodate their needs and wants. Review of the facility's policy titled Storage of Medications, undated, showed it was the policy of the facility that drugs and biologicals be stored in a safe, secure, and orderly manner. 1. Review of Resident #4's face sheet (resident's information at a quick glance) showed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted to facility on 8/20/24; -Diagnoses included malignant neoplasm of unspecified part of unspecified bronchus or lung (lung cancer), secondary malignant neoplasm of brain (a brain tumor that occurs when cancer cells spread from another part of the body to the brain), chronic obstructive pulmonary disease (COPD - a common lung disease that makes it difficult to breathe). Review of the resident's admission plan of care, dated 8/20/24, showed staff did not document the resident was a smoker. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff), dated 08/26/24, showed the resident was cognitively intact. Review of the resident's care plan, updated 10/07/24, showed staff did not document the resident was a smoker. Review of a facility investigation, dated 11/12/24, showed the following: -The Social Service Director's (SSD) handwritten statement showed the resident was found with marijuana on his/her person and in his/her room. State was notified. Please see statements for complete details. -The SSD provided the following statement: The resident said that he/she had never smoked marijuana with another resident, but he/she did smoke marijuana by himself/herself outside of the facility (but still on facility grounds). When the resident was asked where he/she got the marijuana from, the resident said he/she brought it from his/her house. The Administrator and SSD asked the resident if they could search the resident's person for any contraband and resident agreed. Several contraband items as well as medication pills were discovered during the search. The confiscated items found were given to the Administrator. SSD then asked the resident if she could search his/her room and consent was given. Upon search with SSD and Business Office Manager (BOM), there was other contraband found and removed from the resident's room and placed in the Administrators' office. -Statement from the resident, undated, showed I have smoked marijuana a few times here. I smoked it today. I got from my house. I got vape pens. I have cancer and you're only giving me Tylenol. I smoked a joint. I used the vape today. I haven't smoked it with anyone else. Review of the resident's nurses' notes, dated 11/12/24, showed the following: -The DON spoke with the Nurse Practitioner (NP) about the resident smoking marijuana and having vape pen. The NP stated she knew for a while the resident had been smoking. The NP said no medications needed to be held. -The DON educated the resident on the risk of smoking marijuana. (Staff did not document finding medication pills on the resident's person.) Review of a Medication Destruction Record, dated 11/12/24, showed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Two THC vape pens, belonging to the resident, destroyed using drug buster by the DON and Licensed Practical Nurse (LPN) D; -One THC vape liquid refill, belonging to the resident, destroyed using drug buster by the DON and LPN D. During an interview on 11/18/24, at 1:21 P.M., Resident #2 said the following: -Resident #2 saw the resident smoking a marijuana joint a couple of times at the corner of the building; -Resident #2 said he had been outside and could smell marijuana on the resident. During interviews on 11/18/24, at 3:15 P.M., and 11/20/24, at 12:03 P.M., the SSD said the following: -During a facility investigation, the resident told the SSD and former Administrator he/she did smoke marijuana while a resident at the facility. He/She did not smoke inside his/her room. -The BOM searched the resident's room, with the resident's permission, and found an inhaler, two vape pens, one bottle of marijuana concentrate, and baggie that contained unmarked pills. -The resident said he/she did not smoke in the facility. Staff let him/her outside, where he/she smoked the marijuana. The SSD said she never saw the resident go outside. -The resident said he/she brought the vape cartridges and bottle from home. She knew the vape pen contained marijuana because it smelled like marijuana. She never smelled marijuana on the resident or in his/her room. -The staff told the resident he/she could not have these items in his/her room and took the items from the resident and gave them to the former Administrator. -The SSD did not know what pills were in the baggie or where the baggie came from. She did not ask the resident. -The SSD said the word contraband in her written statement dated 11/12/24 meant pills. During an interview on 11/18/24, at 3:34 P.M., the resident said the following: -The resident allowed administration to search his/her person, which included his/her purse; -The resident said that he/she had three marijuana vape pens and a couple of marijuana roaches (the remains of a joint after most of it has been smoked); -The resident said that he/she would smoke the marijuana joints behind the building; -The resident said she smoked marijuana to help with pain relief because of her cancer; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident said that he/she had two Ziploc bags of pills in his/her purse when he/she was searched; -The resident said one small Ziploc bag had pills the facility had given him/her when he/she went on a leave of absence with his/her family. The resident said he/she for got to take the medicine and was going to keep the medication for the next time he/she went out; -The resident forgot to tell staff that he/she had the pills; -The resident said the other bag contained Tylenol and Tylenol PM pills; -The resident said that he/she got the Tylenol while he/she was on a leave of absence. During an interview on 11/20/24, at 10:44 A.M., Certified Nurse Assistant (CNA) A said the following: -The resident doesn't vape or smoke; -The resident went outside with the smokers three weeks ago and was smoking a marijuana joint, staff smelt it; -Any medication found on a resident's person or in a resident's room should be turned over to the charge nurse; -No residents should have over the counter medication in the their room; -He/she was not aware of the resident having any medication on his/her person; -The residents were not allowed to have marijuana at the facility; -The residents were not allowed to have vape pens on their person or in their rooms. During an interview on 11/20/24, at 10:58 A.M., Nurse Assistant (NA) B said the following: -The resident vaped nicotine every now and then; -He/she would turn any pills found on a resident to the nurse; -He/she was not aware of any medication or marijuana being found on the resident. During an interview on 11/20/24, at 12:15 P.M., Licensed Practical Nurse (LPN) C said the following: -Residents are not allowed to have marijuana at the facility; -He/she was not aware of any residents being found with marijuana on their person or in their room; -No residents should have medications in their rooms; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medication found in a resident's room or on their person should be turned over to nursing; -He/she did not know that the resident had any medication on her person. During an interview on 11/20/24, at 12:35 P.M., the Director of Nursing (DON) said the following: -The DON was not fully involved in the facility investigation when medication was found on the resident; -He/she destroyed two marijuana vape pens and liquid marijuana refill in drug buster; -The vape pens and refill belonged to the resident; -If any staff or residents found/smelt marijuana they should report to the registered nurse (RN) or DON immediately; -He/she identified the medication found on resident as Tylenol and Advil; -Information regarding the resident having medication/marijuana on his/her person should have been shared with the staff. MO00245077

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25513 Based on observation, interview, and record review, the facility failed ensure each resident received needed behavioral health care when the facility failed to develop and implement resident specific nonpharmalogical interventions for one resident (Resident #1) who exhibited signs and symptoms of psychosocial distress. The facility's census was 28. Review of the facility's Treatment/Services for Mental/Psychosocial Concerns Policy, undated, showed the following: -The facility will ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. -The facility will ensure that, a resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable. -The facility will provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Review of the facility's policy Behavior and Psychoactive Management Program, undated, showed the following: -The facility believes that all resident behavior has meaning. It is the pledge of the facility to work to identify the cause and meaning of behaviors that are distressing and affect negatively on the resident's quality of life. The facility will work diligently to minimize the use of psychoactive medications in its resident population. -The facility's behavior monitoring management program will consist of: an effective Interdisciplinary Behavior Management Committee; ensuring a thorough and comprehensive assessment of the resident's needs, behaviors, and prior medication and medical history; monitoring the resident's behavior(s) to establish patterns, determine intensity and behavior frequency, and Identifying the specific (targeted) behavior(s) that are distressing to the resident which are decreasing the resident's quality of life. -Planning and implementing appropriate Interventions into the resident's plan of care. -Evaluating the effectiveness of pharmacological and non-pharmacological Interventions. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appleton City Manor	600 North Ohio Appleton City, MO 64724

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Purpose was to implement the most desirable and effective interventions that meet both the known and unknown needs of the resident, to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or Impacting on the resident's quality of life. -The Behavior Management Committee will ensure that the facility staff provide effective monitoring to include evaluating resident's progress towards achieving therapeutic goals and recognizing when adverse consequences may be may be or have already emerged. -The Behavior Management Committee will consist of at least the following: Director of Nursing (DON)/designee, social services, consulting pharmacist, nurse manager(s), activity department representative, and dietary representative (As determined by committee). The committee chair will be the Director of Social Services (SSD). 1. Review of Resident #1's face sheet (a brief summary of the resident's history) showed the following: -Readmitted [DATE]; -Diagnoses included anxiety disorder, dysthymic disorder (a mild, but long-lasting form of depression; also called persistent depressive disorder), depression, history of suicidal ideation, and insomnia. Review of the resident's November 2024 physician order sheet showed the following: -An order, dated 06/07/22, for buspirone (an antianxiety/sedative medication), 10 milligrams (mg), one tablet two times a day for anxiety disorder; -An order, dated 11/16/23, for escitalopram (an antidepressant), 20 mg, one tablet every day for anxiety disorder. Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 07/10/24, showed the following: -Usually understood others; -Moderately impaired vision; -Cognitively intact; -Little interest or pleasure in doing things: Yes. Symptom frequency: 12-14 days (nearly every day); -Felt down, depressed, or hopeless: Yes. Symptom frequency: 2-6 days (several days); -Trouble falling or staying asleep, or sleeping too much: Yes. Symptom frequency: 12-14 days (nearly every day); -Feeling tired or having little energy: Yes. Symptom frequency: 12-14 days (nearly every day); (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Poor appetite or overeating: Yes. Symptom frequency: 12-14 days (nearly every day); -Feeling bad about yourself-or that you are a failure or have let yourself or your family down: Yes. Symptom frequency: 12-14 days (nearly every day); -Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual: Yes. Symptom frequency: 2-6 days (several days); -Patient Health Questionnaire (PHQ-9- a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) total severity score equaled 17 which indicated moderately severe depression; -No behavioral symptoms; -No rejection of care; -Took antidepressant medication; -Took antianxiety medication. Review of the resident's submitted MDSs showed no MDS after 7/10/24. Review of the resident's nurse progress notes showed a nurse documented the following: -On 07/12/24, at 7:45 P.M., the resident went to the nurses' station yelling and demanding to go to bed. He/she did not want staff waiting or assisting someone else. Staff tried to be appropriate with the resident, but he/she kept pushing and getting louder. The resident told staff that when he/she needed them, they should come on his/her command. Staff attempted to explain that there were multiple residents to care for, and they could not come on his/her demand. Staff said that he/she needed to stop being disrespectful to staff, and they were there to assist him/her. The resident said he/she would keep doing it as it gets him/her what he/she wanted. -On 07/13/24, at 8:00 P.M., the resident yelled that he/she wanted up. At 6:00 P.M., the resident went out to smoke and yelled that he/she wanted to go to bed. -On 07/14/24, at 11:00 A.M., the resident was up for smoke breaks, but otherwise spent the day in his/her room. The resident had not yelled at staff that shift. The resident remained quiet and continue to refuse oxygen. -On 07/14/24, at 8:30 P.M., the resident was totally angry at the world. He/she was angry, rude, and disrespectful with no empathy for anyone around. He/she was mean and had a cursed response to everything. The resident was uncooperative with staff when they attempted to assist him/her to transfer. -On 07/16/24, at 3:40 A.M., the resident was up at the beginning of the shift being rude because nobody would assist him/her to bed. He/she kept saying staff were doing it on purpose. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 07/19/24 at 9:00 P.M., the resident exhibited no physical behaviors, just putting peers down. The resident was nice to some staff at times, and at times was quiet. -On 07/20/24, at 2:30 P.M., the resident had been verbally abusive to staff. Resident wanted someone to take him/her out to smoke. -On 07/20/24, untimed, the resident laid in bed at screaming for help, when staff answered he/she said he/she wanted to get up to smoke. Staff assisted the resident and took him/her outside for a smoke break. The resident refused his dinner tray. -On 07/23/24, at 9:40 P.M., the resident yelled because staff did not put him/her into bed quickly after his/her request. Staff did their best, but the resident was still unhappy at times. Review of the resident's November 2024 Physician Order Sheet (POS) showed an order, dated 07/24/24, for lorazepam (a sedative/hypnotic/antianxiety medication), 0.5 mg, one tablet three times a day for anxiety/agitation. Review of the resident's nurse progress notes showed a nurse documented the following: -On 07/24/24, at 10:30 A.M., the physician wrote an order to increase the resident's lorazepam to three times a day. -On 07/25/24, at 6:30 P.M., the resident transferred himself/herself into a wheelchair and went out to smoke. The resident yelled wanting staff to assist him/her into bed, although he/she could transfer himself/herself. -On 07/31/24, at 8:00 P.M., the resident yelled out if staff did not get him/her up or down immediately. He/she cursed at staff as well. He/she went out to smoke breaks. Review of the resident's November 2024 POS showed an order, dated 8/1/24, for trazodone (an antidepressant medication), 50 mg, one tablet at bedtime for insomnia. Review of the resident's nurse progress notes showed a nurse documented the following: -On 08/01/24, at 9:30 P.M., the nurse practitioner saw the resident and wrote an order to decrease his/her trazodone to 50 mg at bedtime due to increased sleeping. -On 08/03/24, at 10:00 A.M., while smoking, staff heard the resident say nobody liked him/her and he/she might as well commit suicide. Staff assisted the resident to the nurses' station and he/she requested to go to his/her room. Staff initiated 15-minute checks for 24 hours for suicide precautions, notified the DON and hospice, and faxed the information to the clinic. Hospice staff and hospice said they would visit the resident. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/03/24, at 2:00 P.M., staff found the resident on the floor. The resident said he/she tried to get up to his/her wheelchair unassisted. The nurse told the resident previously to use the call light and not to get up without help. The nurse also talked to the resident about his/her thoughts of suicide and asked if he/she had a plan. The resident said his/her plan. The nurse reminded the resident if he/she continued to speak of suicide, that he/she would possibly be moved to a locked unit and explained that for his/her safety, staff checked on him/her every 15-minute checks and would monitor his/her behavior. -On 08/03/24, at 4:00 P.M., the hospice nurse visited the resident. The resident told the hospice nurse that he/she was no longer suicidal. -On 08/05/24, at 11:00 A.M., a hospice social worker notified the DON that the resident made homicidal statements. The DON, facility social worker, and hospice nurse entered the resident's room. The resident said he/she wanted to hurt others with the intent to kill them. Affidavits were completed and notarized. Staff notified the physician and called 911. Staff placed the resident on one-on-one observations. -On 08/05/24, at 1:00 P.M., emergency services and police arrived at the facility. The resident went with EMS voluntarily to the hospital for evaluation. The notarized affidavits were sent with them. -On 08/05/24, at 8:00 P.M., the nurse from the hospital called the facility said they completed a psych evaluation and decided they had no grounds to admit the resident and he/she would return to the facility. Staff notified the DON who told staff to initiate 15-minute checks and behavioral charting. -On 08/14/24, at 11:00 A.M., the resident was very rude to staff with inappropriate and demanding behavior. He/she said the facility was the worst place he/she had ever been. -On 08/15/24, at 12:50 A.M., staff reported to the nurse that on 08/13/24 the resident made inappropriate comments to the staff. They finished assisting the resident and left the room. Review of the resident's social service progress notes, dated 8/26/24, showed the previous SSD documented following: -On 8/26/24, no time documented, the resident expressed his/her unhappiness with the SSD. The SSD asked the resident if he/she wanted to move to another city as previously discussed, and the resident said yes, he/she was tired living at the (current) facility. -On 8/27/24, no time documented, the SSD reviewed a list of facilities in the area of the state the resident preferred, and submitted packets to two facilities for review. (The SSD did not document any information regarding the resident's behaviors or further information regarding the referrals.) Review of the resident's nurse progress notes showed a nurse documented the following: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 09/03/24, at 8:15 P.M., the resident was verbally abusive to staff when staff attempted to meet his/her needs. Staff assisted the resident to bed multiple times. Staff reported the resident called him/her a name when he/she tried to explain that he/she was assisting other residents and that they just assisted him/her to bed. The resident turned on his/her call light several times to get staff to come to his/her room to assist him/her and then became agitated and rude when staff attempted to explain, there was more than just him/her who needed attention. On 09/04/24, at 9:00 P.M., the resident sat at the front of the facility being negative to staff. The resident said he/she did not know why everybody was so sensitive. The nurse explained that some words are hurtful to some people and that was why we should be careful how we speak to others. The resident was more understanding but remained negative. -On 09/05/24, at 11:00 P.M., staff reported the resident was rude when they entered his/her room to assist him/her. The resident pushed against staff when they tried to turn him/her. He/she would put his hands against the wall then say staff did it. Staff tried to explain that when he/she pushed against them, it made it difficult for them to move him/her. He/she accused staff of not knowing how to do their job. Review of the resident's physician progress note, dated 9/11/24, included the following information: -The resident was seen for a routine 90-day physician visit. -Since the last visit, the resident continued to lose weight, developed ascites (a condition that occurs when fluid collects in spaces in the belly (abdomen)), refused baths and supplemental Oxygen despite Oxygen saturation (the measure of how much oxygen is traveling through the body in red blood cells. Normal oxygen saturation for healthy adults is usually between 95% and 100%) around 87%. -Reports are that he/she did not wish to know about his/her physical condition. -The resident had a 25-pound weight loss over the past several months. ` -Staff reported the resident exhibited excessive sleeping and not getting up for some meals. -The resident continued to go outside for smoke breaks. -Depression: The resident appeared to have worsening depressive symptoms related to his/her vision loss due to glaucoma (a term for diseases that cause eye pressure to increase, leading to permanent vision loss), and decline in overall health. -The resident received hospice services. -The resident exhibited irritable mood and affect. Review of the resident's nurse progress notes showed a nurse documented the following: -On 09/16/24, at 7:50 P.M., staff assisted the resident to bed, but he/she refused to allow staff to change his/her clothes. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 09/21/24, at 5:00 A.M., the resident refused to allow staff to check him/her for incontinence. -On 10/01/24, at 4:00 P.M., at the beginning of the shift, the resident sat in his/her wheelchair. The resident asked to smoke before the scheduled time and started to yell. -On 10/03/24, at 10:30 P.M., the resident yelled at staff while he/she attempted to assist him/her to bed. The resident told the staff member to get out of the room. The staff reported the behaviors to the nurse. The resident told the nurse the staff member refused to help him/her. The staff again attempted to assist the resident to bed, and he/she refused. At the time of the note, the resident sat in his/her wheelchair in his/her room. -On 10/08/24, at 3:20 P.M., the resident yelled and cursed at staff. Staff offered to assist the resident and he/she refused while yelling, calling staff names, and yelling for staff to get out of his/her room. The resident said he/she would rather be incontinent and make staff clean him/her. -On 10/08/24, at 4:30 P.M., the resident yelled at nursing staff and said he/she would kill them, would punch them, and he/she hated them. The resident said he/she would call the police. Staff continued to assist the resident into bed per his/her request and left the room. Review of the resident's care plan, last reviewed on 10/8/24, showed the following: -The resident used antidepressant and antianxiety medication related to depression, anxiety and insomnia. -Administer antidepressant medications as ordered. -Behavioral health consults as needed (psycho-geriatric team, psychiatrist, etc). -Monitor/record/report to the physician as needed, acute (short term) episode feelings or sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, change in appetite/eating habits, change in sleep patterns. -Monitor/record/report to physician as needed, signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. -Monitor/document/report as needed, any signs and symptoms of depression including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health related complaints, tearfulness. -Consult with pastoral care, social services, psych services, etc. as needed. -When conflict arises, remove residents to a calm, safe environment and allow to vent/share feelings. -The resident had a terminal prognosis. -Assess the resident's coping strategies and respect the resident's wishes. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Encourage the resident to express feelings, listen with non-judgmental acceptance and compassion. Review of the resident's nurse progress notes showed a nurse documented the following: -On 10/23/24, at 8:30 P.M., the resident yelled while in his/her room. Staff entered the room and found the resident on the floor. Staff assisted the resident to bed. The resident refused to stand for staff. The resident was uncooperative and cursed and yelled at staff upon assessment. -On 10/24/24, at 9:00 P.M., the resident refused to allow staff to change his/her wet clothes. The resident was very rude to staff this shift. The resident laid in bed with soaked pants. -On 10/26/24, at 9:00 P.M., the resident yelled a lot and called staff names. -On 10/29/24, at 4:15 A.M., the resident was incontinent and refused for staff to clean him/her or place clean linens on his/her bed. The resident told staff to get out of his/her room and leave him/her alone. -On 11/02/24, at 12:30 A.M., the hospice nurse came to the desk and asked the nurse if the previous shift reported the resident had a fall. -On 11/02/24, at 1:30 A.M., staff said the charge nurse did not report the fall because that nurse thought the fall was a behavior. -On 11/04/24, at 9:00 P.M., the resident often refused to change clothes or receive incontinent care. -On 11/05/24, at 9:30 P.M., the resident refused to have staff change his/her clothes unless they applied a new a brief and pants. -On 11/08/24, at 9:00 P.M., the resident refused to allow staff to check him/her for incontinence. -On 11/08/24, at 11:00 P.M., the resident refused to allow staff to change his/her clothing. They would attempt later. -On 11/10/24, at 4:00 A.M., staff was finally able to change the resident after several attempts through the night. However, the resident yelled and cursed the entire time the aide was in the room. -On 11/12/24, at 2:00 A.M., the resident refused to allow staff to change him/her. -On 11/12/24, at 5:00 A.M., the resident continued to refuse staff changing him/her, multiple attempts were made. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 11/17/24, for Depakote (a mood stabilizer medication that works in the brain), 250 mg, two times a day for increased agitation/behaviors. -An order, dated 11/17/24, if behaviors continue, call the police to have the resident removed. Review of the resident's care plan showed on 11/17/24, staff added to the care plan, the resident exhibited increased behaviors and agitation with threats to peers. The physician ordered Depakote 250 mg, two times a day and to call the police to have the resident removed if behaviors continued. Review of the resident social services progress notes on 11/18/24 showed no progress notes documented after 08/27/24. During an interview conducted on 11/18/24, at 2:10 P.M., Nurse Aide (NA) J said if he/she observed residents arguing, he/she would defuse and deflect the situation. He/she would separate the residents and notify the nurse. The resident was vocal and vulgar. He/she was inappropriate, at times, towards female staff. The resident verbally assaulted him/her (the aide) several times. It seemed that as the resident's abilities decreased, his/her behaviors increased. His/her behaviors were constant. Sometimes his/her outbursts were directed towards other residents. He/she tended to become upset around smoking time. He/she cursed at staff, would say he/she hated this place, and got loud. When staff took him/her to smoke, he/she stopped. The staff assisted the residents outside to smoke eight times a day. The resident did not normally get upset with the other two residents who smoked with him/her. The aide did not know of any verbal altercations between residents which occurred over the weekend. During an interview conducted on 11/18/24, at 2:25 P.M., the Assistant Director of Nursing (ADON) said the following: -If she observed a resident-to-resident altercation, she would separate the residents, ask the residents what happened, obtain vital signs, complete a physical, if applicable, and emotional assessment. She would also interview and obtain staff/witness statements, document the altercation/incident in the residents' nurses' notes, complete an incident report, and notify the DON, physician and residents' family. The DON notified the state agency. -The ADON heard from the DON this morning, that sometime this last weekend, Resident #1 and Resident #2 got into an argument around smoke break. Resident #2 said Resident #1 was verbally aggressive because he/she did not have any cigarettes. The ADON thought there was only one incident between the two residents. -About six months ago, staff called the police per physician instructions, and took the resident to the hospital for an evaluation and 96-hour hold due to statements of wanting to hurt others. The hospital did not keep the resident because the resident was alert and oriented and refused services. When the resident returned, staff placed him/her on 15-minute checks and the physician changed his/her medication. -The resident had a history of verbal altercations, outbursts, and being hateful. His/her anger generally started when he/she ran out of cigarettes. The Business Office Manager (BOM) or SSD bought residents' cigarettes. The resident ran out of cigarettes weekly. And when asked about why he/she ran out, the resident would blame running out on someone else. (continued on next page)

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	265843	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appleton City Manor	600 North Ohio Appleton City, MO 64724

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Not all of the resident's anger came from no cigarettes, sometimes he/she yelled at staff and would say staff refused to assist him/her even when staff did not. The resident's behaviors were consistent and did not occur on any specific shift or with any specific staff member. -The physician recently changed the resident's medications. -The ADON did not think the resident spoke with or had psychological services. The facility did not have a contract with any psychologists, and none visited the facility. -If a resident asked to speak to a psychologist, the nurse contacted the physician and obtained an order for a referral for services. The facility and/or physician did not have a specific clinic they referred to. During an interview on 11/18/24, at 3:15 P.M., the SSD said the following: -She worked at the facility as the SSD for about two months. Her duties included resident discharges and discharge planning, admissions, assisting with grievances, assisting with the MDS and care plans, contacting the ombudsman as needed, and talking to residents per their request. -Whether or not the SSD assisted with behavior management depended on the situation. -If a resident exhibited any type of behaviors, the nurses documented the behaviors in the nurses' notes. The SSD talked to residents if they seemed upset. -Staff should tell the SSD if a resident exhibited behaviors. If staff told the SSD of behavioral issues, he/she would talk to the resident. -Recently (unknown time), she asked the resident about his/her edginess. The resident told her that staff did not listen to him/her and he/she hated the facility. The resident did not tell the SSD he/she wanted to leave therefore she did not send referral to any other facilities. The SSD did not ask the resident if he/she wanted to leave after he/she said he/she hated the facility. Most of the time the SSD documented conversations she had with residents, but t

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25513 Based on observation, interview, and record review, the facility failed to provide appropriate medically related social services for one resident (Resident #1) who had a history of depression, when the Social Services Designee (SSD) did not address or assist with finding the root cause of the resident's yelling and cursing behaviors, refusal of cares, and general unhappiness living at the facility. The facility census was 28. Review of the facility's Treatment/Services for Mental/Psychosocial Concerns Policy, undated, showed the following: -The facility will ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; -The facility will provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Review of the facility's policy Behavior and Psychoactive Management Program, undated, showed the following: -The facility believes that all resident behavior has meaning. It is the pledge of the facility to work to identify the cause and meaning of behaviors that are distressing and affect negatively on the resident's quality of life. -The facility's behavior monitoring management program will consist of an effective Interdisciplinary Behavior Management Committee; ensuring a thorough and comprehensive assessment of the resident's needs, behaviors, and prior medication and medical history; monitoring the resident's behavior(s) to establish patterns, determine intensity and behavior frequency; and identifying the specific (targeted) behavior(s) that are distressing to the resident which are decreasing the resident's quality of life. -Planning and implementing appropriate interventions into the resident's plan of care. -Purpose to implement the most desirable and effective interventions that meet both the known and unknown needs of the resident, to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or Impacting on the residents' quality of life. -The Behavior Management Committee will ensure that the facility staff provide effective monitoring to include evaluating resident's progress towards achieving therapeutic goals and recognizing when adverse consequences may be may be or have already emerged. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Behavior Management Committee will consist of at least the following: Director of Nursing (DON)/designee, social services, consulting pharmacist, nurse manager(s), activity department representative, and dietary representative (as determined by committee). The committee chair will be the SSD. 1. Review of Resident #1's face sheet (a brief summary of the resident's history) showed the following: -Readmitted [DATE]; -Diagnoses included anxiety disorder, dysthymic disorder (a mild, but long-lasting form of depression; also called persistent depressive disorder), depression, history of suicidal ideation, and insomnia. Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 7/10/24, showed the following: -Usually understood others; -Moderately impaired vision; -Cognitively intact; -Little interest or pleasure in doing things: Yes. Symptom frequency: 12-14 days (nearly every day); -Felt down, depressed, or hopeless: Yes. Symptom frequency: 2-6 days (several days); -Trouble falling or staying asleep, or sleeping too much: Yes. Symptom frequency: 12-14 days (nearly every day); -Feeling tired or having little energy: Yes. Symptom frequency: 12-14 days (nearly every day); -Poor appetite or overeating: Yes. Symptom frequency: 12-14 days (nearly every day); -Feeling bad about yourself-or that you are a failure or have let yourself or your family down: Yes. Symptom frequency: 12-14 days (nearly every day); -Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual: Yes. Symptom frequency: 2-6 days (several days); -Patient Health Questionnaire (PHQ-9- a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) total severity score equaled 17 which indicated moderately severe depression; -Took antidepressant medication; -Took antianxiety medication. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's submitted MDSs showed no MDS after 07/10/24. Review of the resident's social service progress notes, dated 8/26/24, showed the previous Social Services Designee (SSD) documented following: -On 08/26/24, no time documented, the resident expressed his/her unhappiness with the SSD. The SSD asked the resident if he/she wanted to move to another city as previously discussed, and the resident said yes, he/she was tired living at the (current) facility. -On 08/27/24, no time documented, the SSD reviewed a list of facilities in the area of the state the resident preferred, and submitted packets to two facilities for review. (The SSD did not document any information regarding the resident's behaviors or further information regarding the referrals.) Review of the resident's nurse progress notes showed a nurse documented the following: -On 09/16/24, at 7:50 P.M., staff assisted the resident to bed, but he/she refused to allow staff to change his/her clothes. -On 09/21/24, at 5:00 A.M., the resident refused to allow staff to check him/her for incontinence. -On 10/01/24, at 4:00 P.M., at the beginning of the shift, the resident sat in his/her wheelchair. The resident asked to smoke before the scheduled time and started to yell. -On 10/03/24, at 10:30 P.M., the resident yelled at staff while they attempted to assist him/her to bed. The resident told the staff member to get out of the room. The staff reported the behaviors to the nurse. The resident told the nurse the staff member refused to help him/her. The staff again attempted to assist the resident to bed, and he/she refused. At the time of the note, the resident sat in his/her wheelchair in his/her room. -On 10/08/24, at 3:20 P.M., the resident yelled and cursed at staff. Staff offered to assist the resident and he/she refused while yelling, calling staff names, and yelling for staff to get out of his/her room. The resident said he/she would rather be incontinent and make staff clean him/her. -On 10/08/24, at 4:30 P.M., the resident yelled at nursing staff and said he/she would kill them, would punch them, and he/she hated them. The resident said he/she would call the police. Staff continued to assist the resident into bed per his/her request and left the room. Review of the resident's care plan, last reviewed on 10/8/24, showed the following: -The resident used antidepressant and antianxiety medication related to depression, anxiety and insomnia. -Behavioral health consults as needed (psycho-geriatric team, psychiatrist, etc); -Monitor/record/report to physician as needed, signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor/document/report as needed, any signs and symptoms of depression including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health related complaints, tearfulness. -Consult with pastoral care, social services, psych services, etc. as needed. -When conflict arises, remove residents to a calm, safe environment and allow to vent/share feelings. -The resident had a terminal prognosis. -Assess the resident's coping strategies and respect the resident's wishes. -Encourage the resident to express feelings, listen with non-judgmental acceptance and compassion. Review of the resident's nurse progress notes showed a nurse documented the following: -On 10/23/24, at 8:30 P.M., the resident yelled while in his/her room. Staff entered the room and found the resident on the floor. Staff assisted the resident to bed. The resident refused to stand for staff. The resident was uncooperative and cursed and yelled at staff upon assessment. -On 10/24/24, at 9:00 P.M., the resident refused to allow staff to change his/her wet clothes. The resident was very rude to staff this shift. The resident laid in bed with soaked pants. -On 10/26/24, at 9:00 P.M., the resident yelled a lot and called staff names. -On 10/29/24 at 4:15 A.M., the resident was incontinent and refused for staff to clean him/her or place clean linens on his/her bed. The resident told staff to get out of his/her room and leave him/her alone. -On 11/4/24, at 9:00 P.M., the resident often refused to change clothes or receive incontinent care. -On 11/5/24, at 9:30 P.M., the resident refused to have staff change his/her clothes unless they applied a new a brief and pants. -On 11/8/24, at 9:00 P.M., the resident refused to allow staff to check him/her for incontinence. -On 11/8/24, at 11:00 P.M., the resident refused to allow staff to change his/her clothing. They would attempt later. -On 11/10/24, at 4:00 A.M., staff was finally able to change the resident after several attempts through the night. However, the resident yelled and cursed the entire time the aide was in the room. -On 11/12/24, at 2:00 A.M., the resident refused to allow staff to change him/her. -On 11/12/24, at 5:00 A.M., the resident continued to refuse staff changing him/her, multiple attempts were made. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/16/24, at 8:00 P.M., the resident went outside for a smoke break at 7:00 P.M. The resident became aggressive and told another resident he/she was sitting in his/her spot. Staff intervened but the resident continued to curse and yell at two other residents. The resident mumbled, as a staff assisted the resident back inside, that he/she was going to bash someone's head with a hammer. Staff redirected the resident, and the residents were separated. Staff assisted Resident #1 to bed. Staff notified the DON and medical director who ordered laboratory tests. Staff initiated 15-minute checks as well as 72 hour incident charting for verbal aggression. Staff searched the resident's room and found no hammer. Review of the resident's care plan showed on 11/16/24, staff added the resident was verbally aggressive, cursing, threatening peer, staff redirected. Fifteen-minute checks were initiated, and a new order received by physician. Review of the resident's nurse progress notes showed a nurse documented the following: -On 11/17/24, at 9:00 A.M., a nurse documented that at 8:30 A.M., the resident was outside on smoke break, and was verbally aggressive and instigating other residents. Staff immediately intervened. Residents were moved to opposite ends of the smoking area and supervised by staff. The resident remained on 15-minute checks and 72-hour charting for aggressive behaviors. After smoking, the staff brought the residents inside and assisted Resident #1 to bed per his/her request. -On 11/17/24, at 1:00 P.M., while the resident waited at the nurses' station for smoke break, the resident started an argument with another resident. A second resident intervened and told Resident #1 to stop and leave the other resident alone. Staff immediately intervened and redirected all parties. When staff took the residents to smoke, Resident #1 told the first resident to hurry up and the second resident again said to stop. Resident #1 then cursed at the second resident. Staff separated the residents in the smoking area and educated Resident #1 on appropriate behaviors. Resident #1 stopped after staff redirected him/her two times. -On 11/17/24, at 1:40 P.M., staff attempted to draw blood for the ordered laboratory test. The resident cursed at staff and said that he/she would never allow staff to draw blood again. He/she was fine. The nurse discussed with the resident the importance of the laboratory tests. The resident refused at first, but then allowed staff to draw his/her blood. The resident cursed while staff drew the blood saying he/she did not need it. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/17/24, at 2:20 P.M., the nurse notified the physician's clinic at 2:00 P.M. and left a message for the nurse practitioner to address the resident's behaviors as the behaviors were progressing. The nurse called the medical director regarding the resident's continued behaviors, escalation, and threats. The physician ordered a mood stabilization medication for agitation and behaviors. The physician also said if the resident continued to exhibit behaviors, staff should call the police to have the resident removed. The nurse notified the resident of the new orders. The resident said he/she would not take the (new) medication. The nurse educated the resident on the right to refuse, but they (the staff) had to notify him/her of any new orders since h/she was his/her own responsible party. The resident became agitated and said he/she hated the facility and the person in the front office. Staff educated the resident on the right to leave the facility or an option to speak with a social worker to arrange for discharge and transportation. Resident also educated on appropriate behaviors at smoke breaks and the physician order that if his/her behaviors and threats continued, staff should call the police to remove him/her from the facility. The resident placed his/her right pointer finger in the air and moved it in a circle and said oh well. Educated the resident to not make threats to other residents to maintain all residents' safety. Resident said oh yeah, they sent you and the other staff member to do their job. Educated the resident that the staff educating the resident was their job. The resident continued to curse and said who told you that and made a derogatory term towards another resident. Again, the nurse educated the resident that staff reported his/her behaviors at smoke break. Resident said oh well and again pointed his/her finger in the air and moved it in a circular motion. The nurse talked again with resident regarding appropriate behaviors and of not threatening others. -On 11/17/24, at 2:40 P.M., the resident turned on his/her call light wanting to go smoke. Staff noted the resident was out of cigarettes. Staff notified the resident that he/she was out, and the resident began cursing and said the staff just kept coming into his/her room and giving him/her bad news. The nurse educated the resident that they just wanted to let him/her know that he/she did not have any cigarettes before he/she went to the nurses' station and exhibited behaviors. The resident again yelled he/she hated this place and that he/she may leave tonight. The nurse educated the resident and notified the social worker that the resident was out of cigarettes via a note on her office door. The resident said someone would give him/her cigarettes, or else. Discussed with resident appropriate behavior and threats and reminded him/her of the physician orders. The resident said he/she did not care, and staff better get him/her a cigarette. The nurse again reminded the resident of appropriate behavior. The resident continued to yell and curse. The nurse asked the resident to calm down. -On 11/17/24, at 2:50 P.M., the nurse reminded the resident of appropriate behavior prior to smoking and gave the resident two cigarettes. -On 11/17/24, at 6:00 P.M., the resident went to the kitchen door and asked dietary staff for cigarettes. Dietary staff said they did not smoke, and the resident yelled and cursed at the staff. Dietary staff notified the charge nurse of the resident's cursing. The resident continued to ask staff for cigarettes. -On 11/17/24, at 6:45 P.M., the resident sat at the nurses' station asking the resident from a previous incident, for a cigarette. The other resident said no, you treated me terribly and walked away. Resident cursed and sat in his/her wheelchair at the nurses' station. Review of the resident's care plan showed on 11/17/24, staff added to the care plan, the resident exhibited increased behaviors and agitation with threats to peers. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident social services progress notes on 11/18/24 showed no progress notes documented after 08/27/24. During an interview conducted on 11/18/24, at 2:25 P.M., the Assistant Director of Nursing (ADON) said the following: -Sometime this last weekend, Resident #1 and Resident #2 got into an argument around smoke break, Resident #2 said Resident #1 was verbally aggressive because he/she did not have any cigarettes. -About six months ago, staff called the police per physician instructions, and took the resident to the hospital for an evaluation and 96-hour hold due to statements of hurting others. The hospital did not keep the resident because the resident was alert and oriented and refused services. When the resident returned, staff placed him/her on 15-minute checks and the physician changed his/her medication. -Resident #1 had a history of verbal altercations, outbursts, and being hateful. His/her anger generally started when he/she ran out of cigarettes. The business office manager or social services designee (SSD) bought residents' cigarettes. The resident ran out of cigarettes weekly. And when asked, he/she would blame running out on someone else. -Not all of Resident #1's anger came from no cigarettes, sometimes he/she yelled at staff and would say staff refused to assist him/her. The resident's behaviors were consistent and did not occur on any specific shift or with any specific staff member. The ADON did not think the resident spoke with or had psychological services. The facility did not have a contract with any psychologists, and none visited the facility. During an interview conducted on 11/18/24, at 3:15 P.M., the SSD said the following: -She worked at the facility as the SSD for about two months. Her duties included discharges and discharge planning, admissions, grievances, assisting with the MDS and care plans, contacting the ombudsman as needed, and talking to residents per their request. -Whether or not the SSD assisted with behavior management depended on the situation. -If a resident exhibited any type of behaviors, the nurses documented the behaviors in the nurses' notes. The SSD talked to residents if they seemed upset. -Staff should tell the SSD if a resident exhibited behaviors and he/she would talk to that resident. -Recently (unknown time), she asked Resident #1 about his/her edginess. The resident told her that staff did not listen to him/her and he/she hated the facility. The resident did not tell the SSD he/she wanted to leave therefore she did not send referral to any other facilities. The SSD did not ask the resident if he/she wanted to leave after he/she said he/she hated the facility. Most of the time the SSD documented conversations she had with residents, but that time, when she spoke to the resident, it was a just a normal conversation and she did not document it. (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #1 issues tended to be related to smoking. He/she would get loud at the nurses' station when it was time to smoke. The BOM bought residents' cigarettes. Resident #1 was friendly with other residents. -This weekend, Resident #1 argued and became loud with another resident. That was out of character for Resident #1. -The SSD did not talk to Resident #1 or Resident #2 about the incident this weekend. She thought someone else took care of it. -The SSD wanted staff to call her if there was a resident-to-resident altercation. No one called her, she found out about it during morning meeting today (11/18/24). The SSD did not know if the policy instructed staff to call her, she had not read the policy. -The resident did not run out of cigarettes that she knew of and did not refuse cares. -The SSD did not review residents' progress notes to identify problems. She did not know she was supposed to. During an interview conducted on 11/18/24, at 4:40 P.M., Licensed Practical Nurse (LPN) I said Resident #1 had behaviors. He/she frequently refused cares and cursed and yelled at staff. When the resident admitted to the facility, he/she was really nice. But for the last eight to twelve months, his/her behaviors had increased. He/she did not know the reason for the increase. When the resident exhibited behaviors, he/she just left him/her alone. He/she documented the behaviors in the nurses' notes. The facility used to have a facility dog who spent a lot of time with the resident. At the beginning of the year, former administration got rid of the dog. No one knew what happened to the dog. The LPN thought the resident's behaviors increased after they got rid of the dog. During an interview conducted on 11/19/24, at 12:45 P.M., LPN E said he/she did not know Resident #1 well, but he/she knew the resident often cursed and was not patient with staff regarding smoking times, but he/she did not usually keep bringing up the same issue over and over. On 11/16/24 and 11/17/24, Resident #1 had issues with Resident #2 and Resident #3. It started while waiting for smoke break and carried on to smoke break and two more times throughout the weekend. Resident #1 lashed out at Resident #2. Resident #3 came to Resident #2's defense. The nurse did not know what triggered Resident #1's anger. The nurse contacted the DON and physician when Resident #1 made a threatening statement. The nurse followed the physician and DON's instructions. On 11/17/24, the nurse contacted the physician again regarding the resident's continued behaviors. The physician ordered a new medication and asked the nurse why the resident acted that way. The nurse said the resident hated the facility and wanted to leave. The nurse told the resident to talk with the SSD which caused the resident to curse. The nurse spoke to the resident multiple times about his/her behaviors, and at times he/she was angry and other times he/she appeared calm. During an interview conducted on 11/20/24, at 10:40 A.M., LPN K said the following: -Sometimes the resident yelled but he/she thought the resident's response or yelling was related to how staff talked to the resident and their tone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265843	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appleton City Manor	600 North Ohio Appleton City, MO 64724

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had not been mean to the LPN. The resident did not really bother the day shift staff. Staff who worked the evening and night shift had told him/her in shift report, that the resident acted hateful towards them. He/she had not witnessed the resident yelling, and thought it usually occurred while he/she was in his/her room. -The LPN thought the resident may be situationally depressed. At that time, the facility did not have any psychologists who visited the facility, but he/she thought someone was working on getting those services to the facility. -The resident once told the LPN that he/she was leaving; he/she appeared angry. The LPN said okay, and that he/she would care for him/her until he/she left. The LPN did not argue with the resident and kept his/her tone soft. After that, the resident never said he/she wanted to go somewhere else. The LPN thought the resident spoke to social services about transferring to another facility, but it was not recent. He/she could not remember the exact timeframe. The LPN did not think the resident really wanted to leave. The resident only said it when he/she was upset. An observation and interview on 11/20/24, at 10:45 A.M., showed the following: -The resident sat in his/her wheelchair in his/her room. -The resident said he/she lived at the facility for a while and wanted to go somewhere else. He/she talked to someone about transferring but could not remember who, and thought it was recent. It seemed that conversation happened more and more often. -The resident said the day shift staff were good. But the evening shift staff took a long time to answer his/her call light which caused him/her to yell out to get their attention. Then, when the staff finally come down the hall to his/her room, they were angry which caused him/her to be angry. -The resident resided at the end of the hall. The resident said he/she did not think staff liked walking all the way to the end of the hall to assist him/her. By the time they walked to his/her room, they were mad. He/she knew the staff were mad by their tone, it was not really what they said but how they said it. -The resident said smoking was very important to him/her. It was really the only activity he/she enjoyed since he/she was blind due to glaucoma. Day shift staff were mostly timely with taking the residents out for their scheduled smoke breaks, but the evening staff were often late which was frustrating. -The resident said he/she took an antidepressant for depression. He/she was depressed and he/she was not sure if the medication was even working. He/she talked to several people about his/her mood and emotional state. He/she did not think his/her mood/emotions were well managed, but he/she did not know what anyone could do about it. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 11/20/24, at 12:36 P.M., the DON said the social services designee's duties included monitoring residents' behaviors, completing trauma screening, assisting with appointments, assisting with referrals to outside services such as mental health care, interviewing residents involved in abuse allegations, and assisting with facility to facility transfers. The DON considered yelling and cursing a behavior. Interventions for behavioral symptoms included redirection, offering activities, notifying the physician and obtaining orders if needed, and finding out the root cause of the behaviors. When staff notified her of the resident's behaviors over the weekend, she told the staff to send the resident to the emergency room . She thought that was what they did and did not expect to see him/her at the facility when he/she arrived on Tuesday (11/19/24). The DON did not know the resident well but did know that he/she became agitated when staff were late taking him/her out to smoke. During an interview conducted on 11/20/24, at 1:30 P.M., the SSD said she did not receive any training at the facility for her job as the SSD. She worked at another facility and tried to use that experience. The SSD had no one she could ask questions to or who could tell her what she should do in a situation.