STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265844	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Health and Rehabilitation	1200 McCutchen Road Rolla, MO 65401

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43024 Based on interviews and record review, facility staff failed to notify the resident's guardian in a timely manner of an allegation of abuse and an injury of unknown source for one resident (Resident #1). The facility census was 68. 1. Review of the facility's Notification of Changes policy, revised March 2022, showed a facility representative will notify the resident, his/her family, or representative when there is a change in condition to include deterioration in health, mental, or psychosocial status. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 12/16/23, showed staff assessed the resident as severely cognitively impaired. Review of the facility's investigation, dated 1/13/24, showed staff documented Certified Nursing Assistant A reported to Registered Nurse (RN) B, Resident #1 had a large bruise on his/her chest. Review showed staff interviewed did not have knowledge of how the resident received the bruise. Review showed the investigation did not contain documentation staff notified the resident's guardian of an allegation of abuse and an injury of unknown source. During an interview on 1/24/24 at 2:06 P.M., the administrator said he/she did not contact the resident's guardian to inform him/her of the allegation of abuse and injury of unknown origin but thought it had been done by someone. He/She said it is the responsibility of him/her or the Director of Nursing (DON) to ensure investigations are complete. During an interview on 1/25/24 at 8:51 A.M., the residents guardian said he/she was not notified of the injury of unknown source until 1/24/24 when the administrator called and left him/her a message. He/She said he/she prefers to be notified when the event takes place or within a reasonable amount of time. During a phone interview on 2/2/24 at 9:26 A.M., RN B said he/she instructed the charge nurse Licensed Practical Nurse (LPN) C to call the resident's guardian and he/she did not. He/She said he/She thinks there was misscommunication because they always contact family or the guardian with any changes, injury of unknown orgin or abuse. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Aurora Health and Rehabilitation	1200 McCutchen Road Rolla, MO 65401

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 2/2/24 at 10:14 A.M., Licensed Practical Nurse (LPN) C said he/she was not instructed to call the guardian nor did he/she call the guardian. He/She said he/she was only asked to input the resident's skin assessment and give a statement. MO002300228

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 43024 Based on interview and record review, facility staff failed to complete a thourough investigation when one resident (Resident #1) reported a staff member held him/her down. Staff did not interview additional residents, witnesses and other who might have knowledge of the allegation. The facility census was 68. 1. Review of the facility's Abuse and Neglect policy, revised 8/22/22, showed the policy is designed to provide protections for the health, welfare and right of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property: -Investigation of alleged abuse: an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur; -Identify and interviewing all involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 2. Review of Resident #1's Quarterly Minimum Data Set, a federally mandated assessment tool, dated 12/16/23, showed staff assessed the resident as severely cognitively impaired. Review of the facility's investigation, dated 1/13/24, showed staff documented Certified Nursing Assistant A reported to Registered Nurse (RN) B Resident #1 had a large bruise on his/her chest. Review showed staff interviewed did not know of how the resident received the bruise. Review showed the investigation did not contain documentation of resident interviews with the resident's roommate, visitors and other possible witnesses until 1/24/24 (11 days after the allegation). During an interview on 1/24/24 at 1:125 P.M., Resident #1 said I don't know if something happened. During an interview on 01/24/24 at 2:06 P.M., the administrator said he/she did not conduct interviews with other residents or others who might possibly have information until 11 days later because he/she thought the report to state was just a for your information. He/She said he/she did not know to continue the investigation if it is just a for you information report. He/She said he/she or the Director of Nursing are in charge of the completion and accuracy of investigations. MO002300228