

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Abundant Acres Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 13277 State Route D Savannah, MO 64485	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44939</p> <p>Based on interviews and record review, the facility failed to protect the resident's right to be free from sexual abuse by Resident #1, when Resident #1 was observed by staff sitting on Resident #2's bed with his/her pants and underwear pulled down to his/her mid thigh and Resident #1's hand inside the front of Resident #2's brief. The facility's census was 56.</p> <p>On 1/3/25, the Administrator was notified of the past noncompliance which began on 12/25/24. Upon discovery, the facility administration immediately conducted an investigation and corrective actions were implemented. The noncompliance was corrected on 12/28/24.</p> <p>Review of the facility's undated Abuse and Neglect policy showed:</p> <p>-It is responsibility of employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any incident or suspect incident of neglect or resident abuse, including injuries of unknown source, exploitation, theft or misappropriation of resident property to the facility management.</p> <p>-The purpose of this policy is to ensure prevention, protection, prompt reporting and interventions in response of property, or exploitation of any facility resident. Our goal at all times will be the protection of our Residents.</p> <p>-All Residents have rights that are guaranteed by the federal Nursing Home Reform Law. The law requires nursing homes to promote and protect the rights of each resident and stresses individual dignity and self-determination.</p> <p>-Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish; the infliction of physical, sexual, or emotional injury or harm;</p> <p>-Sexual abuse is defined as including, but not limited to, sexual harassment, sexual coercion, or sexual assault; Non-consensual sexual contact of any type with a resident.</p> <p>1. Review of Resident #1's quarterly Minimum Data Set, a federally mandated assessment completed by staff, dated 12/8/24, showed:</p> <p>(continued on next page)</p>

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: 265846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Abundant Acres Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 13277 State Route D Savannah, MO 64485	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she was admitted to the facility on [DATE].</p> <p>-He/she has the diagnoses of Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), acidosis (a condition where bodily fluids become too acidic), diverticulosis (a condition in which small, bulging pouches develop in the digestive tract), weakness, unsteadiness on feet, pain, depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), dementia with agitation (a group of thinking and social symptoms that interferes with daily functioning).</p> <p>-He/she scored 11 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). This score indicates moderately impaired cognitive skills.</p> <p>Review of the resident's undated comprehensive care plan showed:</p> <p>-The resident displays inappropriate sexual behaviors and was started on estrogen/estrodial (a hormone/medication used to increase the level of the hormone, estrogen, in a person's body).</p> <p>- The resident is an elopement risk/wanderer related to wandering into other resident's rooms, exit seeking, stating he/she is leaving facility.</p> <p>-He/she has impaired cognitive function and impaired thought processes related to dementia.</p> <p>2. Review of Resident #2's quarterly MDS, dated [DATE], showed:</p> <p>-He/she was admitted to the facility on [DATE].</p> <p>-She has the diagnoses of dementia, chronic post traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event, accompanied by intense emotional and physical reactions), anxiety disorder (a mental health disorder characterized by severe, ongoing anxiety that interferes with daily activities), pain, depression, rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), osteoarthritis (a chronic degenerative joint disease that causes cartilage in the joints to break down over time), anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body).</p> <p>-He/she scored 7 on the BIMS. This score indicates severe cognitive impairment.</p> <p>Review of the resident's undated comprehensive care plan showed:</p> <p>-He/she is a wandering/elopement risk due to impaired cognition and impaired safety awareness.</p> <p>-He/she displays behaviors related to dementia and depression.</p> <p>3. Review of Resident #1's progress notes, dated 12/25/24 at 1:27 A.M., showed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Abundant Acres Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 13277 State Route D Savannah, MO 64485	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #1 was observed by Certified Nurses Assistant (CNA) A in Resident #2's room, sitting on Resident #2's bed. Resident #1's pants and underwear were around his/her mid-thighs. Resident #2's gown and brief were in place. CNA A observed Resident #1 with his/her hand down the front of Resident #2's brief. CNA A then told Resident #1 to stop and remove his/her hand from Resident #2. CNA A then called for the charge nurse to come to the memory care unit. When Licensed Practical Nurse (LPN) A arrived to Resident #2's room, Resident #1 was still sitting on Resident #2's bed with his/her hand on Resident #2's leg. Resident #2 was asleep. LPN A and CNA A began to redirect Resident #1 from Resident #2's room. Resident #1 became verbally agitated, stating it is his/her room and threatened to throw the staff out of the room. Staff were able redirect Resident #1 to the common area. He/she was placed on one to one supervision. The physician was notified and gave an order to increase the resident's estradiol medication to decrease the sexual behaviors.</p> <p>Review of the facility investigation showed:</p> <ul style="list-style-type: none"> - Resident #1 has a history of inappropriate sexual behavior towards residents. - Resident #1 has been off his baseline this shift (12/25/24) with hallucinations and delusions. <p>- Statement by CNA A: On 12/25/24 at 12:30 A.M., he/she was doing rounds when he/she walked into Resident #2's room. Resident #1 was sitting on the bed, touching Resident #2 in the private area. CNA A told resident #1 he/she was not allowed to do this and got him/her to stop. CNA A then reached out for the nurse for assistance. And the Resident #1 came and sat down at the tables.</p> <p>-Statement by LPN A: On 12/25/24 at 1:27 A.M., LPN A was called back to the secure care unit by CNA A. Upon walking into the unit, RNA A went to Resident #2's room. Resident #1 was sitting on Resident #2's bed, with pants and underwear down to mid thigh. Resident #1's hands were still on Resident #2's legs. Resident #2 was wearing a facility provided night gown and a brief and were laying on his/her bed, on top of the covers. Resident #1 was wearing pajama pants, non-skid socks and no shirt. LPN A separated the residents and Resident #1 became verbally aggressive, stating It's not your room and I'll throw right out of here, I'm not going to leave. LPN A and CNA A were able to get Resident #1 from the room and into the living area. Resident #1 was placed on one to one supervision with the CNA on duty. Both resident's were assessed. Resident #2 did not appear to be in distress, but was confused and asked if he/she could go to bed. Resident #1 has a previous history of inappropriate sexual behavior towards residents.</p> <p>-Resident #1 was started on estradiol 1.5 milligrams daily on 10/20/24 for sexual behaviors.</p> <p>-The Director of Nursing (DON) spoke with the physician on 12/25/24 at 4:06 P.M. The physician increased Resident #1's lexapro (a medication used to treat depression and generalized anxiety disorder) from 5 milligrams to 10 milligrams daily. The physician also gave orders to continue to the estradiol at 1.5 milligrams daily.</p> <ul style="list-style-type: none"> - Resident #1's POA had discussed with management members that Resident #1 likes the ladies. - The DON explained to Resident #2s spouse that Resident#1s physician is working to adjust Resident #1s medications and staff are monitoring the two residents to ensure they are safe. <p>During an interview on 1/3/24 at 2:17 P.M., the Administrator said:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Abundant Acres Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 13277 State Route D Savannah, MO 64485	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The physician was notified of the incident between Residents #1 and #2. The Administrator asked the physician about sending Resident #1 out for in-patient psychiatric evaluation. The physician responded that he/she felt the resident's medications can be adjusted in the facility and did not need to be sent out.</p> <p>-The Director of Nursing (DON) immediately began educating all staff on increased observation for Resident #1, increased staffing on the memory care unit, and education on caring for residents with dementia and behaviors. This education was completed on 12/28/24.</p> <p>-Staffing on the memory care unit was increased starting 12/25/24. There are now three staff members during the day shift and two staff members during the night shift. If the aides are assisting residents, the medication technician or nurse will come to the common area to monitor the hall until the aides are available again. If a staff member needs to leave the unit, they will notify the charge nurse who will then come to assist in monitoring the unit until the staff member returns to the unit.</p> <p>-It is his/her expectation that residents are free of abuse.</p> <p>Review of Secure Care Unit Employee In-service sign in sheet showed staff received education on monitoring of individuals on the secure care unit, completed on 12/28/24.</p> <p>During an interview on 1/3/25 at 2:02 P.M., Certified Medication Technician (CMT) A, said:</p> <p>-He/she has received education from the facility about increased monitoring of residents on the secure care unit. There must be at least two staff members at all times on the unit. If the aides are assisting residents, the CMT must bring the cart to the common area so he/she can monitor the hall and common area while the aides are busy.</p> <p>- He/she has observed the resident go into other resident's rooms.</p> <p>During an interview on 1/3/25 at 2:05 P.M., CNA B said;</p> <p>- He/she has observed Resident #1 go into other resident's rooms.</p> <p>- After the incident he/she received education from facility leadership about monitoring residents on the secure unit.</p> <p>- There now is to be at least two staff people on the unit at all times.</p> <p>- If a staff person needs to leave the unit, they need to call the charge nurse and make sure another staff person comes to the unit to monitor before the staff person leaves.</p> <p>During an interview on 1/3/25 at 2:08 P.M., CNA C said;</p> <p>-He/she has observed Resident #1 go into other resident's rooms.</p> <p>- After the incident he/she has received education from facility leadership about the need to increase monitoring of residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Abundant Acres Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 13277 State Route D Savannah, MO 64485	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- There now is to be two staff members on the secure unit at all times and staff are to watch the hall and the common areas.</p> <p>- If a staff member needs to leave, another staff member is to cover the unit.</p> <p>During an interview on 1/3/25 at 2:47 P.M. CNA A said:</p> <p>-He/she was doing bed checks/rounds on 12/25/24 at 12:30 A.M., and saw Resident #1 sitting on Resident #2's bed.</p> <p>-When CNA A entered the room, he/she saw that Resident #1's pants were around his/her thighs and Resident #1's hand was inside the front of Resident #2's brief. Resident #2 was asleep.</p> <p>-CNA A told Resident #1 to stop and he/she removed his/her hand from Resident #2's brief but would not leave the room.</p> <p>-CNA A called for the charge nurse to come to the room.</p> <p>-The charge nurse, Registered Nurse A came to the room and assisted in redirecting Resident #1 from the room. Resident #1 became verbally aggressive and Resident #2 woke up.</p> <p>-RN A and CNA A were able to redirect Resident #1 from the room.</p> <p>During an interview on 1/10/25 at 9:10 A.M., the Physician said:</p> <p>-He/she was notified of the incident involving Residents #1 and #2.</p> <p>-He/she declined to send Resident #1 out for in-patient geriatric psychiatric evaluation.</p> <p>-He/she adjusted Resident #1's medication to assist in decreasing inappropriate sexual behaviors.</p> <p>MO247062</p>