STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265858	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
E W Thompson Health & Rehabilitation Center	975 Mitchell Road Sedalia, MO 65301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from verbal and emotional abuse when Certified Nurse Aide (CNA) B demanded multiple times for the resident to perform his/her toileting independently although he/she was unable to perform, and aggressively pulled resident under the arm to stand him/her up without a gait belt. The facility census was 60. The administrator was notified on 5/1/25 of past Non-Compliance, which occurred on 4/28/25 when staff reported the allegation. Staff immediately suspended CNA B pending the results of the investigation, assessed the resident for physical and psychological harm, conducted an investigation, in-serviced staff on abuse and neglect, and terminated the employee on 4/25/25. Review of the facility's Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy, date September 2022, showed all reports of resident abuse to include injuries of unknown origin, neglect, exploitation, or misappropriation of resident property are reported to local, state, and federal. agencies, and thoroughly investigated by facility management. Investigation findings are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and the other officials according to state law. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Review of the facility's investigation, dated 4/25/25, showed the administrator was notified by Resident #1's family, CNA B was verbally and emotionally abusive. The administrator reported the allegations of verbal and emotional abuse to the required agencies and suspended CNA B. The administrator documented CNA B was terminated. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the video footage, dated 4/24/25, showed CNA B and Nurse Aide (NA) C enter the resident's room to offer toileting. CNA B and NA C assisted Resident #1 to his/her feet with his/her walker. CNA B is heard telling the resident I need you to turn around and sit on the toilet so turn around, well turn! Resident #1 said I'm trying. CNA B assisted the resident with being changed while the resident stood then demanded he/she sit on his/her walker. CNA B said Sit down, you're not doing anything, I can't be in here for 30 minutes cause you can't sit. Resident #1 sat on the walker while CNA B finished putting the resident's pants on. CNA B then pushed the resident backwards in his/her walker. CNA B said We have other things to do, we're both stuck in here and we should've been done a long time ago. CNA B said to the resident stand up. CNA B forcefully grabbed the resident under his/her right arm and jerked him/her up to standing , pulled his/her pants up, and pivoted the resident to his/her recliner. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment tool, dated 4/29/25, showed staff assessed the resident as: -Cognitively intact; -Diagnoses of Dementia and Obsessive Compulsive Disorder; -Required substantial to maximum assistance from staff for toileting. During an interview on 5/1/25 at 11:45 A.M., the administrator said he/she was made aware of CNA B when family notified him/her and brought a video for him/her to watch. CNA B was immediately suspended and sent home after family notified Licensed Practical Nurse (LPN) A of what they saw on the video. LPN A who was on duty watched the video and educated NA C regarding gait belt use and inappropriate resident communication. LPN A assessed the resident, spoke with family, and notified the administrator. After the administrator was able to watch the video it was decided to terminate the CNA B on 4/25/25. During an interview on 5/1/25 at 12:38 P.M., LPN A said he/she was approached by the resident's family the evening of 4/24/25, and explained CNA B had said some things to the resident that they did not appreciate. LPN A said he/she watched the video and called the administrator. He/She was directed to send CNA B home. LPN A said he/she assessed the resident and educated NA C on inappropriate resident communication. During an interview on 5/1/25 at 12:53 P.M., CNA B said he/she and NA C went to the resident's room to assist him/her to the toilet because he/she was soaked. He/She said they assisted the resident to the bathroom but the resident would not turn around and sit on the toilet. CNA B said he/she tried coaxing the resident but he/she did not listen. CNA B said he/she has a loud voice and sometimes can come off as if he/she is yelling or being rude but he/she is not, he/she is just loud. CNA B said he/she does not think he/she was demeaning or abusive in anyway toward the resident and doesn't feel like he/she did anything wrong. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/25 at 1:03 P.M., the residents family said they reviewed the video in real time and did not appreciate how the CNA was talking to the resident. He/She said he/She went to the facility with the video and showed LPN A. He/She said LPN A sent the CNA home and assessed the resident. He/She said the next [NAME] they came back to the facility to show the video to the administrator. At the time the administrator told him/her the would be investigating the way CNA B talked to the resident and had the CNA would be terminated. The family confirmed they felt the interaction between CNA B towards the resident was abusiveafter they had spoke to the administrator. During an interview on 5/1/25 at 1:47 P.M., NA C said he/she and CNA B went into the residents room to change him/her. He/She said everything was going okay until they got the resident to the bathroom. He/She said the resident did not understand what was being asked of him/her and they tried for at least 10 minutes to try and have the resident sit down. He/She said CNA B got very rude, demanding, and was telling the resident they didn't have time to deal with him/her. He/She said after the CNA B changed the resident standing, they got him/her back in front of his/her recliner. He/She said CNA B was demanding the resident to stand and then forcefully grabbed the resident under his/her right arm and jerked him/her up to a standing position. He/She said CNA B pulled the residents pants up and sat him/her in his/her recliner. MO00253253