

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/07/2025
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NAME OF PROVIDER OR SUPPLIER ARBORS AT HARMONY GARDENS- MEM CARE BY AI	STREET ADDRESS, CITY, STATE, ZIP CODE 539 EAST YOUNG AVENUE WARRENSBURG, MO 64093
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8025	<p>19 CSR 30-88.010(25) Report A/N to DHSS/DMH When Needed</p> <p>If the administrator or other employee of a long-term care facility has reasonable cause to believe that a resident of the facility has been abused or neglected, the administrator or employee shall immediately report or cause a report to be made to the department. Any administrator or other employee of a long-term care facility having reasonable cause to suspect that a vulnerable person has been subjected to abuse or neglect or observes such a person being subjected to conditions or circumstances that would reasonably result in abuse or neglect shall immediately report or cause a report to be made to the department and to the Department of Mental Health. I/II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observation, interview and record review, the facility failed to thoroughly investigate an allegation of possible staff to resident abuse for one sampled resident (Resident #1) out of 3 sampled residents. On 8/4/25 Level One Medication Aide (LIMA) A and LIMA B forcibly held the resident down in the shower chair, engaged in inappropriate conversation with the resident while he/she was yelling and upset about taking a shower. The facility census was 11 residents.</p> <p>Review of the facility's policy Abuse and Neglect revised, showed the following: -Resident will be free of physical, emotional, and sexual abuse, neglectful treatment. Each resident has the right to be free from all type of</p>	A8025		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

Neonle Morales

6899

DBH611

Executive Director

If continuation sheet 1 of 11

8/13/25

Missouri Department of Health and Senior Services

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A8025	Continued From page 1 abuse, including mental abuse. Mental abuse includes, but is not limited to, abuse that is facilitated caused by facility staffing, taking or using photographs or recording in any manner that would mean or humiliating resident. -The accompanying procedures are employee to assure complete staff adhere to this policy and ensure prohibition of any retaliation against any employee who makes a report, cause a law for report to be made or take steps to make a life report according to the policy investigation any report of neglect or abuse made by resident, family member, visitor or employee is investigated within 24 hours. -Administrators, Director of Nursing (DON) or designee shall be notified immediately by report. Any allegation of abuse, neglect, or exploitation will be reported to the regional director of operations and regional nurse consultant. Investigation may be conducted by administrators, DON or any member of the administrative staff. -All employees are educated concerning their responsibility to immediately report or cause a report to be made to the appropriate state agency, of any abuse or neglect they win or are aware. The administrator, DON or designee will notify the state agency within 24 hours of the incident of suspected abuse Unless suspicious of crime has occurred that involve serious bodily injury most reports to both law-enforcement and state survey agencies immediately, but no later than two hours after forming suspicion. **NOTE** The policy did not identify the expectations regarding the facility investigation. 1. Review of Resident #1's face sheet showed he/she was admitted to the facility on 7/14/25	A8025		

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A8025	<p>Continued From page 2</p> <p>with the following diagnoses:</p> <ul style="list-style-type: none"> -Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome.) -Dementia (the loss of cognitive functioning like thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities.) -Hypertension (is a condition where the pressure of blood against the walls of your arteries is consistently too high). -Edema (the accumulation of excess fluid in the body's tissues, leading to swelling). <p>Observation of the undated video footage from LIMA C phone camera showed:</p> <ul style="list-style-type: none"> -LIMA A and LIMA B was in the shower room with the resident. -The resident was sitting in the shower on a shower chair with a black sweater on. -LIMA A had one hand on the resident's arm and the other hand was spraying the water. -The video went black and the audio could still be heard. -The resident yelled to "stop," "turn the water off," "get me out of here," and to "leave me alone." -The resident said "you are scaring me." -The staff were heard with elevated voices say to the resident he/she was going to take a shower. -LIMA A said the resident was super "shitty" to LIMA B. -LIMA A said the water was not hot and told the resident to sit back and to not press the call button. <p>Review of the resident's record found no facility investigation or grievance regarding the video.</p>	A8025		

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A8025	<p>Continued From page 3</p> <p>During an interview on 8/6/25 at 11:37 A.M. the Administrator said:</p> <ul style="list-style-type: none"> -LIMA C immediately reported to the DON of what he/she witnessed. -LIMA D saw LIMA A shouting inappropriate remarks at the resident, such as "fuck your mother." -The DON had reported the incident to him/her - He/she did not consider the actions to be abusive but acknowledged that LIMA A had engaged in a verbal altercation. -There was no obligation to report if he/she thought there was no physical or verbal abuse. -He/she had watched the staff video and since abuse or neglect was not suspected he/she had not completed an investigation or suspended any staff. -He/she was trained at another facility about reporting possible abuse or neglect and they have to report it immediately. <p>During an interview on 8/6/25 at 11:52 A.M. the DON said:</p> <ul style="list-style-type: none"> -After review of the video he/she thought the incident was possible abuse and reported the incident to the Administrator on 8/4/25. -He/she was under the impression the Administrator reported all possible allegations to state agency. -He/she has been trained to report abuse or neglect to his/her Administrator. -The Administrator was responsible for all investigations when there was a possible allegation of abuse or neglect. -The staff that were involved in the incident completed their shifts. <p>During an Interview on 8/6/25 at 12:28 P.M.</p>	A8025		

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A8025	<p>Continued From page 4</p> <p>LIMA D said: -He/she was trying to assist another resident with his/her cares, and trying to count medications and he/she heard the resident yelling out, and told LIMA A to leave him/her alone. -The resident told LIMA A to leave him/her "the fuck alone" then LIMA A told the resident no they were not "leaving you the fuck alone." -LIMA A and LIMA B grabbed the resident underneath his/her arms and yanked him/her to the spa room. -LIMA A and LIMA B started to undress the resident and begun to wash him/her when the resident started to "freak out." -LIMA A and LIMA B were holding the resident down in the shower chair. -That's when he/she told LIMA C to call the DON and report the incident. -He/she was always trained and told to report abuse and or neglect.</p> <p>During an interview on 8/6/25 at 1:16 P.M. LIMA C said: -When he/she heard and seen what happened between LIMA A and LIMA B with the resident he/she begun to record the incident on his/her phone. -To protect the resident privacy she placed his/her phone in his/her pocket so the recording has no video. -He/she immediately look the recording and reported it to the DON because he/she thought it was abuse.</p> <p>MO00257723</p>	A8025		
A8030	19 CSR 30-88.010(29) Dignity/Privacy	A8030		

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A8030	<p>Continued From page 5</p> <p>Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III</p> <p>This regulation is not met as evidenced by: Class II*</p> <p>Based on observation, interview and record review, the facility failed to ensure the dignity of one sampled resident (Resident #1) out of 3 sampled residents. On 8/4/25 Level One Medication Aide (LIMA) A and LIMA B forcibly held the resident down in the shower chair, engaged in inappropriate conversation with the resident while he/she was yelling and upset about taking a shower. The facility census was 11 residents.</p> <p>Request for resident policy from facility was not provided.</p> <p>1. Review of Resident #1's face sheet showed he/she was admitted to the facility on 7/14/25 with the following diagnoses: -Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome.) -Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily</p>	A8030		

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ARBORS AT HARMONY GARDENS- MEM CARE BY AI

STREET ADDRESS, CITY, STATE, ZIP CODE
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A8030	<p>Continued From page 6</p> <p>life and activities.)</p> <ul style="list-style-type: none"> -Hypertension (is a condition where the pressure of blood against the walls of your arteries is consistently too high). -Edema (the accumulation of excess fluid in the body's tissues, leading to swelling). <p>Observation of the undated video footage from LIMA C phone camera showed:</p> <ul style="list-style-type: none"> -LIMA A and LIMA B was in the shower room with the resident. -The resident was sitting in the shower on a shower chair with a black sweater on. -LIMA A had one hand on the resident's arm and the other hand was spraying the water. -The video went black and the audio could still be heard. -The resident yelled to "stop," "turn the water off," "get me out of here," and to "leave me alone." -The resident said "you are scaring me." -The staff were heard with elevated voices say to the resident he/she was going to take a shower. -LIMA A said the resident was super "shilly" to LIMA B. -LIMA A said the water was not hot and told the resident to sit back and to not press the call button. <p>Review of the facility Abuse & Neglect (A&N) training showed:</p> <ul style="list-style-type: none"> -LIMA D had completed 1/11/25. -LIMA C had completed 4/8/25. -LIMA B had completed 7/8/25. -LIMA A had no record of completing A&N training. <p>During an interview on 8/6/25 at 11:37 A.M. the Administrator said:</p>	A8030		

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A8030	<p>Continued From page 7</p> <ul style="list-style-type: none"> -LIMA C immediately reported to the Director of Nursing (DON) of what he/she witnessed. -LIMA D saw LIMA A shouting inappropriate remarks at the resident, such as "fuck your mother." -The DON had reported the incident to him/her. -He/she did not consider the actions to be abusive but acknowledged that LIMA A had engaged in verbal altercation. -He/she did not consider the actions to be abusive but acknowledged that LIMA A had engaged in verbal altercation. -There was no an obligation to report if he/she thought there was no physical or verbal abuse. He/she had watched the staff video and since abuse or neglect was not suspected he/she had not completed an investigation or suspended any staff. -He/she was trained at another facility about reporting possible abuse or neglect and they have to report immediately. -He/she had encouraged the staff to be gentle with resident and had not seen any issues with staff giving the resident a shower in the past. The resident should not be left soaked in urine at any time. -He/she agreed there could be a dignity issue but the incident was not abuse. The staff did not have to force the resident to take a shower. <p>During an interview on 8/6/25 at 11:52 A.M. the DON said:</p> <ul style="list-style-type: none"> -After review of the video he/she thought the incident was possible abuse and reported the incident to the Administrator on 8/4/25. -He/she received training related to dignity/respect/customer service during orientation. 	A8030		

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A8030	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Regardless if the incident was abuse or a dignity issue it was not okay for any staff to force a resident to take a shower, however if there was a resident soaked in urine staff had to clean the resident. -He/she was aware of the resident fear of water. The fear was not documented in the resident's care plan. -Instead of the staff trying to force the resident to take a shower the staff could have wiped down with wipes. -He/she was not sure if the staff had been educated on alternatives methods to do with the resident when he/she was upset and refused a shower. <p>During an interview on 8/6/25 at 12:28 P.M. LIMA D said:</p> <ul style="list-style-type: none"> -He/she was trying to assist another resident with his/her cares and trying to count medications when he/she heard the resident yelling out and he/she told LIMA A to leave him/her alone. -The resident told LIMA A to leave him/her the "fuck" alone, LIMA A told the resident no were not "leaving you the fuck" alone. -LIMA A and LIMA B grab resident under neath his/her arms and yanked him/her in the spa room. -LIMA A and LIMA B started to undress and wash the resident when the resident started to "freak out." -LIMA A and LIMA B were holding the resident down in the shower chair. -He/she had received no training related to the resident not liking to take showers, they were just responsible to get to know the resident. <p>During an interview on 8/6/25 at 1:16 P.M. LIMA</p>	A8030		

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A8030	<p>Continued From page 9</p> <p>C said:</p> <ul style="list-style-type: none"> -When he/she heard and had seen what happened between LIMA A and LIMA B with the resident he/she begun to record the incident on his/her phone. -LIMA A and LIMA B were grabbing the resident forcefully. LIMA A was telling the resident that he/she was going to take a shower. -He/she should have spoken up and told the staff members to stop. -He/she had no training on what to do if the resident refused a shower and that the resident did not like showers. <p>During an interview on 8/6/25 at 1:52 P.M. the resident's Durable Power of Attorney (DPOA) said:</p> <ul style="list-style-type: none"> -The resident doesn't like to take showers because he/she prefers a male to assist him/her with showers. -The resident doesn't want females to help him/her shower. -He/she doesn't agree with staff forcefully giving the resident shower, they should give the residents space. -They should let the resident decided if they want to take a shower or sponge bath. -He/she knows the resident liked to be clean so the issue was not cleanliness it was the resident did not like to take a shower. <p>Attempted to contact LIMA A on 8/6/25 at 11:00 A.M., 1:23 P.M. and 5:16 P.M., 8/7/25 at 8:12 A.M., 2:09 P.M. and 6:25 P.M.</p> <ul style="list-style-type: none"> -Certified Letter sent on 8/7/25. <p>**The higher classification merited due to the extent of the violation and the violation effect on</p>	A8030		

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A8030	Continued From page 10 the resident." CMP ## MO00257723	A8030		

PLAN OF CORRECTION

Provider Name:	Arbors at Harmony Gardens Memory Care Asstd Living by Americare	
Street Address, City, Zip:	539 East Young Ave, Warrensburg, MO 64093	
Date of Survey:	08/07/2025	
Provider number:	31389	
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A8025	<ul style="list-style-type: none"> • Regional Nurse Consultant will provide education on 10/09/2025 to Administrator, DON regarding: <ul style="list-style-type: none"> ○ Time line of reportable offenses ○ Abuse and neglect policy <p>Administrator will ensure that additional interventions to ensure ongoing compliance are initiated as needed.</p>	10/13/2025
A8030	<p>All residents ISPs will be reviewed to ensure treatments and cares are appropriate for the level of care needed</p> <ul style="list-style-type: none"> • Director of Nursing (DON) will review Individual Service Plan (ISP) for all residents to ensure that these plans have been developed and discussed with family and resident and will ensure that all ISP documents have family signatures where appropriate. • Regional Nurse Consultant will provide education on 10/09/2025 to Administrator, DON regarding: <ul style="list-style-type: none"> ▪ interventions and updates to ISP ○ ISP meetings and documentation • Administrator or designee will ensure ongoing compliance through daily CUE meetings: <ul style="list-style-type: none"> ○ Meetings to include review of previous day's incidents, notification of family and physician, interventions implemented, review of post incident documentation to ensure completion and updates to ISP include new interventions related to incident. <p>DON and Admin to provide education to all staff on 10/10/2025 regarding:</p> <ul style="list-style-type: none"> ▪ interventions and updates to ISP ○ ISP meetings and documentation • Administrator or designee will ensure ongoing compliance through daily CUE meetings: <ul style="list-style-type: none"> ○ Meetings to include review of previous day's incidents, notification of family and physician, interventions implemented, review of post incident documentation to ensure completion and updates to ISP include new interventions related to incident. 	10/13/2025

