STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to keep one resident (Resident #2) free from verbal and physical abuse when Nurse Aide (NA) A held resident's arms down and cussed at resident (Resident #2) and when Licensed Practical Nurse (LPN) A yelled at resident (Resident #2) and forced the resident to wear a bi-pap mask (A device that forces oxygenated air through mask that is suctioned against a person's face to provide respiratory support) against the resident's will . The facility census was 26. Review of facility policy, dated 11/2017, showed: -It is the policy of the facility that at each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property, and exploitation, corporal punishment, or involuntary seclusion. The resident will be free from physical and chemical restraints imposed for purposes of	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 03/25/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 1	F 600		

discipline or convenience and that are not required to treat the resident's medical symptoms. The resident will be protected from abuse, neglect, and harm while they are residing at the facility.
-All employees who have been alleged to commit abuse will be suspended immediately pending investigation.
-If allegation is substantiated there is a potential that the employee will be terminated, added to the Employee Disqualification List and not allowed to work in a nursing home, disciplined by their licensing agency, and charged with a crime.

1. Review of Resident #2's Significant change Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 3/20/25, showed:
-The resident was now on hospice care.

Review of Resident #2's Quarterly MDS, dated 3/15/25, showed:
-Cognition intact;
-He/She had clear speech;
-He/She was able to make self-understood and usually understood others;
-He/She was dependent on a wheelchair;
-He/She had impairment to both sides of his/her lower extremities range of motion;
-He/She required set up or clean up assistance with eating and oral care;
-Health conditions included shortness of breath, trouble breathing when exertion, sitting at rest, and lying flat;
-He/She received oxygen therapy;
-He/She did not use any restraints;
-Diagnoses included:, Heart failure, hypertension (high blood pressure), schizophrenia (mental health condition that affects a person's thoughts,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 2	F 600		

feelings, and behaviors), asthma (a respiratory condition marked by spasms in the bronchi of the lungs, causing difficulty in breathing), shortness of breath.

Review of care plan, revised 3/12/25, showed:
-He/She had an order for a Bi-level Positive Airway Pressure (Bi-Pap). The higher pressure helped with inhaling, while the lower pressure level helped with exhaling) during naps and at bedtime. He/She was on continuous oxygen.
-Resident had been non-compliant with Bi-pap order;
-Staff would assist resident with putting on his/her Bi-Pat every evening at bed time and encourage him/her to leave it on during the night; staff would check every one to two hours to make sure Bi-pap was on and working correctly;
-Staff will remind and encourage resident to leave his/her oxygen on as ordered. Resident had been non-compliant at times and needs lot of reminding of orders;
-Chronic non-compliance will be reported to ordering providers;
-Oxygen saturations will be checked by nursing shiftily and documented on the Treatment Administration Records;
-He/She would have advanced directives honored. He/She is a Do Not Resuscitate (DNR) as of 2/27/25. He/She was placed on hospice on 3/20/25.

Review of physician's orders showed:
-Order started 8/30/24, Bi-Pap: to wear at bedtime and naps. Settings: 12/6, 35%, rate 12;
-Order started 8/30/24, Check oxygen saturations as needed and notify physician if lower than 90%;
-Order started 2/17/25, oxygen therapy: 1-2 liters each nostril nasal cannula as need to keep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 3	F 600		

oxygen saturation levels above 92%. Special instructions: As needed (PRN);
-Order started 2/22/25, Continue home oxygen as directed and use Bi-Pap as directed. Special instructions: Continue home oxygen use as directed and use Bi-pap as directed;
-Order started 2/28/25, code status DNR.

Review of progress notes, dated 3/16/25-3/20/25, showed:
-On 3/16/25 at 6:34 A.M., LPN A wrote oxygen saturations were checked every 30-45 minutes and were 90-95%, at 3:00 A.M. resident saturations were at 75%. Resident's Bi-Pap was placed on and oxygen went up to 84% saturation. Breathing treatment was given. Resident kept saying he/she wanted to go to the hospital. Residents saturations dropped to 38-50%. Resident became combative and not leaving Bi-pap on. Family Nurse Practitioner was contacted at 4:30 A.M. and new order was obtained to transfer to emergency room. At 5:35 A.M. ambulance was notified and EMS left with resident. Guardian notified by phone, fax sent to family nurse practitioner to notify of resident's transfer.
-On 3/16/25 at 10:23 A.M., Registered Nurse (RN) A wrote call received from emergency room and transfer of resident was pending as soon as hospital bed was located for him/her;
-On 3/16/25 at 4:50 P.M., RN A wrote resident was sent to hospital in Kansas City. Resident's guardian and family were made aware;
-On 3/18/25, Facility received an email from resident's guardian regarding assessing resident for palliative care or hospice when discharged back to facility;
-On 3/20/25 at 11:50 A.M., RN A wrote that resident was discharged from hospital;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 4	F 600		

-On 3/20/25 at 2:55 P.M., RN A received report from RN at Kansas City hospital that resident had been hospitalized for acute chronic respiratory failure with hypoxia and hypercapnia. Resident continued to be noncompliant with bi-pap but did wear bi-pap 3.5 to 4 hours the previous night.
-On 3/20/25 at 7:32 P.M., RN A wrote that the resident returned to facility.

Review of facility investigation, dated 3/18/25 at 3:30 P.M., showed:
-Notification: Facility was notified by Resident #2's guardian on 3/17/25 at 3:30 P.M. that Resident #2 told his/her family member that LPN A was condescending and told Resident #2 he/she would die if he/she was noncompliant with care and told NA B to hold Resident #2 down.
-Witness Interview showed:
-NA B informed facility that NA was frustrated at resident for not wearing his/her mask through the night, called Resident #2 stupid and to keep his/her fucking mask on and punched a pillow. NA B said LPN A was yelling and arguing with Resident #2 over compliance with mask and held Resident #2's right hand down to put his/her mask on face;
-Interviews with alleged perpetrators showed:
-LPN A said Resident #2 was having extremely low oxygen saturations, being combative, and noncompliant. NA A did have a heated episode according to coworker NA A and he/she removed him from the room but did not hear it and told NA A not to talk to residents rudely. Resident #2's oxygen was extremely alarmingly low and he/she called emergency medical services. He/She tried to get Resident #2's oxygen saturations up and Resident #2 was being combative, not in his/her right state of mind, so he/she did hold Resident #2's hand down just to get his/her mask

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 5	F 600		

repositioned. Resident #2 was not hurt at all and was not restrained.

-NA A said: Resident #2's oxygen was low like down in the 30's. It was very emotional and intense. He/She got upset Resident #2 would not keep his/her mask on so he/she admitted that he/she called Resident #2 stupid and to keep his/her fucking mask on. He/She regretted it and realized it was wrong. The charge nurse, LPN A talked me through it and told me my behavior was unacceptable. Resident #2 was combative and ripped his/her mask off. LPN A was trying to talk us through it. He/She held down Resident #2's hands so the nurse, LPN A, could put Resident #2's mask on. It was a life or death situation and very intense.

-Conclusion: Allegation was verified by eyewitness statement, confirming abuse and neglect by both perpetrators. NA A verbal abuse and LPN B physical abuse from using restraint.

-Corrective Action: Facility immediately suspended perpetrators and following investigation terminated both LPN A and NA A. Psychosocial visits to victim upon return. Education to facility staff on abuse and neglect, restraints, and reporting abuse and neglect.

-Facility interviewed five residents with BIMS over 12, all residents said they had no issues or bad experiences with either perpetrator. All denied abuse or neglect by a staff member.

-Review of facility investigation, dated showed:

-Twenty-three residents were interviewed regarding if they had experienced abuse or neglect from staff member, if they had been held down, constrained, or restricted by staff, and if there was anything they wanted to report or were too shy to report.

-Statements were obtained from NA B on 3/17/25;

-Interview was conducted with Resident #2 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 6	F 600		

3/24/25;
-Facility reported LPN A to professional Missouri licensing board;
-Facility reported NA B to CNA Registry.

Review of resident's medical chart, dated 3/25/25, showed Do Not resuscitate orders were signed by Resident #2's guardian on 2/27/25 and were also signed by two physicians.

During an interview on 3/25/25 at 9:28 A.M., Resident #2 said:
-He/She had staff at facility mistreat him/her when Licensed Practical Nurse (LPN) A, Nurse Aide (NA) A, and NA B came into his/her room and said they were going to give him/her a treatment;
-LPN A came into his/her room and wanted to do a respiratory treatment;
-He/She told LPN A that he/she would rather not do the respiratory treatment;
-LPN A said he/she needed to do the treatment and started to get abrupt with him/her;
-LPN A again said you need to do this treatment and started yelling and screaming at him/her that he/she would die over and over;
-He/She said to LPN A that maybe LPN A could come back but LPN A proceeded with his/her respiratory treatment;
-LPN A had the NA B hold me back and he/she pushed me down by the shoulders;
-NA B continued to force me down;
-It made him/her feel bad and upset;
-He/She was not sure if it was NA A or NA B who held him/her down but it was a male staff who held his/her hands down;
-He/She thinks LPN A cussed at him/her;
-He/She had not seen LPN A back working at facility since that day;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 7	F 600		

During an interview on 3/25/25 at 11:43 A.M., NA A said:
-Situation with Resident #2 was stressful due to Resident #2 refusing to wear his/her bi-pay and his/her oxygen dropped to 35 and kept going down;
-He/She held resident's arms down;
-He/She said "keep your fucking mask on and called the him/her stupid";
-Resident #2 was swinging his/her arms;
-NA B was holding resident's mask on his/her face per direction he/she received from LPN A;
-Resident #2 did have his/her bi-pap on prior to that but when he/she took off his/her bi-pap his/her oxygen saturations kept dropping;
-He/She was the only staff member that held Resident #2 down;
-He/She received abuse and neglect training in monthly meaning;
-Administration talked about restraints and how staff were not allowed to secure someone to wheelchair and we were supposed to allow residents to still be able to move;
-He/She felt he/she had a good rapport with Resident #2;
-He/She had not received any training on doing holds or restraints on residents.
-There were other times he/she had held residents as he/she did not have option to leave residents soaked in their urine;
-Residents could get very combative.

During an interview on 3/25/25 at 11:56 A.M., NA B said:
-Resident #2 was supposed to wear his/her bi-pap machine at night;
-Resident #2's oxygen saturations went from 90's, to 50's, to the 40's;
-LPN A held Resident #2's hand down and said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 8	F 600		

you got to keep that thing on;
-LPN A and NA A yelled at Resident #2;
-NA A was on Resident #2's right side, and he/she was on Resident's left side;
-NA A said 'Hey stupid, you need to put your fucking mask back on' and then punched the pillow beside resident #2's head;
-Resident #2 said he/she was scared;
-Resident #2's eyes got wide and resident said did he/she really just do that? He hit my pillow! and resident looked terrified;
-Resident #2 wanted the ambulance;
-LPN A said Resident #2 was not getting ambulance that Resident #2 had us;
-It was normal for Resident #2 to take of his/her bi-pap machine;
-He/She had to loosen up the bi-pap for him/her
-The bi-pap did look tight around resident #2's head and ears;
-LPN A told Resident #2 'you are going to keep that thing on, I don't care';
-LPN A held Resident #2's hand down;
-When LPN A would leave room Resident #2 would put his/her bi-pap mask back on his/her face;
-NA A came back into room to do Resident #2's vitals and Resident #2 did not like the idea of NA A being back in his/her room;
-Resident #2 said he/she was going to tell and it was not right what LPN A was doing;
-Facility talked about abuse and neglect all the time;
-He/She was trained that he/she was not supposed to restrain anybody;
-If resident was soiled, he/she would let them know they needed changed;
-He/She knew some residents did not believe they were wet;
-He/She spoke to Administrator and DON about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 9	F 600		

what he/she observed;
-He/She was aware that LPN A had been fired;

During an interview on 3/25/25 at 1:46 P.M., LPN A said:
-He/She was in and out of Resident #2's room on 3/16/25;
-Resident #2 would not leave his/her bi-pap on;
-He/She notified the nurse practitioner who gave him/her an order to send resident out if resident's saturations got down to 75;
-He/She got residents oxygen saturations back up to the 80's;
-He/She ripped off bi-pap and his/her oxygen saturations got down to 38;
-Resident #2 was combative;
-He/She did take Resident #2's hand and held it and said to Resident #2 he/she needed to keep his/her bi-pap on;
-He/She could not get saturations higher so he/she called 911;
-He/She did not hold Resident #2 down;
-He/She took Resident #2's hand because he/she was fighting;
-When he/she held Resident #2's hand she pulled on his/her wrist lightly;
-He/She laid Resident #2's wrist down and left the room;
-He/She told staff to keep Resident #2's mask on;
-He/She called 911 because resident would have died due to not getting oxygen saturations up higher;
-At the beginning, Resident #2 did ask him/her to call 911, but he/she said she would call the doctor;
-He/She called the nurse practitioner when resident's saturations were in the 70's and 80's;
-He/She did not scream or yell at Resident #2;
-He/She was told by NA B regarding NA A getting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 10	F 600		

angry and saying to Resident #2 to keep that fucking bi-pap on;
-He/She did talk to NA A and gave him a warning and he/she said he/she was sorry;;
-It was normal for Resident #2 to not want to keep his/her bi-pap on;
-It was routine for them to check resident #2 oxygen saturations throughout the night;
-There was times resident's oxygen nasal cannulas kept his/her saturations up;
-He/She would sometimes have staff lay resident down, reposition him/her, and pull him/her up in bed;
-The protocols that were in place when resident not wanting to keep his/her bi-pap on were just to check residents saturations and if they got to low to call the nurse practitioner;
-Resident #2 was a DNR;
-It would have been Resident #2's right to have his/her bi-pap off;
-He/She tried to encourage Resident #2 to have his/her bi-pap on because he/she did not Resident #2 to die;
-Facility protocol was that no restraints were to be used on residents;

During an interview on 3/25/25 at 2:22 P.M., RN A said:
-Resident #2 was very non-compliant with wearing his/her bi-pap;
-Agency nurses had issues with Resident #2 being non-complaint with wearing his/her bi-pap;
-Facility protocol for resident #2 at night was to watch his/her oxygen saturations;
-He/She was aware that LPN A had gotten an order to send Resident #2 out but nurse practitioner had said to try and not send Resident #2 out;
-He/She would try to allow residents who were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 11	F 600		

agitated or frustrated to calm down and or get a staff member that they liked to talk to them to support them in calming down;
-All staff had been educated that they could not hold down a resident or force a resident;
-He/She had not seen residents forced or provided unwanted cares;
-LPN A called him/her when he/she was suspended;
-LPN A indicated that it was out of desperation that he/she was trying to get Resident #2's oxygen saturations up;

During an interview on 3/25/25 at 3:05 P.M., Business Office Manager (BOM) said:
-He/She observed LPN A call residents name if he/she was referring to them but not directly to residents face;
-Behaviors in facility were often instigated by staffs approach with resident.

During an interview on 3/25/25 at 4:26 P.M., Director of Nursing (DON) said:
-Resident #2's guardian notified facility with concerns when Resident #2 had told his/her family member that the LPN A was making him/her put his/her bi-pap on and tried to get the one of the nurse aides to hold him/her down and make Resident #2 wear the bi-pap;
-Resident #2 said that LPN A kept screaming that he/she was going to die;
-Resident #2's oxygen saturations were down to 30's so it was an intense situation;
-LPN A had said during the facility interview that LPN A wasn't intending to hold Resident #2 down to harm him/her but was just trying to get his/her oxygen saturations up;
-Resident #2 was a DNR at that time;
-NA A said during facility interview that he/she did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 12	F 600		

tell Resident #2 to put his/her mask on but said he/she did not hit the pillow;
-LPN A had said he/she was not in the room when NA A cussed and hit pillow but as soon as NA B reported it to LPN A;
-LPN A had talked to NA A and NA had said he/she was just worked about resident #2's safety;
-LPN A said NA B did not hold Resident #2 down;
-He/She expected residents to be free from physical and verbal abuse;
-It was never okay for residents to be held down to provide cares;
-Resident did have a right to refuse cares.

During an interview on 3/25/25 at 4:48 P.M., Administrator said:
-LPN A resigned prior to facility planned termination of his/her employment;
-LPN A said during facility interview that he/she used a loud voice with resident #2;
-LPN A did admit to holding hand of Resident #2 in an attempt to prevent Resident #2 from hitting NA A and pull off his/her mask;
-NA A admitted to holding Resident #2 down, cussing, yelling, and using bad language indicating he/she was in a heated situation;
-Facility did interview Resident #2, Resident #2's mother;
-Resident #2 said he/she did not like the feeling of being restrained in any way;
-He/She expected residents to be free from all abuse;
-Abuse and neglect had been an issue since he/she started in his/her position in facility;
-He/She implemented monthly education with employees;
-He/She implemented doing pop in interviews (unannounced visits to the facility) with residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 600	Continued From page 13 and had changed descriptions he/she used in those interviews to be more comprehensive for residents in facility such as asking residents if they had ever been held down by staff or ignored instead of asking if they had ever been abuse. MO251220.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to assure one resident (Resident #1) was free from misappropriation of his/her property when the resident's narcotic medications were found missing from the facility. The facility census was 26. Review of facility's abuse policy, dated 11/2017, showed: -It is the policy of the facility that at each resident will be free from abuse. Abuse can include misappropriation of resident property -All employees who have been alleged to commit abuse will be suspended immediately pending investigation. -If allegation is substantiated there is a potential that the employee will be terminated, added to the Employee Disqualification List and not allowed to	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 14	F 602		

work in a nursing home, disciplined by their licensing agency, and charged with a crime.

Review of facility policy, Scheduled II-V Medications, undated, showed:
-Schedule II-V medications may be kept in medication cart lock box, refrigerator, boxes, or double lock box maintained in medication room.
-Scheduled medications will have disposition records that are in a binder on medication cart or area instructed by Director of Nursing (DON).
-Scheduled medications that are as needed (PRN) must be kept in medication cart locked box.
-Additional cards may be kept in the medication room locked box or in the medication locked box in nurse medication cart. Dispositions records will be kept with the schedule II medication disposition records.
-When a Schedule II, III, IV, V car is emptied, the CMT will place the card with the disposition record in the designated area for the DON or licensed designee to collect.
-When new or refill schedule II, III, IV, or V cards arrive from the pharmacy, the disposition record is filled out, the card is counted and placed in the locked box in the medication cart.
-All schedule II, III, IV, and V medications must be counted (comparing number of pills to disposition record) at every change of shift by two CMT, or one CMT and one licensed nursing staff. Both personnel must sign verification of correct count for Schedule II, III, IV, and V.
-If at any time the count is incorrect, CMT must notify licensed nursing staff, who will call DON or designee for instruction.
-All scheduled II medications will be administered by the nurse or authorized CMT.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 15	F 602		

Review of facility policy, destruction of medications, undated, showed:
-Two licensed nurses or one licensed nurse and facility pharmacist will destroy all medications, except controlled substances which will require DON supervision.
-Documentation of medication destruction will include:
  -date;
  -Name of medication;
  -RX number;
  -amount of medication to be destroyed;
  -method of destruction;
  -signature of nurses and/or pharmacist;
-Scheduled II-IV medication will be destroyed as stated above with the following exceptions:
  -the controlled medication count sheet will include the following information:
    -signature of nurses and/or pharmacist destroying the medication
    -amount destroyed
    -date destroyed
-The following method of destroying medications will be utilized:
  -Medications to be destroyed including pills, capsules, liquids, creams, etc.. will be placed in a sealable container such as a plastic bag.
  -An unpalatable substance such as kitty litter or used coffee grounds will be added to the plastic bag of medications.
  -Before sealing plastic bag approximately one cup of fluid (i.e. water, liquid detergent, etc..) will be added to the plastic bag of medications.
  -The plastic bag will then be sealed and placed in the trash.

1. Review of Resident #1's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 16	F 602		

3/14/25, showed:
-Cognition severely impaired;
-He/She had limited range of motion to both lower extremities;
-He/She was dependent on a wheelchair;
-He/She required partial to moderate assistance with toileting, upper body dressing, rolling left and right, sit to stand transfers, and toilet transfers;
-He/She required substantial to maximal assistance for chair to bed transfers, lying to sitting transfers, and bathing;
-He/She was on scheduled pain medication regimen;
-He/She was taking an opioid;
-Diagnoses included: vascular dementia (cognitive decline caused by damage to the blood vessels in the brain), major depressive disorder (persistently depressed mood), pain, and anxiety.

Review of Medication Administration log, dated 2/1/25-2/28/25, showed:
-Document header, Nurses MAR flow sheet, showed: As needed pain medication.
-Order date 1/21/25, Hydro/Apap tablet; 7.5/325; amount to administer: 1 tablet; oral three times a day, every 4 hours as needed for pain, for pain unspecified not to exceed 3 GM Apap/24 hours.
-On 2/25/25, Resident received medication at 8:00 A.M., 12:00 P.M., and 8:00 P.M.;
-On 2/26/25, Resident received medication at 8:00 A.M., 12:00 P.M., and 8:00 P.M.;
-On 2/27/25, Resident received medication at 8:00 A.M., 12:00 P.M., and 8:00 P.M.;
-On 2/28/25, Resident received medication at 8:00 A.M., and 12:00 P.M.
-Document header, Medications Flow sheet, showed: Routinely scheduled medication.
-Order started 1/20/25,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 17	F 602		

hydrocodone-acetaminophen - Schedule II tablet; 7.5-325mg;, amount to administer: 1 tab TID PO; oral TID, pain in left hip;
-On 2/25/25, Resident received medication between 8:00 A.M.-10:00 A.M., 11:00 A.M.-2:00 P.M., and 3:00-6:00 P.M.;
-CMT A signed he/she administered medication all three administration times;
-On 2/26/25, Resident received medication between 8:00 A.M.-10:00 A.M., 11:00 A.M.-2:00 P.M., and 3:00-6:00 P.M.;
-CMT A signed he/she administered medication between 11:00 A.M.-2:00 P.M.;
-On 2/27/25, Resident received medication between 8:00 A.M.-10:00 A.M., 11:00 A.M.-2:00 P.M., and 3:00-6:00 P.M.;
-CMT A signed he/she administered medication between 8:00 A.M.-10:00 A.M. and 11:00 A.M.-2:00 P.M.;
-On 2/28/25, Resident received medication between 8:00 A.M.-10:00 A.M., 11:00 A.M.-2:00 P.M., and 3:00-6:00 P.M.;
-CMT A signed he/she administered medication at all three administration times.

Review of care plan, revised 3/7/25, showed the resident had constant chronic back pain.

Physician's orders, dated 3/25/25, showed the order started 1/20/25,
Hydrocodone-acetaminophen -schedule II tablet; 7.5-325mg, 1 tab three times a day by mouth.

Observation of medication room on 3/25/25 at 2:58 P.M., showed:
-There were two bubble packs for resident #1 of hydrocodone-acetaminophen 7.5-325mg in medication cart, 1 card had 20 remaining, the other card had 60 count.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 18	F 602		

-Controlled drug count sheet matched the number of pills found in medication cart;
-Controlled drug box inside the medication cart was not locked.

Review of pharmacy facility delivery receipts, 1/30/25-2/14/25, showed:
-On 1/30/25, 60 quantity, hydrocodone-acetaminophen 7.5-325 mg tablets, were delivered to the facility;
-On 2/5/25, 60 quantity, hydrocodone-acetaminophen 7.5-325 mg tablets, were delivered to the facility;
-On 2/14/25, 60 quantity, hydrocodone-acetaminophen 7.5-325 mg tablets, were delivered to the facility.

2. Review of facility investigation, dated 3/11/25, showed:
-Facility became aware of incident on 3/11/25 at 3:00 P.M.;
-RN A reported that on 2/28/25 she returned to work from having two days off and noted a missing pack of Resident #1's hydrocodone-acetaminophen as he/she had previously had two bubble packs of the hydrocodone-acetaminophen when he/she had worked on 2/25/25. He/She had inquired with CMT A what had happened to them and CMT A reported that DON and Administrator had destroyed medications due to state survey agency being in building and facility having too many controlled drugs and an inhaler. RN A shrugged off the information but later heard a conflicting story on 3/11/25 when CMT A had said that he/she had destroyed the controlled drugs so he/she reported information to facility administration. DON and Administrator informed RN A that they had not destroyed any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 19	F 602		

medications.
-Steps taken included:
-Suspended CMT A;
-Obtained written statements;
-Searched for medication destruction and controlled medication sheet for Resident #1 but were unable to locate either documentation;
-Notified pharmacy
-Educated all nurses on narcotics;
-Review of written statements showed:
-On 3/11/25, Administrator wrote: On 2/27/25, RN A reported an incident to him/her, DON, and Quality Assurance Nurse regarding a missing narcotic medication (Hydrocodone-Acetaminophen) for Resident #1. RN A had questioned CMT about the missing medication to which CMT said Administrator and DON were cleaning out the med room since state was in building trying to destroy all expired or non-labeled medications, they must have gotten rid of it. The DON and he/she clarified that this statement was false and that neither of us had cleaned out the medication room. RN A expressed concerns that CMT A might be involved with theft, citing his/her strong desire to pass narcotics at the start of his/her shift, although RN A did not have sufficient evidence to formally accuse CMT A of stealing. As a result of incident, CMT A will be terminated from his/her role as CMT, but will be allowed to maintain his/her position as a CNA without medication administration privileges.
-On 3/11/25, RN A wrote: On Friday February 28, 2025 while getting a narcotic out I noted that resident #1 only had one full card of hydrocodone-acetaminophen and one partial card. When he/she had worked on Tuesday, February 25 there was one partial card and two full 60 count cards of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 20	F 602		

hydrocodone-acetaminophen. CMT A said that Administrator and DON had been in the medication room going through the medication cart and cleaning and that they had taken a card of hydrocodone-acetaminophen because facility had too much and it looked back with state agency in the facility. He/She inquired with CMT A what Administrator and DON did with the card and CMT A said he/she did not know. The sign out sheet for the hydrocodone-acetaminophen was also missing from the narcotic count book. He/She intended to speak with the DON about the medication, but was not able to until 3/11/25. He/She did know for a fact that there were two sixty count cards of hydrocodone-acetaminophen in the medication cart because hospice nurse A and him/her had counted the controlled medications for hospice patients on 2/25/25 and he/she had discussed the controlled drug count for Resident #1 yesterday on 3/10/25. Hospice nurse showed me his/her computer that showed the partial count plus 120 more.

-On 3/13/25, Business Office Manager (BOM) wrote: CMT had told him/her he/she had taken a controlled drug home when he/she went to pick CMT A up for work. He/She said he/she had told RN A that he/she had taken it home and he/she would bring the medication back in the morning. CMT A said he/she had left medication on the dryer. BOM offered for CMT A to go back and pick up the medication and CMT A said no that RN A would not say anything or write him/her up for it;

-On 3/13/25, CMT A wrote: On February 25, 2025 state notified him/her that he/she had an abundance of extra medications on his/her medication cart. He/She put extra eye drops, nasal sprays, inhalers on the counter to be destroyed. RN A asked him/her about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 21	F 602		

medications being destroyed and he/she said that we had a lot from his/her cart. The only narcotics he/she seen to be destroyed was morphine and RN A was doing correctly so with another nurse. He/She did not normally pop out the narcotics but he/she did get into their cart. He/She accident took home another resident's bromoimide drops. He/She did say that RN A probably wouldn't write him/her up for it.

-Undated, DON wrote, CMT A came to him/her and Administrator and informed them that state made him/her and RN A destroy several medications which included an inhaler, morphine, and a medication that belonged to Resident #1 but he/she could not remember the name of the medication. He/She spoke to RN A on 3/11/25 and informed hi/her that it was weird that CMT A told RN A that DON and Administrator had gotten rid of a card of hydrocodone-acetaminophen for Resident #1. He/She took RN A to administrator and Corporate Quality Assurance nurse to repeat what he/she had said. With guidance from Corporate Quality Assurance nurse, CMT would no longer do medications in facility, a soft file had been started, nurses were in-service and medication sheet is unavailable as he/she, RN A looked for the controlled drug sheet and medication and were unable to locate either items.

-On 3/14/25, Hospice Nurse A wrote: He/She served as hospice case manager for Resident #1 and had conversation with RN A. RN A had asked him/her if he/she had destroyed any of Resident #1's medications. He/She responded no. RN A stated he/she did not feel Resident #1's controlled drug count was correct. RN A stated that CMT A had told RN A that he/she, DON, and a state agency representative was in medication room discussing Resident #1's medications and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 22	F 602		

that had stated Resident #1 had too many hydrocodone-acetaminophen and that Resident #1 did not need that many. I told RN A that conversation never took place and that he/she had not destroyed any of Resident #1's medications. According to his/her charting of Resident #1's medications he/she had 135 tabs of hydrocodone-acetaminophen 7.5/325 on 2/25/25 and 55 tablets of hydrocodone-acetaminophen 7.5/325 mg on 3/3/25.
-Corrective Actions showed:
-CMT A suspended
-Pharmacy and Hospice were notified and medications were replaced;
-CMT A would no longer be allowed to work as CMT, only as a CNA;
-Only licensed nurses were allowed to pass controlled drugs;
-Licensed nurses must count controlled drugs between shifts. Neither nurse shall leave facility if there was miscount, missing narcotics, or undocumented destruction until the DON was informed and approved.
-Controlled drug destruction required direct approval from the DON.
-Plan of oversight included: Education to nurses regarding corrective action;
-DON to audit narcotics weekly for any unreported missing narcotics;
-Systemic changes included: Change in facility policy that revoked CMT privileges to pass controlled medications.
-Conclusion of investigation showed: Inconclusive. Facility could not confirm or disprove due to lack of sufficient evidence. No direct observation of CMT stealing narcotics as charge nurse did not witness theft and BOM did not observe the narcotics in CMT's possession. It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 23	F 602		

was verified that controlled drug was missing from Resident #1's supply. It remained inconclusive whether it was misplaced, destroyed, discarded, or stolen.
-Inservice was completed on 3/14/25 with three facility nurses regarding passing of controlled medications;

During an interview on 3/25/25 at 1:46 P.M., Licensed Practical Nurse (LPN) A said:
-Two nurses counted narcotics together;
-If a medication was discontinued the facility had a jug of drug buster and two nurses fill out a form and both nurses have to sign, destroy, and put it in the drug buster stuff;
-He/She knew Resident #1's narcotic medication count was off;
-He/She was informed that there had been two cards but they were just using the one card;
-One of the nurses reported to him/her that one of the cards was missing;
-Evidently someone took the whole controlled dug page out of the controlled medication book and everything;
-RN A or RN B had to be the nurse that told him/her that Resident #1's medication card was missing;
-He/She worked night shift from 6:00 P.M.-6:30 A.M.;
-He/She had never had any issues with missing medication bubble packs;
-CMT A had access to the narcotics;
-This was a new policy that they allowed CMT's access to narcotics when they hired CMT A;
-CMT was allowed to go into both medication carts;
-The nurses cart had the narcotics in it;
-Resident #1 received Hydrocodone-Acetaminophen scheduled for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 24	F 602		

his/her pain;
-CMT A was always asking charge nurse if he/she could give Resident #1 and Resident #4 pain medication;
-Resident #4 was on same medication as Resident #1;
-Resident #4 was on morphine which we had not been giving to him/her because the hydrocodone-acetaminophen seemed to hold his/her pain;
-There was time he/she had to give Resident #4 the morphine and it was always when CMT A had passed his/her hydrocodone-acetaminophen;
-There was one time Resident #1 was crying he/she had so much pain.

During an interview on 3/25/25 at 2:22 P.M., Registered Nurse (RN) A:
-He/She normally counted narcotics of hospice residents when the hospice nurse was in the building;
-He/She had counted narcotics with the hospice nurse on 2/25/25;
-On 2/25 he/she counted two bubble packs of 60 count pills of hydrocodone-apap for Resident #1;
-The hospice nurse had logged his/her counts with me on his/her computer;
-When he/she returned to work on 2/28 Resident #1 only had one bubble pack of 60 plus a partial card of hydrocodone-apap;
-He/She asked CMT A what had happened to Resident #1's bubble pack of hydrocodone;
-CMT A said that the Administrator and DON had been in the medication room going through stuff and took the extra card of hydrocodone-acetaminophen for Resident #1 out because it had looked bad having that much hydrocodone-acetaminophen on hand for one resident;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 25 -From that point on he/she never got an opportunity to tell the DON about it until he/she remembered on 3/11/25; -DON immediately took him/her to Administrators office and he/she relayed the information she had with the Administrator, Corporate Nurse, and the DON; -DON reported to him/her that CMT A had reported that he/she and CMT A had wasted Resident #1's drugs; -There had been no reason to waste Resident #1's medications; -We were unable to locate Resident #1's hydrocodone-acetaminophen controlled drug count sheet the missing bubble pack; -Facility had a box that the completed controlled drug count sheets went into when they had been completed, the box was checked and the missing narcotic sheet was not located; -CMT A did pass controlled drugs for the nurses; -The controlled drugs were maintained in the nurses medication cart; -The nurse would have to unlock the cart for CMT A; -When CMT A needed a controlled drug for a resident he/she would ask for it; -He/She would pop the medication for CMT A and give it to him/her to administer; -He/She learned that he/she should not have been popping the medication for CMT A and he/she should have popped his/her own medications for residents; -The controlled drug counts were completed with the oncoming nurse; -He/She did not know if CMT A had completed the controlled drug counts with staff; -The controlled drugs were always maintained in the nurses cart; -CMT A was the only CMT the facility had	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 26	F 602		

employed;
-He/She had notified interim DON his/her concerns with CMT A having access to the nurses cart and a long write up was received back from the facility corporate nurse notifying us that CMT A could pass narcotics;
-He/She had identified concerns regarding CMT A with controlled drug passes but did not have any solid proof because the residents in the facility had a routine with their medications;
-In the mornings, CMT A would always want Resident #1 and Resident #4's controlled medications of Hydrocodone-Acetaminophen;
-One day CMT A asked him/her for Resident #1 and Resident #4's medications at breakfast. The aids then had came to me and said Resident #4's was in a lot of pain;
-He/She felt this was unusual as Resident #4's pain was usually managed by his/her hydrocodone/acetaminophen;
-When He/She went into Resident #4's room to assess Resident #4', he/she found that Resident #4 was crying;
-He/She had to administer Resident #4's morphine for the pain;
-He/She had charted that he/she had administered the morphine to Resident #4's for break through pain rated 10 out of 10 on the pain scale;
-Sometimes he/she had to crush Resident #4's medication in pudding because Resident #4 could not take his/her medication in a whole pill form;
-Another instance, a day aide came up and asked if he/she could give Resident #3's his/her medications because they were getting ready to change him/her and the day aide thought it would help him/her. CMT A already had Resident #3's medication cup ready in medication cart, but when he/she looked in his/her medication cup

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 27	F 602		

Resident #3's did not have his/her Ativan in the cup and there was no Ativan in the medication cart. CMT A had popped pills in advance and had them already in a pill cup in the medication cart;
-Resident #1 is fairly agreeable resident but at times he/she would become hateful on days CMT A passed Resident #1's medications. He/She had wondered if Resident #1 had been experiencing pain;
-CMT A was in medication room helping straighten Medication Administration Records (MARS) during this past month and the MDS Coordinator was working to pass medications that evening;
-CMT A was not in facility working to pass medications that shift but he/she asked him/her three times if he/she wanted him/her to go and pass Resident #4's pain medication. On the third time of CMT A asking about Resident #4's pain medication, he/she went to ask and assess Resident #4's pain. Resident #4 said he/she was fine and was not having any pain. CMT A became upset with me.

During an interview on 3/25/25 at 3:05 P.M., Business Office Manager (BOM) said:
-He/She transported CMT A to and from work;
-He/She dropped CMT A off from work on 2/25/25 and he/she had a back pack he/she carried with him/her;
-He/She picked up CMT A on morning of 2/26/25 and when he/she backed out of CMT A's driveway, CMT A said he/she had forgotten medication. He/She asked CMT A if he/she needed to go back into get the medication and CMT A said no it was just a pill in a cup;
-He/She observed CMT A open his/her backpack and pulled medicine out of his/her bag. Inside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 28	F 602		

his/her bag he/she had long oval pills that were loosely laying in his/her bag;
-He/She had also observed some pill bottles and CMT A did indicate he/she took Xanax and Tramadol;
-The next day CMT A did bring a pill in a white paper cup up to the Business Office Manager's office and said resident no longer took the medication;
-CMT A did not mention any eye drops to him/her, he/she was not aware of any eye drops;
-He/She had observed concerns regarding CMT A's behavior at work;
-He/She had observed CMT standing at medication cart acting loopy and dozing off and did not appear functional;
-He/She had residents ask him/her what was wrong with CMT A and why CMT A would fall asleep or was falling over while trying to write;
-He/She reported his/her concerns to the Director of Nursing (DON) and encouraged DON to send CMT A home from work;
-DON did not send CMT A home from work;
-CMT A would yell at residents;
-CMT A would drop medications on the floor and pre-set his/her medications;
-CMT A would set up medications for LPN A because LPN A could not see;
-CMT A would put medications in baggies or cups;
-LPN A would have to use a magnifying glass or flashlight to be able to see;
-LPN A used to stay in facility because he/she had quit driving cause he/she could not see;

During an interview on 3/25/25 at 3:39 P.M., Certified Medication Technician (CMT) A said:
-RN A asked him/her why there were multiple items in the medication box that were missing;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 29 -He/She told RN A that he/she did not touch anything; -He/She told RN A that he/she had extra inhalers, eye drops in his/her medication cart and he/she had put them on the counter to be destroyed; -The medications he/she put on the counter were not narcotics; -We had multiple doses of medications on the medication cart; -He/She did not know what medications RN A was concerned about; -He/She had passed medications to all residents in facility; -He/She had passed narcotic medications to residents that were on his/her hall; -He/She knew residents (Resident #3) received Ativan, Resident #4 received hydrocodone-acetaminophen at breakfast and lunch, and Resident #1 received narcotic at 8, noon and 8 P.M.; -He/She sometimes completed narcotic counts with the nurse; -He/She never had an issue with narcotic count being wrong; -He/She never passed the liquid narcotics, only the pill narcotics; -He/She was not allowed to destroy medications; -He/She had put meds in the destroy box and wrote on a piece of paper to destroy; -Due to narcotics being in the nurses cart he/she would sometimes have the nurse pop the narcotic and he/she would administer the medication; -He/She would sometimes get into the nurses medication cart to pass medications if the nurse was running late; -If he/she was getting into the nurses medication cart then it was to do count because he/she touched the medications; -He/She would set up medications for the night	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 30	F 602		

nurse, LPN A;
-LPN A had a hard time reading and he/she felt it was safer for the resident cause he/she could not see;
-He/She would leave medications for nurse to destroy cause legally he/she could not destroy them;
-He/She accidentally took home medications;
-He/She took home eye drops, it was bromide eye drops;
-He/She had placed the eye drops in his/her pocket by accident while he/she had administered them to resident;
-He/She had never taken pills home;
-He/She did not know where the allegation that he/she took medications from facility came from;
-The facility suspended him/her and he/she had not worked since the suspension

During an interview on 3/25/25 at 4:26 P.M., DON said:
-CMT A mentioned to him/her that when the state survey team had been in the building they had said there had been too many narcotics on hand and too many being used at one time;
-He/She passed the information on to Administrator and Corporate Nurse;
-RN A came up to him/her and said CMT A had told her something that had been really odd to him/her that Administrator and myself had taken Resident #1's hydrocodone-acetaminophen and put them up until after state survey team left the building;
-He/She made RN A go into Administrator's office and repeat information he/she had shared with the Administrator and Corporate Nurse;
-When he/she questioned CMT A, CMT A said he/she had never said that;
-BOM reported that CMT A had said he/she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 31	F 602		

taken medication while he/she had transported CMT A to work which was also reported to Administrator;
-Administrator and myself started an investigation;
-CMT A was suspended;
-State agency was notified of investigation;
-They had interviewed all individuals who had access to medications at time the medications went missing including day shift nurses, CMT A, BOM, and the hospice nurse;
-CMT A had access to the controlled medications and did pass controlled medications;
-He/She did not have any concerns regarding CMT A passing medications;
-He/She had not had any concerns reported to him/her regarding CMT's behavior other than some would say he/she was tired;
-He/She had never been able to catch her tired or extra sleepy;
-No staff had reported to him/her that residents had more pain when CMT A would pass medications;
-He/She expected that staff would pass pills immediately and pre-setting medications was unacceptable;
-He/She was aware that staff had been pre-setting medications prior to his/her start date with facility and that it had been addressed through a facility in-service;
-He/She was aware that CMT A stayed late to assist LPN A with passing medications;
-It was difficult for LPN A to see little words on the MARs;
-Resident #1's controlled medication count sheet was lost and unable to be located for the missing bubble pack of hydrocodone;
-He/She expected residents to be free from misappropriation of their property;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 602	Continued From page 32 -The facility replaced Resident #1's missing medications with the pharmacy. During an interview on 3/25/25 at 4:48 P.M., the Administrator said: -CMT A went through a period of working an excessive amount of hours of the facility; -CMT A had been sent home two times for being drowsy; -CMT A did not show signs of being intoxicated; -BOM had reported that CMT A had been drowsy when the BOM had been working the floor with CMT A toward the end of January; -He/She had not received any concerns from residents regarding CMT A's behavior; -He/She expected residents to be free from misappropriation of their personal property; -Facility implemented interventions of suspending CMT A, implemented policy that only nurses are allowed to pass controlled drugs, a strict counting policy is in place and nurses may not leave their shift until the controlled drug count is accurate or DON has approved staff to leave, and destruction of medications only was to occur with oversight of DON or under his/her instruction. MO251028	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 609	Continued From page 33	F 609		

are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to report to the state survey agency and law enforcement, misappropriation of resident property (missing narcotics), when the facility became aware on 3/11/25 that one resident (Resident #1) had one bubble pack card of a narcotic medication, hydrocodone-acetaminophen 7.5-325mg (a controlled drug used to relieve severe pain) missing. The facility census was 26.

Review of facility abuse and neglect policy, dated 11/2017, showed:
-The facility will ensure that any reasonable suspicion of crimes committed against a resident of the facility will be reported to the appropriate Law Enforcement Agency as established by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 609	Continued From page 34	F 609		

section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010. When there is reasonable suspicion that a crime had occurred, then in addition to reporting the allegation of abuse to the state survey agency, the incident must be reported to the local law enforcement.
-All reports of suspected crime must be reported immediately reported to local law enforcement to be investigated. The facility will fully cooperate with local law enforcement.

1. Review of Resident #1's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 3/14/25, showed:
-Cognition severely impaired;
-He/She had limited range of motion to both lower extremities;
-He/She was dependent on a wheelchair;
-He/She required partial to moderate assistance with toileting, upper body dressing, rolling left and right, sit to stand transfers, and toilet transfers;
-He/She required substantial to maximal assistance for chair to bed transfers, lying to sitting transfers, and bathing;
-He/She was on scheduled pain medication regimen;
-He/She was taking an opioid;
-Diagnoses included: vascular dementia (cognitive decline caused by damage to the blood vessels in the brain), major depressive disorder (persistently depressed mood), pain, and anxiety.

Review of care plan, revised 3/7/25, showed the resident had constant chronic back pain.

Review of facility investigation, dated 3/11/25, showed:
-Facility became aware of one bubble pack of 30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 609	Continued From page 35	F 609		

missing narcotics for resident #1 when Registered Nurse (RN) A reported on 3/11/25 that when she returned to work on 2/28/25 there was one package of narcotics that were missing from when he/she had previously worked on 2/25/25. RN A reported that Certified Medication Technician (CMT) A said to him/her that with state in building for survey the Director of Nursing (DON) and Administrator destroyed medications because they had too much narcotics. RN A reported he/she shrugged off the comment until 3/11/25 when he/she heard a conflicting story that CMT A had reported that he/she had destroyed the narcotics. DON and Administrator reported to RN A that they had not destroyed any medications.
-Facility steps in their investigation included notifying the state survey agency, gathering statements, suspending alleged perpetrator, informing pharmacy and paying for replacement medications, and education to their nurses;
-Law enforcement was not contacted.

Physician's orders, dated 3/25/25, showed the order started 1/20/25, Hydrocodone-acetaminophen -schedule II tablet; 7.5-325mg, 1 tab three times a day by mouth.

During an interview on 3/25/25 at 1:15 P.M., Administrator said:
-He/She did not contact law enforcement regarding the missing medications;
-He/She felt like the narcotics had been missing for too long when it had been reported to him/her.

During an interview on 3/25/25 at 4:26 P.M., Director of Nursing (DON) said:
-He/She did not know if Administrator had contacted law enforcement regarding missing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265480	A. BUILDING _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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) COMPLETION DATE
F 609	Continued From page 36 narcotics; -Administrator was the facility investigator. During an interview on 3/25/25 at 4:48 P.M., Administrator said: -The resident's missing narcotics should have been reported to local law enforcement. -He/She expected resident's to be free from misappropriation of their personal property. MO251028	F 609		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16939	A. BUILDING: _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND RIVER HEALTH CARE	118 TRENTON ROAD CHILLICOTHE, MO 64601

(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
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II *Higher classification merited due to the extent of the violation and when combined with other deficiencies. Please refer to F600, F602, and F609. MO251220 and MO251028	A8023		

PLAN OF CORRECTION

Provider/Supplier Name:	Grand River Health Care
Street Address, City, Zip:	118 Trenton Rd. Chillicothe, MO 64601
Date of Survey:	03/25/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	16939

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F600 SS=G	**Free from Abuse and Neglect** **CFR(s): 483.12(a)(1)** §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: F 600 SS=G Based on record review and interview, the facility failed to keep one resident (Resident #2) free from verbal and physical abuse when Nurse Aide (NA) A held resident's arms down and cussed at resident (Resident #2) and when Licensed Practical Nurse (LPN) A yelled at resident (Resident #2) and forced the resident to wear a bi-pap mask (A device that forces oxygenated air through mask that is suctioned against a person's face to provide respiratory support) against the resident's will . The facility census was 26. **Immediate action(s) taken for the identified problem include:** 1. Nurse Aide (NA) A was immediately suspended pending investigation and then terminated when found substantiated.	04/22/2025

	2. LPN A was immediately suspended pending investigation and then terminated when found substantiated. 3. Resident #2 was sent out to the hospital due to critical vitals. Facility was unable to assess for physical or mental trauma until resident returned to the facility on 03/20/2025. Follow-up counseling and support were provided by Social Services Designee. 4. Administrator and DON immediately investigated the alleged abuse. The two staff members were interviewed and the guardian and physician were notified of the incident. **Identification action(s) taken for the identified problem include:** 1. All residents in the facility have the potential to be affected by this alleged deficient practice. A full census questionnaire was performed to ensure that abuse and neglect, with specific questioning of being held down or restrained, was not being unreported by other residents. **Actions taken/systemic changes put into place to ensure deficient practices will not recur:** 1. Admin/Designee(s) to provide education to facility staff regarding resident rights and abuse and neglect towards residents, explaining different kinds of abuse and neglect included restraints and forcing residents to do something they do not want to do. **How the facility plans to monitor its performance to make sure that solutions are sustained:** 1. Admin/DON/Designee will audit facility residents weekly for 4 weeks, bi-weekly for 1 month, and monthly for 3 months and as needed thereafter for abuse and neglect, including resident-to-resident altercations and specific questioning over restraints. 2. The Administrator and DON conduct random "walk-ins" on shifts and units to engage with residents and identify environmental or behavioral concerns proactively. 3. All new staff receive abuse prevention training upon hire and annually thereafter. Additional training sessions will be provided quarterly.	

	4. All monitored findings will be reported to the Quality Assurance Performance Improvement Committee monthly or as needed for further review and or changes. **Date of Compliance: 04/21/2025**	
F602 SS=D	**Free from Misappropriation/Exploitation** **CFR(s): 483.12 §483.12** The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: F 602 SS=D Based on observation, interviews, and record reviews, the facility failed to assure one resident (Resident #1) was free from misappropriation of his/her property when the resident's narcotic medications were found missing was 26. **Immediate action(s) taken for the identified problem include:** 1. Resident #1 was assessed for trauma due to the misappropriation of his/her property. 2. Facility purchased and replaced the missing narcotics, and the resident did not miss any scheduled doses of the narcotic. No adverse health outcomes were noted. 3. Certified Medication Technician (CMT) A was immediately suspended upon suspicion and permanently removed from medication administration responsibilities. **Identification action(s) taken for the identified problem include:** 2. All residents in the facility have the potential to be affected by this alleged deficient practice. The facility will perform a full inventory of all medications, specifically narcotic medications, in the facility to verify that no other medications are missing. Any discrepancies will be promptly	04/22/2025

	addressed, and all medication storage practices will be reviewed **Actions taken/systemic changes put into place to ensure deficient practices will not recur:** 2. Admin/DON/Designee(s) to provide education to facility staff regarding exploitation of resident goods. All staff involved in medication administration will undergo additional training focused on the handling, storage, and documentation of narcotic medications. This training will include awareness of the risks associated with narcotics and procedures to prevent theft or misuse. 3. Staff will be educated on their responsibility to prevent misappropriation, report any suspicious behavior, and maintain a secure and ethical environment. 4. Admin/DON/Designee will review and reinforce its policies regarding the secure storage of narcotic medications. Narcotics will be stored in locked, secure locations with restricted access to authorized personnel only. Logging and tracking all controlled substances will be established. These logs will be reviewed regularly by a designated staff member to ensure all medications are accounted for and any discrepancies are identified immediately. **How the facility plans to monitor its performance to make sure that solutions are sustained:** 5. Admin/DON/Designee will conduct audits of medication storage areas and the handling of narcotics weekly for 4 weeks and monthly for 3 months. These audits will include reviewing medication logs, inspecting medication storage areas, and ensuring that no further misappropriation occurs. 6. All monitored findings will be reported to the Quality Assurance Performance Improvement Committee monthly or as needed for further review and or changes. **Date of Compliance: 04/21/2025**	
F609 SS=D	**Reporting of Alleged Violations** **CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c)**	04/22/2024

	In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report to the state survey agency and law enforcement, misappropriation of resident property (missing narcotics), when the facility became aware on 3/11/25 that one resident (Resident #1) had one bubble pack card of a narcotic medication, hydrocodone-acetaminophen 7.5-325mg (a controlled drug used to relieve severe pain) missing. The facility census was 26. **Immediate action(s) taken for the identified problem include:** 1. The facility notified local law enforcement regarding the missing narcotic medication that went missing. Report #25-308 2. Resident #1 was assessed for trauma due to the misappropriation of his/her property. 3. Facility purchased and replaced the missing narcotics, and the resident did not miss any scheduled doses of the narcotic. **Identification action(s) taken for the identified problem include:**	

	All residents in the facility have the potential to be affected by this alleged deficient practice. The facility will perform a full inventory of all medications, specifically narcotic medications, in the facility to verify that no other medications are missing. Any discrepancies will be promptly addressed, and reported to local law enforcement immediately. **Actions taken/systemic changes put into place to ensure deficient practices will not recur:** Director of Operations/Designee(s) to provide education to facility Administrator and DON regarding the notification to law enforcement regarding abuse, neglect, and exploitation. Administrator will utilize the checklist for MO Facility Self Reports, which includes the notification to local law enforcement if necessary. **How the facility plans to monitor its performance to make sure that solutions are sustained:** 4. Admin/DON/Designee will conduct audits of medication storage areas and the handling of narcotics weekly for 4 weeks and monthly for 3 months. Any discrepancies will be reported to local law enforcement immediately. Admin/DON will ensure all future reports of abuse, neglect, and exploitation will be reported to local law enforcement in a timely manner. 5. All monitored findings will be reported to the Quality Assurance Performance Improvement Committee monthly or as needed for further review and or changes. **Date of Compliance: 04/21/2025**	
A8023	**19 CSR 30-88.010(23) Develop/Implement A/N Policies** The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person	04/22/2025

	whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: A8023 Class II *Higher classification merited due to the extent of the violation and when combined with other deficiencies. Please refer to F600, F602, and F609. MO251220 and MO251028 ***Refer to F600, F602, and F609*** **Date of Compliance: 04/21/2025**	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.