STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

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

Administrator 5-20-25

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
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all residents were treated in a dignified manner, when one staff member (Social Services Director (SSD)) would not allow one resident (Resident #1) to smoke after the resident displayed behaviors. The facility census was 49. Review of the facility policy titled "Resident's Rights," undated, showed the following: -The resident has a right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility; -The resident has the right to exercise his/her rights as a resident of the facility and as a citizen or resident of the United States; -The resident has the right to be free of interference, coercion, discrimination and reprisal form the facility in exercising his/her rights, and be supported by the facility in the exercise of his/her rights. 1. Review of Resident #1's face sheet (admission data) showed the following: -Admission date of 01/21/25; -Diagnoses included transient cerebral ischemic attack (disruption of blood flow to the brain), dementia (loss of memory), major depressive disorder, severe with psychotic symptoms (person experiences sadness and a loss of contact with reality), anxiety disorder (feelings of worry and fear), post-traumatic stress disorder (PTSD - mental health condition that can develop after experiencing or witnessing a traumatic event).	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 550	Continued From page 2 Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/03/25, showed the following information: -Moderate cognitive impairment; -Behaviors; -Independent with eating and required set up with oral hygiene; -Substantial assistance required with toileting hygiene, showers, and upper/lower body dressing; -Dependent on staff for personal hygiene. Review of the resident's care plan, last revised on 04/01/25, showed the following: -Resident had history of verbal and physical aggression towards staff related to underlying psychiatric disorder and cognitive impairment. Staff to speak softly and avoid confrontational or punitive language, and redirect if the resident becomes physically aggressive; -Resident ad diagnosis of dementia, persistent mood (affective) disorder as evidence by persistent forgetfulness and disorientation. Have anxiety, fear and paranoia associated with memory loss; -Resident had chronic pain in back, knees, and ankles. Also muscle spasms. He/she takes narcotics; -Resident was unable to perform all activities of daily living (ADL) functions without extensive assistance of one to two staff due to weakness and impaired use of left leg, arm, and hand. Review of the resident's progress note dated 04/16/25, at 2:40 P.M., showed the SSD documented he/she and another staff took the	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 550	Continued From page 3	F 550		

resident to the social security office. The resident was "throwing a fit" in the social security office. The resident blurted out he/she had gotten two facilities closed down and was working on the current facility next. The resident would not quit with his/her yelling so staff could write down what paperwork the resident needed from the facility in order to get the resident's money to come to the facility. Workers and clients in the office could hear the resident yelling and causing an "ugly" scene. We were outside and the resident yelled "give me my goddamn cigarette." The SSD replied the resident would not get a cigarette because he/she "caused a whole scene in the building and outside the building." The resident's smoke breaks were taken away for the rest of the day.

During interviews on 04/30/25, at 9:17 A.M. and 1:30 P.M., the resident said the SSD took away his/her smoke breaks.

During an interview on 04/30/25, at 12:15 P.M., the SSD said the following:
-If a resident had a guardian and the guardian has given permission, one smoke break can be withheld from the resident for having bad behaviors;
-The resident was having behaviors at the social security office and missed his/her 11:00 A.M., cigarette, but had them the rest of the day.

During an interview on 04/30/25, at 11:40 A.M., Certified Nurse's Aide (CNA) A said the following:
-Staff can't take away a resident's smoke breaks if they don't have a guardians;
-Taking away a resident's privileges, such as smoking, is against their rights;
-The resident was his/her own person. He/she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 550	Continued From page 4 was not aware of staff taking away the resident's smoke breaks. During an interview on 04/30/25, at 11:50 A.M., CNA B said the following: -When a resident had a guardian and the guardian gave permission, the resident's smoke breaks could be taken if they have behaviors; -If the resident was their own person, staff were not allowed to take away their smoke breaks; -Taking away a resident's smoke break as a punishment would be against their rights; -He/she didn't know if the resident had smoke breaks taken away. During an interview on 04/30/25, at 12:05 P.M., Certified Medication Tech (CMT) D said the following: -Staff were not allowed to take away a resident's smoke breaks when the resident misbehaves. That would be taking away their rights; -He/she knew of one occasion when the resident's smoke break was taken away. During an interview on 04/30/25, at 12:25 P.M., Registered Nurse (RN) E said the following: -It would not be appropriate to withhold a resident's smoke break as punishment. This would be against their rights; -He/she knew they tried to withhold the resident's cigarette break at least once, but staff was told they couldn't do that. He/she didn't know the date. During an interview on 04/30/25, at 12:50 P.M., the Business Office Manager (BOM) said the following: -If a resident had a guardian, and it was okay with the guardian, a resident's smoke break could be withheld;	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 550	Continued From page 5 -If a resident was their own person, like the resident, staff can not take the smoke break; -He/she was not aware of the resident missing any smoke breaks. During an interview on 04/30/25, at 12:30 P.M., the Director of Nursing (DON) said the following: -Staff didn't have the right to take away a resident's smoke break when they have behaviors. That would be against their rights; -It did happen one time with the resident, but it was a miscommunication as one side of the building didn't know the resident was his/her own person and did not have a guardian; -All staff know that only those with guardians, that give permission to withhold smoke breaks, can have those smoke breaks taken away; -Only social services, administration, or nurses can decide when a smoke break was taken; -It was not appropriate for the SSD to withhold the resident's smoke break on 04/16/25. During an interview on 05/01/25, at 10:15 A.M., the Administrator said the following: -He/she had told staff when residents are their own person, they can not withhold smoke breaks; -He/she was not aware of the resident missing any smoke breaks; -On 04/16/25, the SSD encouraged the resident to get into the vehicle as they were on a time frame and it there wasn't a scheduled smoke break. The resident did smoke when he/she arrived back to the facility.	F 550		
F 609 SS=D	MO00253134 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 6 §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, 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 interviews and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to management and within two hours to the state licensing agency (Department of Health and Senior Services - DHSS) when staff failed to report two allegations of abuse involving one resident (Resident #1) to management and DHSS in a timely fashion. The facility census was 49.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 7 Review of the facility policy titled "Abuse Prohibition Protocol Manual," revised 11/28/16, showed the following: -Educate all staff to report to the Administrator and/or designees any alleged violations involving abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property; -The Administrator or designee must report to the State Survey agency no later than two hours after the allegation is made if the event involved abuse or resulted in injury. -All residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation; -Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents regardless of their age, ability to comprehend, or disability; -Physical abuse is defined as hitting, slapping, pinching, kicking, biting, etc. It also includes controlling a resident's actions through personal punishment; -Report immediately, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury. 1. Review of Resident #1's face sheet (admission data) showed the following: -Admission date of 01/21/25; -Diagnoses included transient cerebral ischemic attack (disruption of blood flow to the brain), dementia (loss of memory), type II diabetes, (body doesn't produce enough insulin), major depressive disorder, severe with psychotic symptoms (person experiences sadness and a loss of contact with reality), anxiety disorder	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 8 (feelings of worry and fear), post-traumatic stress disorder (PTSD - mental health condition that can develop after experiencing or witnessing a traumatic event). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/03/25, showed the following information: -Moderate cognitive impairment; -Behaviors; -Independent with eating with set up assistance with oral hygiene; -Substantial assistance with toileting hygiene, showers, and upper/lower body dressing; -Dependent on staff for personal hygiene. Review of the resident's care plan, last revised on 04/01/25, showed the following: -Resident had history of verbal and physical aggression towards staff related to underlying psychiatric disorder and cognitive impairment. Staff to speak softly and avoid confrontational or punitive language, redirect if becomes physically aggressive, -Resident had diagnosis of dementia, persistent mood (affective) disorder as evidence by persistent forgetfulness and disorientation. Resident had anxiety, fear, and paranoia associated with memory loss; -Resident had chronic pain in back, knees, and ankles and muscle spasms. Resident takes narcotics; -Resident was unable to perform all ADL functions without extensive assistance of one to two staff due to weakness and impaired use of left leg, arm, and hand.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 9	F 609		

Review of the resident's progress note dated 03/31/25, at 11:54 A.M., showed SSD documented he/she went to the resident and sat down to list to what the resident had to say. The resident said that two staff members were abusing him/her and he/she had bruising all over his/her body. SSD replied "well I have to take a look at your complaint and see bruising" and SSD had the charge nurse look as well. There was no bruising found by the SSD or the charge nurse. The two staff members the resident accused had not been at work. (The SSD did not document notification of facility administration or DHSS of the allegation of abuse.)

Review of DHSS records showed the facility did not report the allegations of abuse.

Review of the resident's progress note dated 04/16/25, at 2:40 P.M., showed the SSD documented he/she and another staff took the resident to the social security office. The resident was "throwing a fit" in the social security office. The resident blurted out "he/she had gotten two facilities closed down and was working on the current facility next." The resident said "we abuse him/her and leave residents in the floor." (The SSD did not document notification of facility administration or DHSS of the allegation of abuse.)

Review of DHSS records showed the facility did not report the allegation of abuse.

During an interview on 04/30/25, at 12:15 P.M., the SSD said the following:
-When staff are told a resident is being abused, they come to him/her;
-He/she talked to the resident to see what's going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 10	F 609		

on and what type of abuse was being alleged;
-On 03/31/25, the resident came to him/her and said staff were hitting and abusing him/her and he/she had bruises on his/her body;
-He/she got the charge nurse and they assessed the resident and he/she did not have bruises on him/her;
-He/she went to the Administrator and let him/her know what was going on;
-The charge nurse documented in the chart an assessment of the skin was completed;
-The resident did not know the names of the staff that abused him/her;
-He/she didn't know if the incident was reported to the state, but should be reported in either 24 or 2 hours;
-On 04/16/25, he/she took the resident to the social security office. The resident yelled in the office that staff abused him/her, don't do anything for the resident, and they were starving the resident. The resident had never been abused at the facility;
-The Administrator looked into the allegations, but the SSD didn't know if the allegations were reported to the state.

During an interview on 04/30/25, at 11:40 A.M., Certified Nurse's Aide (CNA) A said the following:
-If a resident accuses staff of abuse, and he/she was in the room and believes it's a misunderstanding, he/she would speak to the resident to explain that it wasn't abuse;
-If he/she witnessed abuse, or was told by the resident they've been abused, he/she would speak to the SSD and the charge nurse;
-Allegations of abuse are to be reported to the state in less than 24 hours.

During interviews on 04/30/25, at 11:50 A.M.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 11 CNA B said the following: -If a resident reported abuse, he/she told the charge nurse and the nurse called the state within two hours. -The resident accused him/her of abuse. He/she didn't recall when that was, but he/she wasn't working the day the resident made the accusations; -The resident has said staff hit him/her. During an interview on 04/30/25, at 12:00 P.M., Certified Medication Technician (CMT) C said the following: -If a resident reported abuse, he/she notified the charge nurse; -He/she assumed it should be reported to the state, possibly in two hours. During an interview on 04/30/25, at 12:05 P.M., CMT D said the following: -When a resident reported abuse, he/she told the charge nurse; -The charge nurse tells the Administrator and Director of Nursing (DON) and the state is called within two hours. During an interview on 04/30/25, at 12:25 P.M., Registered Nurse (RN) E said the following: -If a resident reported abuse, he/she reported it to the DON or the Administrator. The state is notified in two hours; -They have training on abuse at most in-services; -The resident had not reported abuse to him/her. He/she heard other staff talk about the resident accusing staff of abuse that wasn't working or no longer worked at the facility; -He/she didn't know if the allegations were reported to the state.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 12 During an interview on 04/30/25, at 12:50 P.M., the Business Office Manager (BOM) said the following: -Allegations of abuse were reported to the DON and Administrator, or the supervisor; -The Administrator reported to the state in two hours. During an interview on 04/30/25, at 12:30 P.M., the DON said the following: -Abuse allegations should be reported to the charge nurse, DON, and Administrator; -The allegations of abuse are reported to the state if the abuse allegations are valid. He/she didn't know for sure what the time frames of reporting the abuse; -The resident had made allegations of abuse; -Skin assessments were completed and there was no bruising; -On 3/31/25, he/she believed the Resident accused the two evening shift people, the SSD talked to the staff, the next time they were in the building. He/she doesn't know if the SSD documented anything. It was not reported to the state; -On 4/14/25, he/she was not aware of the resident made allegations of abuse on this date. During an interview on 05/01/25, at 10:15 A.M., the Administrator said the following: -He/she did remember the one event, possibly from 03/31/25, where the SSD and a nurse interviewed the resident saying an aide put him/her to bed too hard. A skin assessment was done and they did not find anything; -He/she was not aware of allegations of abuse from 04/16/25; -When abuse is alleged, staff are to tell him/her and he/she investigates, speaks with the resident,	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 13 and other residents and staff, and calls the state within two hours; -The two incidents were not reported to the state. MO00253134	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 staff failed to complete and document a full investigation of all allegations of abuse with steps taken to protect residents during the investigation documented when staff failed to fully investigate two allegations of abuse made by one resident (Resident) alleging abuse by staff. The facility census was 49. Review of the facility policy titled "Abuse	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 610	Continued From page 14	F 610		

Prohibition Protocol Manual," revised 11/28/16, showed the following:
-Educate all staff to report to the Administrator and/or designees any alleged violations involving abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property;
-All residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation;
-Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents regardless of their age, ability to comprehend, or disability;
-Physical abuse is defined as hitting, slapping, pinching, kicking, biting, etc. It also includes controlling a resident's actions through personal punishment;
-During an investigation, if a staff member is accused, that person will be suspended immediately, pending investigation, and all staff on duty need to complete witness statements and cannot leave until they complete one.

1. Review of Resident #1's face sheet (admission data) showed the following:
-Admission date of 01/21/25;
-Diagnoses included transient cerebral ischemic attack (disruption of blood flow to the brain), dementia (loss of memory), type II diabetes, (body doesn't produce enough insulin), major depressive disorder, severe with psychotic symptoms (person experiences sadness and a loss of contact with reality), anxiety disorder (feelings of worry and fear), post-traumatic stress disorder (PTSD - mental health condition that can develop after experiencing or witnessing a traumatic event).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 610	Continued From page 15 Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/03/25, showed the following information: -Moderate cognitive impairment; -Behaviors; -Independent with eating and required set up help with oral hygiene; -Required substantial assistance with toileting hygiene, showers and upper/lower body dressing; -Dependent on staff for personal hygiene. Review of the resident's care plan, last revised on 04/01/25, showed the following: -He/she had a history of verbal and physical aggression towards staff related to underlying psychiatric disorder and cognitive impairment. Staff to speak softly and avoid confrontational or punitive language, and redirect if resident becomes physically aggressive, -He/she had diagnoses of dementia and persistent mood (affective) disorder as evidence by persistent forgetfulness and disorientation. Resident had anxiety, fear, and paranoia associated with memory loss; -He/she had chronic pain in back, knees, and ankles and muscle spasms. He/she took narcotics; -He/she was unable to perform all ADL functions without extensive assistance of one to two staff due to weakness and impaired use of left leg, arm, and hand. Review of the resident's progress note dated 03/31/25, at 11:54 A.M., showed the SSD documented he/she went to the resident and sat down to listen to what the resident had to say.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 610	Continued From page 16 The resident said that two staff members were abusing him/her and he/she had bruising all over his/her body. The SSD replied "well I have to take a look at your complaint and see bruising" and SSD had the charge nurse look as well. There was no bruising found by the SSD or the charge nurse. The two staff members the resident accused had not been at work. Review of the facility records shows the facility did not provide a documented full investigation, to include interviewing other residents and staff. Review of the resident's progress note dated 04/16/25, at 2:40 P.M., showed the SSD documented he/she and another staff took the resident to the social security office. The resident was "throwing a fit" in the social security office. The resident blurted out he/she had gotten two facilities closed down and was working on the current facility next. The resident said the staff "abuse him/her and leave residents in the floor." Review of the facility records shows the facility did not document an investigation of the allegations of potential abuse. During an interview on 04/30/25, at 12:15 P.M., the SSD said the following: -When staff are told a resident is being abused, they come to him/her; -He/she talked to the resident to see what's going on and what type of abuse was being alleged; -On 03/31/25, the resident came to him/her and said staff were hitting and abusing him/her and he/she had bruises on his/her body; -He/she got the charge nurse and they assessed the resident and he/she did not have bruises on him/her;	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 610	Continued From page 17 -He/she went to the Administrator and let him/her know what's going on; -The charge nurse documented in the chart an assessment of the skin was completed; -The resident did not know the names of the staff that abused him/her; -If the Administrator knew the names of the accused staff, he/she will suspend them pending an investigation; -On 04/16/25, he/she took the resident to the social security office, the resident yelled in the office that the facility abused him/her, don't do anything for the resident, and were starving the resident; -The Administrator looked into the allegations. During an interview on 04/30/25, at 11:40 A.M., Certified Nurse's Aide (CNA) A said the following: -If a resident accused staff of abuse, and he/she was in the room and believed it was a misunderstanding, he/she would speak to the resident to explain that it wasn't abuse; -If he/she witnessed abuse, or was told by the resident they had been abused, he/she would speak to the SSD and the charge nurse; -The accused staff would be suspended pending the outcome of the facility investigation. During an interview on 04/30/25, at 11:50 A.M., CNA B said the following: -If a resident reported abuse, he/she told the charge nurse and the nurse; -He/she didn't know if the accused staff was suspended. He/she did know the facility was supposed to investigate;. -The resident accused him/her of abuse. He/she didn't recall when that was but he/she wasn't working the day the resident made the accusations;	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 610	Continued From page 18 -He/she was not suspended, however the Director of Nursing (DON) did ask him/her questions. During an interview on 04/30/25, at 12:00 P.M., Certified Medication Technician (CMT) C said the following: -If a resident reported abuse, he/she notified the charge nurse; -He/she believed the facility suspended the staff that's been accused and investigates. During an interview on 04/30/25, at 12:05 P.M., CMT D said the following: -When a resident reported abuse, he/she told the charge nurse; -The charge nurse told the Administrator and DON, and they begin an investigation. During interviews on 04/30/25, at 12:25 P.M., Registered Nurse (RN) E said if a resident reported abuse, he/she reported it to the DON or the Administrator, and they complete an investigation. The accused staff was sent home. During an interview on 04/30/25, at 12:50 P.M., the Business Office Manger said the following: -The administrator investigates allegations of abuse; -He/she didn't know of any physical or verbal abuse allegations the resident had made against staff. During an interview on 04/30/25, at 12:30 P.M., the DON said the following: -Abuse allegations should be reported to the charge nurse, DON, and Administrator; -The resident is interviewed to find out what's going on, as well as the roommate, and the staff	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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 610	Continued From page 19	F 610		

member;
-The accused staff is suspended, an investigation is completed, including interviews with other staff and residents;
-The resident has made allegations of abuse. Skin assessments were completed and there was no bruising;
-On 03/31/25, he/she believed the resident accused the two evening shift people and the SSD talked to the staff, the next time they were in the building. He/she didn't know if the SSD documented anything. The two staff were not suspended;
-On 04/14/25, he/she was not aware of the resident making allegations of abuse on this date.

During an interview on 05/01/25, at 10:15 A.M., the Administrator said the following:
-He/she had not completed an investigation for abuse on the resident. He/she knew the SSD did one or two. He/she was not certain the dates on those;
-He/she was not aware of allegations of abuse from 04/16/25;
-When abuse is alleged, staff are to tell him/her and he/she investigates, speaks with the resident and other residents and staff. If he/she knew the names of the staff, he/she would suspend them;
-He/she was not aware of whether the two incidents were investigated.

MO00253134

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
	04996	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	3111 HIGHWAY A MANSFIELD, MO 65704

(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* 1. Please refer to F609. 2. Please refer to F610. *The higher classification merited due to the extent of the violation. MO00253134	A8023		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III	A8030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04996	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY RIDGE MANOR	**3111 HIGHWAY A MANSFIELD, MO 65704**

(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
A8030	Continued From page 1 This regulation is not met as evidenced by: Class II* 1. Please refer to F550. *The higher classification merited due to the extent of the violation and the violations effect on the resident. MO00253134	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Rocky Ridge Manor
Street Address, City, Zip:	3111 Highway A Mansfield, MO. 65794
Date of Survey:	4/30/25

	This plan of correction is submitted as required under State and Federal law. The submission of this does not constitute an admission on the part of as to the accuracy of the surveyor's findings or the conclusion drawn there from. The plan of correction does not constitute an admission on the part of the facility that the findings or that the scope and severity regarding any of the deficiencies cited are correctly applied. This plan should be considered as the facility's letter of credible allegation. Compliance and corrections were or will be considered completed on 6/14/25.	Completed on 6/14/25 and ongoing.
.F-550	The Facility will continue to ensure all residents are treated in a dignified manner by all staff members. 1. Resident #1, all current and future admitted residents will be treated with dignity by all staff members of the facility. 2. Resident #1 - A care plan meeting was held on **5/22/2025** with the resident, interdisciplinary team, and family/representative (if applicable) to review the resident's rights, support preferences, and clarify boundaries for behavioral expectations without infringing on resident rights. 3. A **facility-wide audit** of the last 60 days of progress notes, incident logs, and grievance records was conducted to identify any other **unreported or late-reported allegations of abuse**. This will be completed on or before 6/14/25. If any allegations of abuse are found, the Administrator will report to DHSS. 4. The Administrator in-serviced the Social Service Director on Resident Rights on 5/23/2025 5. All staff were in-serviced per the Administrator/Designee on resident rights, support preferences, and clarifying boundaries for behavioral expectations without infringing on resident rights on 5/23/25. This in-service also included: All allegations of abuse, neglect, or	Completed on 6/14/25 and ongoing.

	mistreatment must be reported immediately to the Administrator or designee. Any allegation involving abuse o resulting in injury must be reported to DHSS within two hours. Reporting is required even if the allegation appears unsubstantiated or questionable. 6. The **Administrator or DON** will **audit 100% of resident complaints and progress notes** weekly for four weeks to ensure proper identification and reporting of abuse allegations. 7. These audits will continue monthly for 3 months then quarterly. 8. Results will be discussed during QAPI meeting.	
F-609	The Facility will continue to ensure all allegations of abuse are reported to management immediately and within 2 hours to DHSS. 1. Resident #1, all current and future admitted residents will have any allegations of abuse reported to management immediately and reported to DHSS within 2 hours. 2. The Administrator in-serviced the SSD on reporting and documenting the reporting of any allegation of abuse immediately to the Administrator/designee and reporting to DHSS within 2 hours on 5/23/2025 3. All staff were in-serviced per Administrator/Designee on 5/23/25 the protocol of reporting an allegation of abuse. 4. The **Administrator or DON** will **audit 100% of resident complaints and progress notes** weekly for four weeks to ensure proper identification and reporting of abuse allegations. 5. These audits will continue monthly for 3 months then quarterly. 6. Results will be discussed during QAPI meeting.	Completed on 6/14/25 and ongoing.
F-610	The Facility will continue to ensure all allegations of abuse are investigated, documented and steps are taken to protect the resident during the investigation. 1. Resident #1, all current and future admitted residents will have a complete investigation of any allegation of abuse reported and will be provided protective oversight during investigation. 2. The Administrator/Designee in-serviced all staff on Abuse protocol investigating and reporting on 5/23/25. 3. The Director of Nursing or designee will audit all abuse allegations weekly for 3 months to ensure compliance with policy. 4. Any incomplete investigations will be addressed immediately with re-education and corrective	Completed on 6/14/25 and ongoing.

	action. 5. All findings will be discussed in QAPI meeting.	
A-8023 A-8030	Refer to F 609 and F 610 Refer to F 550	Completed on 6/14/25 and ongoing.