STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265431	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Lake Manor Inc	600 East 7th St Lowry City, MO 64763

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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 Survey Agency (Department of Health and Senior Services - DHSS) when staff failed to report an allegation of possible abuse made by one resident (Resident #1). The facility census was 71.Review of the facility's policy titled Abuse Investigation and Reporting, revised July 2017, showed the following:-All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and injuries of unknown source shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management;-All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source will be reported by the facility Administrator to the state licensing agency responsible for surveying the facility; the local ombudsman; the resident's representative; the resident's attending physician; and the facility medical director;-An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source) will be reported immediately, but not later than two hours for abuse or serious bodily injury and 24 hours if it does not involve abuse and had not resulted in serious injury.1.Review of Resident #1"s face sheet (admission data) showed the following:-admission date of 10/10/25;-Diagnoses included paranoid schizophrenia (a chronic mental health disorder characterized by significant disturbances in thought, perception, and behavior). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/16/25, showed the resident had moderate cognitive impairment, delusions, and verbal behavioral symptoms directed at others.Review of the resident's progress note dated 12/23/25, at 11:21 P.M., showed Licensed Practical Nurse (LPN) F documented the resident had been yelling and screaming since his/her return from the emergency room. Resident was heard yelling That N word, next door is putting his penis in my butthole. The man the resident referred to was unable to get up out of bed unassisted and was sleeping at the time. This nurse asked the resident what he/she was talking about, and he/she made a ring with his finger and thumb and moved his index finger of the other hand in and out of the ring and stated he is putting his penis in my butthole. This nurse explained to resident that it was impossible, and the facility did not tolerate racial slurs and name calling. Resident resting in bed at this time. (The LPN did not document notifications related to the allegation of possible abuse.) Review of DHSS records showed the facility did not report the allegation of possible abuse on 12/23/25. During an interview on 01/07/26, at 10:20 A.M., LPN F said the following:-Types of abuse would include mental, physical, isolation, and neglect;-Staff should report to the DON and Administrator immediately any allegation of abuse; -The facility should call the state immediately with an allegation of abuse;-The resident was heard yelling for help on 12/23/25;-He/she checked on the resident and he/she stated the n***** next door put his penis in my butthole;-He/she told the resident that the other resident was asleep in his/her bed;-LPN F thought the other resident was (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to walk, but was later informed that he/she was ambulatory;-LPN F did not think the other resident could do anything to Resident #1;-LPN F made a progress note about the incident and reported it to the oncoming nurse in report;-LPN F did not think the allegation should be reported due to the resident's diagnosis of paranoid schizophrenia and thought it was a hallucination;-LPN F did not notify the Administrator of the abuse allegation.During an interview on 01/07/26, at 8:45 A.M., Certified Nurse Assistant (CNA) D said the following:-Types of abuse would include neglect, isolation, or physical;-He/she would report any abuse to the charge nurse and Administrator immediately;-An allegation of abuse should be reported to the state within 24 hours.During an interview on 01/07/26, at 10:05 A.M., CNA E said the following:-Types of abuse would include verbal, physical, and sexual;-He/she would advise the nurse immediately of any abuse;-The state should be notified within two hours of any abuse allegations.During an interview on 01/07/26, at 5:00 A.M., Certified Medication Technician (CMT) A said the following:-Types of abuse would include physical, mental, financial, and sexual;-He/she would make sure the resident was safe if abuse was observed and report it to the charge nurse as soon as possible;-The facility should contact the state within two hours with an allegation of abuse.During an interview on 01/07/26, at 5:30 A.M., LPN B said the following:-Types of abuse would include neglect, physical, mental, and financial; -He/she would report abuse to the Director of Nursing (DON) and Administrator immediately;-The facility should contact the state within two hours with an allegation of abuse;-He/she was unaware of any resident-to-resident abuse reported by Resident #1;-He/she would report any allegation as soon as possible and make sure the residents were separated.During an interview on 01/07/26, at 8:10A.M. LPN C said the following:-Types of abuse would include neglect, physical, verbal, and mental; -He/she would report abuse to the administrator immediately;-The facility should contact the state within two hours with an allegation of abuse;-He/she heard about the incident of abuse reported by Resident #1 in report from another nurse;-He/she did not know if the incident had been reported to the Administrator;-The allegation should have been reported to the administrator, but he/she was unsure if it should be reported to the state.During an interview on 01/07/26, at 12:00 P.M., the Assistant Director of Nursing (ADON) said the following:-Types of abuse would include physical, sexual, and financial;-Staff should notify administration immediately;-State should be notified of an abuse allegation within two hours;-The resident's abuse allegation should be taken seriously;-The allegation from the resident should have been reported to the state and investigated. During an interview on 01/07/26, at 1:20 P.M., the Administrator said the following:-An allegation of abuse should be reported to the administrator or on-call staff as soon as possible;-The facility had two hours to report an abuse allegation to the state;-The resident's allegation should have been treated as possible abuse and reported to administration and the state.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to all allegations of abuse were investigated timely and steps taken to protect residents were documented when the facility did not complete a timely documented investigation with steps taken to protect the resident documented after an allegation of abuse was made by one resident (Resident #1). The facility had a census of 71.Review of the facility's policy titled Abuse Investigation and Reporting, revised July 2017, showed the following:-All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and injuries of unknown source shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management;-The Administrator will assign the investigation of an incident or suspected incident of resident abuse or injury of unknown source to an appropriate individual;-The individual conducting the investigation will, at a minimum, review the completed documentation forms; review the resident's medical record; interview the person reporting the incident; interview any witness to the incident; and interview the resident; interview the resident's physician as needed to determine the resident's current cognitive level and medical condition; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interview the resident's roommate, family, and visitors; interview other residents to whom the accused employee provides care for; and review all events leading up to the alleged incident;-Interviews will be conducted separately in private location;-Witness reports will be obtained in writing, signed, and dated.1.Review of Resident #1"s face sheet (admission data) showed the following:-admission date of 10/10/25;-Diagnoses included paranoid schizophrenia (a chronic mental health disorder characterized by significant disturbances in thought, perception, and behavior). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/16/25, showed the resident had moderate cognitive impairment, delusions, and verbal behavioral symptoms directed at others.Review of the resident's progress note dated 12/23/25, at 11:21 P.M., showed Licensed Practical Nurse (LPN) F documented the resident had been yelling and screaming since his/her return from the emergency room. Resident was heard yelling That N word, next door is putting his penis in my butthole. The resident referred to was unable to get up out of bed unassisted and was sleeping at the time. This nurse asked the resident what he/she was talking about, and he/she made a ring with his finger and thumb and moved his index finger of the other hand in and out of the ring and stated he is putting his penis in my butthole. This nurse explained to resident that it was impossible, and the facility did not tolerate racial slurs and name calling. Resident resting in bed at this time. (The LPN did not document any steps taken to begin an investigation or steps taken to protect the resident during an investigation.)Review of the resident's electronic medical record showed staff made no additional entries related to an assessment, notifications, or further information related to sexual abuse allegation.Review of the Department of Health and Senior Services (DHSS) records, on 01/02/26 showed the facility had not submitted an investigation of the incident completed by facility. During an interview on 01/07/25, at 10:20 A.M., LPN F said the following:-The resident was heard yelling for help on 12/23/25;-He/she checked on the resident and he/she stated the n***** next door put his penis in my butthole;-He/she told the resident that the other resident was asleep in his/her bed;-LPN F thought the other resident was unable to walk but was later informed that he/she was ambulatory;-LPN F did not think the other resident could do anything to Resident #1;-LPN F made a progress note about the incident and reported it to the oncoming nurse in report;-LPN F did not complete an assessment of the resident after allegation;-He/she would have moved the resident to a safer location and continued to monitor the resident if he/she thought it was a credible abuse (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation.During an interview on 01/07/26, at 12:00 P.M., the Assistant Director of Nursing (ADON) said he/she was involved in abuse investigations, and they should consist of staff and resident interviews. The Administrator was responsible for documenting an investigation. During interviews on 01/02/26, at 1:45 P.M. and 2:50 P.M., and on 01/07/26, at 1:20 P.M., the Administrator said the following:-He/she was unaware of the allegation of sexual abuse;-A resident assessment should have been completed after the allegation was made;-He/she would begin an investigation. -An abuse report should result in an investigation being started;-The nurse should complete an assessment of the resident, notify family, physician, and responsible party, and document all information in a progress note;-A resident should be monitored after an abuse report;-An abuse investigation would consist of staff and resident interviews and a review of the resident chart, including diagnosis and medications;-Investigation should be completed within five days of allegation.