STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265702	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Manor	200 Thompson Drive Troy, MO 63379

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure one resident (Resident #1), who resided on the dementia care unit, in a review of ten sampled residents, was free from verbal abuse when Certified Nurse Assistant (CNA) A used derogatory language including cursing at the resident, while providing personal care and assisting the resident. This incident was witnessed by CNA B and CNA C. The facility census was 97. The administrator was notified of the past noncompliance on 05/30/25, which occurred on 05/03/25. On 05/05/25, the administrator became aware of a staff to resident abuse allegation involving Resident #1. Upon discovery, the facility began an investigation and terminated the staff member. In-servicing of staff members had begun on the facility abuse policy, including the different forms of abuse, when to report abuse and who to report allegations of abuse to. This deficiency was corrected on 05/05/25. Review of the facility's policy, Abuse Prohibition, dated November 2016, showed the following: -It is the purpose of this facility to prohibit mistreatment and abuse. To assist the facility staff members in recognizing incident of abuse, the following definitions of abuse are provided. -Abuse is the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, and mental abuse; -Verbal abuse is defined as any use of oral, written or body language that includes disparaging or derogatory terms to a resident or their families, or within their hearing-distance, regardless of their age, ability to comprehend or disability. 1. Review of Resident #1's undated face sheet showed diagnoses included schizophrenia (a serious mental health condition that affects how people think, feel and behave) and unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a type of dementia-a progressive decline in cognitive function, including memory, thinking, and reasoning, severe enough to affect a person's daily life-where the specific cause is unknown or unspecified). Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 04/09/25, showed the following: -Hearing: moderate difficulty; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Sometimes understands; -The resident was rarely understood; -No behaviors or rejection of cares; -Dependent on staff for personal hygiene; -Substantial to maximal assistance for mobility. Review of the resident's care plan, dated 04/30/24, showed the following: -Problem: behavioral symptoms; -Approach: maintain a calm, slow, understandable approach with the resident; -Activities of Daily Living (ADLs): resident is a stand-by assist (SBA) by one person for transfers, toileting, and personal hygiene. - The care plan included no information the resident rejected cares other than the resident would refuse medications at times. 2. Review of an undated facility investigation showed the administrator documented the following: -Investigation for incident on 05/03/25 at 4:00 P.M.; -Two CNAs reported CNA A had sworn at Resident #1 while attempting to provide care to the resident; -When asked to come in (to the facility) and give a statement, CNA A said yes, he/she had sworn, but not at Resident #1 directly, but as a response to being attacked by the resident; -CNA A's actions were unacceptable and he/she was terminated from the facility. 3. During an interview on 05/14/25 at 10:20 A.M., CNA B said the following: -He/She worked on the dementia unit on the evening of 05/03/25; -He/She attempted to redirect another resident out of Resident #1's room when he/she saw CNA A trying to change Resident #1's incontinence brief while Resident #1 lay in bed; -Resident #1 yelled at CNA A and said No, leave me alone!; -CNA A said Son of a mmmmm; -He/She (CNA B) directed the unnamed resident out of Resident #1's room when he/she heard CNA A say, You fucking bitch to Resident #1; -CNA A left Resident #1's room and said Resident #1 ripped his/her glasses off, scratched CNA A, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and bit his/her shoulder; CNA A then left the unit; -He/She (CNA B) went back into Resident #1's room and the resident was on the floor by his/her bed but did not appear hurt; -He/She stayed with the resident until CNA A and CNA C returned; -He/She (CNA B) left the dementia unit to get the charge nurse (Registered Nurse (RN) D); -He/She told RN D that Resident #1 bit and scratched CNA A, and the resident was on the floor by his/her bed; -He/She told RN D that CNA A had cussed at Resident #1 when RN D asked what had happened; -He/She had never seen the resident be aggressive like that before with staff. Review of a facility statement, dated 05/03/25, showed CNA B wrote the following: -CNA A went into Resident #1's room to change the resident's brief and was rough (talking loudly and harshly) with Resident #1; Resident #1 was a little combative; -CNA A continued to be rough with Resident #1 as CNA B tried to help another resident out of Resident #1's room; -When he/she walked out of Resident #1's room, he/she heard CNA A call Resident #1 a fucking bitch and Resident #1 was yelling; -CNA A came out of Resident #1's room and said the resident bit him/her; -CNA A left the unit but then returned with CNA C; -The resident was on the floor when he/she went back into the room; -CNA A called the resident a fucking bitch more than once. During an interview on 05/13/25 at 3:50 P.M., CNA C said the following: -Resident #1 would yell Mom sometimes or get loud when staff changed him/her, but the resident had never bitten or yelled at a staff person before that he/she was aware of; -He/She worked on another hall on the evening of 05/03/25 when he/she saw CNA A sitting across from the nurses' station; -CNA A said he/she needed help with Resident #1 because the resident scratched and bit him/her when CNA A was trying to change the resident's brief; -He/She went with CNA A to Resident #1's room where the resident was on the floor by his/her bed; -When the resident saw CNA A, the resident said, You're a monster and CNA A hurt him/her and to not (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	touch him/her; -CNA A said to the resident, You're a fucking witch, and kept repeating this; -He/She would consider CNA A's behavior (yelling and cursing at Resident #1) as verbal abuse. Review of a facility statement, dated 05/03/25, showed CNA C wrote the following: -CNA A said he/she was scratched and bitten by Resident #1 and CNA A needed help; -He/She went with CNA A back to Resident #1's room and he/she saw the resident on the floor and CNA B was with the resident; -While he/she told CNA B to go get the charge nurse, CNA A called Resident #1 a fucking witch multiple times. During an interview on 05/13/25 at 3:05 P.M. and 05/14/25 at 10:00 A.M., the Director of Nurses (DON) said the following: -She was made aware that CNA A yelled and cussed at Resident #1 on the evening of 05/03/25 by the administrator, following her return from vacation on or about 5/5/25; -CNA A was terminated by telephone on 05/05/25, for reported cursing at the resident; -CNA A had had many inservices on A/N; -CNA A usually worked the dementia unit; -Yelling and cursing at a resident was a form of abuse; -Resident #1 did not typically have any behaviors, but he/she would shake his/her head no if he/she wanted to be left alone. During an interview on 05/13/25 at 5:20 P.M., the Administrator said the following: -He found a written statement from CNA B and CNA C under his door the morning of 05/05/25; -He began an investigation on the morning of 05/05/25; -Both CNA B and CNA C said they heard CNA A curse at Resident #1; -CNA A should have stepped away when the resident became agitated; -CNA A had been counseled in the past about speaking gruffly to others; some residents and staff had complained before; -Yelling and cursing at a resident was considered a form of abuse. MO00253797

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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 interview and record review, the facility failed to report a staff to resident allegation of verbal abuse to the State Agency per regulation and facility policy for one resident (Resident #1), who resided on the dementia care unit, in a review of ten sampled residents. Certified Nurse Assistant (CNA) B and CNA C witnessed CNA A yell and use demeaning and derogatory language, including cursing directed at the resident, while providing care. CNA B and CNA C left written statements under the administrator and Director of Nurses (DON) office door on 05/03/25, but did not report the abuse to the registered nurse (RN) D on duty. The administrator did not find the written statements until two days later, at which time it was reported to the State Agency, at least 40 hours following the occurrence of the alleged event. The facility census was 97. The administrator was notified of the past noncompliance on 05/30/25, which occurred on 05/03/25. On 05/05/25, the administrator became aware of a staff to resident abuse allegation involving Resident #1. Upon discovery, the facility began an investigation and terminated the staff member. In-servicing of staff members had begun on the facility abuse policy, including the different forms of abuse, when to report abuse and who to report allegations of abuse to. This deficiency was corrected on 05/05/25. Review of the facility's policy, Abuse Prohibition, dated November 2016, showed the following: -It is the purpose of this facility to prohibit abuse of any resident. To assist the facility staff members in recognizing incident of abuse, the following definitions of abuse are provided. -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish; -Verbal abuse is defined as any use of oral, written or body language that includes disparaging or derogatory terms to a resident or their families, or within their hearing-distance, to describe residents, regardless of their age, ability to comprehend or disability. A review of the facility document, Guidelines for Facility Self-Reporting, dated November 28, 2016, showed the following: -It is the policy of this facility that abuse allegations are reported per Federal and State law. The facility will ensure that all alleged violations involving abuse 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 bodily injury; -Employees must always report any abuse or suspicion of abuse immediately to the administrator, if the administrator is not there, report to the Director of Nurses or the immediate supervisor and they will report to the administrator; -The administrator will involve key leadership personnel as necessary to assist with reporting, investigation and follow-up; -Initial reporting of allegations: If an incident or allegation is considered reportable, the administrator or designee will make an initial (immediate-within 2 hours for allegations of abuse or an (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident which results in serious bodily injury) to the State Agency. A follow-up investigation will be submitted to the State Agency within five (5) working days. 1. Review of Resident #1's undated face sheet showed diagnoses included schizophrenia (a serious mental health condition that affects how people think, feel and behave) and unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a type of dementia-a progressive decline in cognitive function, including memory, thinking, and reasoning, severe enough to affect a person's daily life-where the specific cause is unknown or unspecified). Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 04/09/25, showed the following: -Hearing: moderate difficulty; -Sometimes understood; -The resident was rarely understood; -No behaviors or rejection of cares; -Dependent on staff for personal hygiene; -Substantial to maximal assistance for mobility. Review of the undated facility investigation showed the administrator documented the following: -Investigation for incident on 05/03/35 at 4:00 P.M.; -Two CNAs reported that CNA A had sworn at Resident #1 while attempting to provide care to the resident; -CNA A said yes, he/she had sworn, but not at Resident #1 directly, but as a response to being attacked by the resident; -CNA A's actions were unacceptable, and he/she was terminated from the facility. During an interview on 05/14/25 at 10:20 A.M., CNA B said the following: -He/She worked on the dementia unit on the evening of 05/03/25; -He/She attempted to redirect another resident out of Resident #1's room when he/she saw CNA A trying to change Resident #1's (incontinence) brief while Resident #1 lay in bed; -Resident #1 yelled at CNA A and said No, leave me alone!; -CNA A said Son of a mmmmm; -He/She directed the unnamed resident out of Resident #1's room when he/she heard CNA A say, You (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fucking bitch to Resident #1; -CNA A left the dementia unit; -He/She (CNA B) went back into Resident #1's room and the resident was on the floor by his/her bed; -He/She stayed with the resident until CNA A and CNA C returned; -He/She (CNA B) left the dementia unit to get the charge nurse, Registered Nurse (RN) D; -He/She told RN D that CNA A had cussed at Resident #1 when RN D asked what had happened; -He/She (CNA B) completed a written statement on a facility form that CNA C gave him/her, then gave the paper back to CNA C; -He/She did not speak with RN D anymore that shift. Review of a facility statement, dated 05/03/25, showed CNA B documented the following: -CNA A went into Resident #1's room to change the resident's (incontinence) brief and was rough (talking loudly and harshly) with Resident #1; -CNA A continued to be rough with Resident #1 as he/she (CNA B) tried to help another resident out of Resident#1's room; -When CNA B walked out of Resident #1's room, he/she heard CNA A call Resident #1 a fucking bitch and Resident #1 was yelling; -CNA A left the unit but then returned with CNA C; -The resident was on the floor when he/she went back into the room; -CNA A called the resident a fucking bitch more than once; -Review of CNA B's written facility statement did not show that he/she reported to RN D that he/she (CNA B) heard CNA A yell and curse at Resident #1. During an interview on 05/13/25 at 3:50 P.M., CNA C said the following: -He/She worked on another hall on the evening of 05/03/25 when he/she saw CNA A sitting across from the nurses' station; -CNA A said he/she needed help with Resident #1 because the resident scratched and bit him/her when CNA A was trying to change the resident's (incontinence) brief; -He/She went with CNA A to Resident #1's room where they found the resident on the floor by his/her bed; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When the resident saw CNA A, the resident said, You're a monster and that CNA A hurt him/her and to not touch him/her; -CNA A told the resident, You're a fucking witch, and kept repeating it; -He/She started to write out a statement about what had happened on a plain piece of paper; -Licensed Practical Nurse (LPN) E came on duty and gave CNA C a facility statement paper to use instead of a piece of plain paper; -He/She completed the written statement and left it under the administrator and Director of Nursing's (DON's) office doors; -He/She did not tell RN D that CNA A had yelled and cursed at Resident #1; -Yelling and/or cursing at a resident was a form of abuse and should be reported to the charge nurse right away. Review of a facility statement, dated 05/03/25, showed CNA C documented the following: -He/She (CNA C) went with CNA A back to Resident #1's room and he/she saw the resident on the floor, and CNA B was with the resident; -While he/she told CNA B to go get the charge nurse, CNA A called Resident #1 a fucking witch multiple times; -Resident #1 called CNA A a monster and did not want anyone touching him/her; -Review of CNA C's written facility statement did not show that he/she reported to RN D that he/she (CNA C) heard CNA A yell and curse at Resident #1. During an interview on 05/14/25 at 11:32 A.M., LPN E said the following: -He/She worked the evening shift on 05/03/25; -RN D did not tell him/her about any alleged verbal abuse of Resident #1 by CNA A during shift report; -CNA C asked him/her for two facility statement forms, but did not tell him/her why he/she (CNA C) wanted it; -He/She gave CNA C two facility statement forms and did not ask CNA C why he/she wanted them because he/she didn't think it was his/her business; -He/She was not aware that CNA A had yelled and cursed at Resident #1 until a couple of days later when he/she heard that CNA A had been terminated; -Yelling and cursing at a resident was a form of abuse; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Any abuse or neglect allegation should be reported to administration immediately. During an interview on 05/13/25 at 3:05 P.M., and 05/14/25 at 10:00 A.M., the DON said the following: -She was unaware that CNA A yelled and cussed at Resident #1 on the evening of 05/03/25 until the administrator made her aware following her return from vacation on or about 05/05/25; -She was not sure why RN D did not report this event to administration when it occurred (if CNA B had reported the allegation to him/her); there was always an on-call weekend nursing manager available; -She would expect facility staff to report any allegation of abuse or neglect immediately so administration could start an investigation; -Yelling and cursing at a resident was a form of abuse; -CNA A completed his/her shift after the event with Resident #1 occurred, and then returned for his/her next shift the following day, where he/she worked on the dementia unit again and had continued contact with Resident #1; -If administration had been made aware of the allegations of verbal abuse by CNA A towards Resident #1, he/she (CNA A) would have been suspended and an investigation started. During an interview on 05/13/25 at 5:20 P.M. and 05/29/25 at 11:15 A.M., the Administrator said the following: -He was not made aware that CNA A had yelled or cursed at Resident #1 on 05/03/25; he was only made aware after he had come to work on the morning of 05/05/25 and found a written statement from CNA B and CNA C under his door; -Written statements by both CNA B and CNA C said they heard CNA A curse at Resident #1 but did not show that they reported it to RN D when it occurred; -CNA B and CNA C failed to report the incident to the administrative staff; -He expected all facility staff to report allegations of abuse immediately to the administrative staff; -He was not sure why CNA B and CNA C did not tell RN D that CNA A yelled and cursed at Resident #1; -A written statement about an alleged abuse event, placed under his office door, was not an acceptable means of reporting an abuse allegation; -RN D was the charge nurse on 05/03/25 and RN D told him that he/she was not aware that CNA A had yelled or cursed at Resident #1 on the evening of 05/03/25; -If RN D was aware that CNA A yelled and cursed at Resident #1, he/she (RN D) should have removed (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA A from his/her duties and reported the event immediately to administration. MO00253797

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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 conduct a timely and thorough investigation of reported abuse for one resident (Resident #1), who resided on the dementia care unit, in a review of ten sampled residents, when certified nurse assistants (CNA) B and CNA C witnessed CNA A use demeaning and derogatory language including cursing directed at the resident while providing personal care. CNA B and CNA C left written statements under the administrator and Director of Nurses (DON's) door on 05/03/25. The administrator did not find the written statements until two days later. CNA A continued to work on the dementia unit with Resident #1 for the remainder of his/her shift on 05/03/25 and worked on 05/04/25 where CNA A had continued contact with Resident #1 and other residents on the dementia unit. The administrator did not conduct a thorough investigation, per facility policy, when he did not interview all involved staff, did not interview or obtain a statement from Resident #1, or interview three to four residents who received care from the alleged staff per facility policy. The facility census was 97. Review of the facility's policy, Abuse Prohibition, dated November 2016, showed the following: -It is the purpose of this facility to prohibit mistreatment, abuse, of any resident. To assist the facility staff members in recognizing incident of abuse, the following definitions of abuse are provided; -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, and mental abuse; -Verbal abuse is defined as any use of oral, written or body language that includes disparaging or derogatory terms to a resident or their families, or within their hearing-distance, to describe residents, regardless of their age, ability to comprehend or disability. Review of the facility's policy, Abuse Investigation, undated, showed the following: -It is the policy of this facility that reports of abuse are promptly and thoroughly investigated; -The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration; -When an incident or suspected incident of abuse is reported, the administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: -Who was involved; -Residents' statements; -For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings; -Resident's roommate statements (if applicable); (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interviews obtained from three to four residents who received care from the alleged staff; -Interviews obtained from three to four different department staff, (if applicable); -Involved staff and witness statements of events; -A description of the resident's behavior and environment at the time of the incident; -Injuries present including a resident assessment; -Observation of resident and staff behaviors during the investigation; -Environmental considerations. 1. Review of Resident #1's undated face sheet showed the resident with diagnoses including schizophrenia (a serious mental health condition that affects how people think, feel and behave) and unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a type of dementia-a progressive decline in cognitive function, including memory, thinking, and reasoning, severe enough to affect a person's daily life-where the specific cause is unknown or unspecified). Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 04/09/25, showed the following: -Hearing: moderate difficulty; -Sometimes understands; -The resident was rarely understood; -No behaviors or rejection of cares; -Dependent on staff for personal hygiene; -Substantial to maximal assistance for mobility. 2. Review of an undated facility investigation showed the administrator documented the following: -Investigation for incident on 05/03/35 at 4:00 P.M.; -Two CNAs reported that CNA A had sworn at Resident #1 while attempting to provide care to the resident; -CNA A's actions were unacceptable, and he/she was terminated from the facility. 3. During an interview on 05/14/25 at 10:20 A.M., CNA B said the following: -He/She worked on the dementia unit on the evening of 05/03/25; (continued on next page)

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	265702	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Manor	200 Thompson Drive Troy, MO 63379

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She attempted to redirect another resident out of Resident #1's room when he/she saw CNA A trying to change Resident #1's (incontinence) brief while Resident #1 lay in bed; -Resident #1 yelled at CNA A and said No, leave me alone!; -CNA A said Son of a mmmmm; -He/She directed the unnamed resident out of Resident #1's room when he/she heard CNA A say, You fucking bitch to Resident #1; -CNA A left Resident #1's room and told him/her (CNA B) that Resident #1 ripped his/her glasses off, scratched CNA A, and bit CNA A's shoulder; -CNA A left the dementia unit; -He/She (CNA B) went back into Resident #1's room and the resident was on the floor by his/her bed but did not appear hurt; -He/She stayed with the resident until CNA A and CNA C returned; -CNA A continued to work that shift and care for Resident #1; -He/She (CNA B) completed a written statement on a facility form that CNA C gave him/her, then gave the paper back to CNA C. Review of a facility statement, dated 05/03/25, showed CNA B documented the following: -CNA A went into Resident #1's room to change the resident's (incontinence) brief and was rough (talking loudly and harshly) with Resident #1; -CNA A continued to be rough with Resident #1 as he/she (CNA B) tried to help another resident out of Resident #1's room; -When CNA B walked out of Resident #1's room, he/she heard CNA A call Resident #1 a fucking bitch and Resident #1 was yelling; -CNA A left the unit but then returned with CNA C; -The resident was on the floor when he/she went back into the room; -CNA A called the resident a fucking bitch more than once. During an interview on 05/13/25 at 3:50 P.M., CNA C said the following: -He/She worked on another hall on the evening of 05/03/25 when he/she saw CNA A sitting across from the nurses' station; -CNA A said he/she needed help with Resident #1 because the resident scratched and bit him/her when CNA A was trying to change the resident's (incontinence) brief; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She went with CNA A to Resident #1's room where they found the resident on the floor by his/her bed; -When the resident saw CNA A, the resident said, You're a monster and the resident said that CNA A hurt him/her and to not touch him/her; -CNA A told the resident, You're a fucking witch, and kept repeating it; -He/She (CNA C) put a gait belt on the resident and both he/she and CNA A assisted the resident back to bed; -CNA A proceeded to change Resident #1's (incontinence) brief; -CNA A continued to work on the dementia unit that night; -He/She started to write out a statement about what had happened on a plain piece of paper; -Licensed Practical Nurse (LPN) E came on duty and gave CNA C a facility statement paper to use instead of a piece of plain paper; -He/She completed the written statement and slipped it under the administrator and DON's door; -He/She thought CNA A also worked on the dementia unit the next day. Review of a facility statement, dated 05/03/25, showed CNA C documented the following: -CNA A said he/she was scratched and bitten by Resident #1 and CNA A needed help; -He/She (CNA C) went with CNA A back to Resident #1's room and he/she saw the resident lying on the floor, and CNA B was with the resident; -While he/she told CNA B to go get the charge nurse, CNA A called Resident #1 a fucking witch multiple times; -Resident #1 called CNA A a monster and did not want anyone touching him/her. Review of the facility electronic timecard for CNA A, dated 05/01/25 through 05/15/25, showed the following: -On 05/03/25, CNA A clocked in at 02:00 P.M., and clocked out at 09:00 P.M.; -On 05/03/25, CNA A clocked in at 09:30 P.M., and clocked out at 06:54 A.M. on 05/04/25; -On 05/04/25, (the day after the alleged abuse), CNA A clocked in at 02:00 P.M., and clocked out at 09:00 P.M.; -On 05/04/25, CNA A clocked in at 09:30 P.M. and clocked out at 06:43 A.M. on 05/05/25. During an interview on 05/28/25 at 10:23 A.M., CNA A said the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She went to Resident #1's room around 3:00 P.M. on 05/03/25 and the resident lay in bed; -He/She told Resident #1 it was time for a shower and the resident said No, so he/she (CNA A) left the room; -He/She went back into Resident #1's room around 4:30 P.M. to assist the resident up for supper; -Resident #1 required one to two staff for transfers; -The resident allowed him/her to assist him/her up out of bed and he/she (CNA A) began to transfer Resident #1 across the floor when the resident bit down on his/her (CNA A's) left shoulder and scratched his/her face with his/her fingernails, knocking his/her glasses off and onto the floor; -No other staff or residents were present in Resident #1's room when this incident occurred; -He/She lowered Resident #1 to the floor since he/she was combative, to provide for the resident's safety; -He/She left Resident #1's room and told CNA B (who was in the hallway) to stay with Resident #1 because he/she had to lower the resident to the floor; -He/She left the dementia unit and went to another hall of the facility to get the charge nurse (RN D); -He/She, RN D and CNA C went back to the dementia unit; -CNA C used a gait belt and transferred Resident #1 back to bed; -He/She and CNA C assisted the resident to reposition in bed, and he/she changed the resident's (incontinence) brief; -CNA C left the resident's room; -He/She served Resident #1 supper in the resident's room and continued working on the dementia unit; -He/She went to Resident #1's room around 8:30 P.M. on 05/03/25 because the resident still needed a shower; -He/She had CNA B accompany him/her to the resident's room, because he/she was not sure if Resident #1 would become combative again; -He/She assisted Resident #1 to get up on the morning of 05/04/25 without the help of CNA B; -He/She returned for another 16-hour shift on the dementia unit at 02:00 P.M. on 05/04/25 and continued to care for Resident #1 and other residents; -He/She clocked out on the morning of 05/05/25 around 06:00 A.M. and left the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/25 at 11:32 A.M., LPN E said the following: -He/She worked the evening shift on 05/03/25; -CNA C asked him/her for two facility statement forms, but did not tell him/her why he/she wanted them; -He/She gave CNA C two facility statement forms and did not ask CNA C why he/she wanted them because he/she didn't think it was his/her business; if CNA C wanted him/her to know something had happened, CNA C would have told him/her; -CNA A continued to work his/her shift on the dementia unit on 05/03/25 and returned for his/her next shift on the dementia unit on 05/04/25; -He/She was not aware that CNA A had yelled and cursed at Resident #1 until a couple of days later when he/she heard that CNA A had been terminated; -Yelling and cursing at a resident was a form of abuse; During an interview on 05/13/25 at 3:05 P.M. and 05/14/25 at 10:00 A.M., the Director of Nurses (DON) said the following: -She was unaware that CNA A yelled and cussed at Resident #1 on the evening of 05/03/25 until the administrator made her aware following her return from vacation on or about 05/05/25; -She thought CNA A was terminated by telephone on 05/05/25 by the administrator; -When she was made aware of this event, she reviewed what employees had been in-serviced on abuse and neglect, but could not say for sure that every employee had been in serviced immediately following the incident; -CNA A usually worked the dementia unit but had worked on the other facility halls in the past; -Yelling and cursing at a resident was a form of abuse; -If administration had been made aware of the report that CNA A had yelled and cussed at Resident #1, CNA A would have been immediately sent home and an investigation started; -CNA A completed his/her shift after the event with Resident #1 occurred, and then returned for his/her next shift the following day, where he/she worked on the dementia unit again and had contact with Resident #1; -Administration (to include the administrator or his designee, the DON, or the on-call weekend nursing manager) were responsible for abuse investigations; -Investigation of abuse would include interviews and written statements from the resident(s) and staff involved or who may have witnessed the incident, interviews with other residents that may have had contact with the staff accused of abuse, and an assessment of the resident(s) involved; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An employee accused of resident abuse would immediately be suspended pending an investigation of the alleged abuse; -A resident who may have been abused would be assessed for any physical or mental changes immediately with follow-up assessments completed as necessary to make sure the resident was at or returned to his/her baseline. During an interview on 05/13/25 at 5:20 P.M., the Administrator said the following: -He was not made aware that CNA A had yelled or cursed at Resident #1 on 05/03/25 until he came to work on the morning of 05/05/25 and found a written statement from CNA B and CNA C under his door; -He began an investigation on 05/05/25; RN D was the charge nurse on 05/03/25 and RN D told him that he/she was not aware that CNA A had yelled or cursed at Resident #1 on the evening of 05/03/25; -Both CNA B and CNA C said (based on written statement provided under his door) they heard CNA A curse at Resident #1; -CNA A had worked on other halls in the facility, but for the past several months, had primarily worked on the dementia unit; -He spoke with CNA A for the first time about the event on the morning of 05/05/25; -CNA A had been counseled in the past about speaking gruffly to others; some residents and staff had complained before; -CNA A completed his/her shift the night that he/she yelled and cursed at Resident #1 and returned the following day to work another shift on the dementia unit where Resident #1 resided; -Yelling and cursing at a resident was considered abuse; -He expected all facility staff to report allegations of abuse or neglect immediately if they occur so an investigation could be started; -He did not speak with CNA B or CNA C after he reviewed their written statements; -He did not interview LPN E; (facility policy directs all involved staff were to be interviewed); -He did not attempt to interview Resident #1 or any of the residents on the dementia unit where the incident took place; (facility policy directs a statement from the resident as well as interview should be obtained if possible); -He did not interview any other residents or staff on the other halls of the facility, even though CNA A had worked in some of those areas in the past; (facility policy directs interviews should be obtained from three to four residents who received care from the alleged staff); -He started an in-service on abuse and neglect for the day and evening shifts on 05/05/25, after he was made aware of the verbal abuse allegations, but he did not offer an in-service to the incoming night shift; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He was not sure what his plan was to in-service the night shift employees on abuse and neglect; -Some employees had still not been in-serviced since this abuse allegation occurred; -The DON had been on vacation and he relied on her to help with investigations, so there were likely some things missed. MO00253797