STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll House	307 Grand Carrollton, MO 64633

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect the rights of a resident's ability to make confidential phone calls to the state abuse and neglect hotline for three of the three sampled residents, Residents #16, #109, and #18, when the facility's provided phones would not allow any outgoing call to dial the Missouri abuse and neglect hotline number. This had the potential to impact all residents of the facility who wished to make a phone call to the Missouri abuse and neglect hotline. The facility census was 56. Review of the facility's policy titled, Residents Rights, undated, showed:-Residents have the right to exercise their rights. Encouragement and assistance is provided for the exercise of the resident's right as a resident and as a citizen. Residents may voice grievances and recommend changes to facility staff or to outside representatives free from restraint, interference, coercion, discrimination or reprisal.-Residents have the right to confidentiality. All information related to a resident's medical, personal, social, or financial affairs shall be treated confidentially;-The right to privacy in medical treatment, personal care, telephone and mail communications, visits and meetings of family and of resident groups. Residents should be treated with consideration and respect, with full recognition of their dignity and individuality;-The right to communicate freely, that residents may associate with and communicate privately with persons of their choice and send and receive mail unopened.1. Review of Resident #16's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/10/25 showed:-Cognition intact;-Independent with activities of daily living;-Diagnoses: high blood pressure and psychiatric mood disorder. During an observation of Resident #16 on 6/30/25 at 10:00 A.M., showed the facility phone would not reach the hotline, it would drop the call after a partial ring. During an interview on 6/30/25 at 10:00 A.M., the resident said:-He/she was not able to call the toll free abuse and neglect hotline phone number;-He/she was not allowed by the facility to use his/her personal phone due to guardian restricting resident from having a personal cell phone;-He/she was not allowed by the facility to access the internet on his/her personal devices for one month;-He/she would need to borrow another resident's personal phone to call the hotline, as all the facility phones will not go through to the state hotline phone number;-This upsets him/her and would like to be able to make a phone call, if needed. 2. Review of Resident #18's Quarterly MDS, dated [DATE] showed: -No cognitive impairment;-The resident had delusions;-The resident received antipsychotics (a class of medications primarily used to treat mental health disorders) daily;-Diagnoses included, schizophrenia, bipolar disorder, anxiety, and depression. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's care plan, dated 05/29/25, showed:-The resident was at risk for falls;-The resident had behaviors;-Maintain a safe environment. During an observation of Resident #18 on 6/30/25 at 2:56 P.M., showed the facility phone would not reach the hotline, it would drop the call after a partial ring. During an interview with Resident #18 on 6/30/25 at 2:56 P.M., said:-He/she was not able to make phone calls to the state hotline as the calls seem to be blocked or cut off when he/she calls it; -He/she would have to ask to use another resident's personal phone in order to reach the hotline;-He/she reported the concern to staff, but nothing was done to fix the issue, was unsure of the date; -He/She felt angry when he/she could not call the hotline the night his/her knee was broken. During an interview with Resident #18 on 07/01/25 at 09:28 A.M., the resident said:-The facility blocked the state hot line on the resident's phone;-When the number was called it rang once and then nothing happened;-He/She tried the number four or five times and it did not work;-He/she tried to call on the resident's phone and the phone at the nurses desk and none of them worked;-There was a code used to dial long distance and he/she used that and it still did not work;-He/She wanted to call the state hotline the night his/her knee got broke, but he/she could not because the number did not work;-He/She felt angry when he/she could not call the hotline the night his/her knee was broken. 3. Review of Resident #109's Care plan, dated 6/24/25, showed:-Post traumatic stress disorder;-Cognition intact, but has attention deficit;-Psychiatric disorder;-Goal was for resident to not harm self or others. During an observation of Resident #109 on 6/30/25 at 1:15 P.M., showed the facility phone would not reach the hotline, it would drop the call after a partial ring. During an interview on 6/30/25 at 1:15 P.M., the resident said:-He/she is not able to use the facility phones to call out for help; -When he/she tried to call the abuse and neglect line, the facility phone would not work - Not being able to make calls to the hotline frustrates him/her and makes him/her feel helpless. -He/She told Certified Medication Technician (CMT) A about the phone not working but nothing had been done; -He/She had a right to call the state anytime he/she would like. 4. Observation of the Administrator on 6/30/25 at 1:00 P.M., showed:-The administrator attempted to call the hotline from his/her office unsuccessfully;-The administrator attempted to call the hotline from the all three of the residents (Resident #16, #109, and #18) phones unsuccessfully;-The administrator attempted to call the hotline from his/her personal cell phone and the call was successful;-The administrator attempted to make a call using the code prefix on the residents (Resident #16, #109, and #18) phone calls unsuccessfully;-The administrator had other staff try making a call to the hotline number from the resident's three phones and they were all three unsuccessful.Observation on 07/01/25 at 2:57 P.M., this surveyor tested the facility hand-held phone and the two desk phones that residents are allowed to use. All three phones did not successfully call the abuse and neglect hotline number.Observation on 07/01/25 at 2:59 P.M., this surveyor tested the hotline number using a personal cell phone and the call to the abuse hotline went through.Observation on 07/02/25 at 10:02 A.M., this surveyor tested the facility handheld phone and the two desk phones that residents are allowed to use. None of the calls went through to the abuse hotline.Observation on 07/03/25 at 9:00 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A.M., this surveyor tested the facility handheld phone and the two desk phones that residents are allowed to use. None of the calls went through to the abuse hotline.Observation on 07/03/25 at 9:05 A.M., this surveyor tested the hotline number using a personal cell phone and the call to the abuse hotline went through. Observation on 07/03/25 at 10:35 A.M., showed the administrator dialed the state abuse hotline phone number on the phones at the nurse's desk and the number could not be reached. During an interview on 6/30/25 at 1:00 P.M., the Administrator said he/she attempted to dial the hotline from his/her office and the call dropped after one partial ring. The Administrator said that all residents can ask the nurses to use the desk phones and then they can dial the hotline number. He/She attempted to dial out from the two desk phones that residents can use and the resident's land line for public use and the call to the hotline dropped after one ring. The Administrator then attempted to call the same phone number with his/her own personal phone and the call went through. He/she said that there is a code used for long distance calls, but not needed for 1-800 numbers. The Administrator said the residents should be allowed to make and receive calls in private. During an interview on 6/30/25 at 3:00 P.M., the Assistant Director of Nursing (ADON) dialed the abuse and neglect hotline phone number from his/her office and received one partial unanswered ring and then a dead phone line. The ADON said that he/she had not needed to try dialing the hotline before but did not understand how it was not working in the building. She said there is a code to enter before long distance calls are made however the code is not working with the state hotline phone number. She then attempted to call a different number using the code, the phone number for Emergency Service calls and did not get through successfully either. The ADON Attempted to call the emergency phone service without using the code and it did not go through, and the call dropped. During an interview on 6/30/25 at 3:15 P.M., the Director of Nursing (DON) tried to dial the abuse and neglect hotline from his/her office and received one partial unanswered ring and then a dead phone line. He/she said that this phone line is confusing. He/she stated residents should be able to make and receive calls in private when needed. During an interview on 07/03/25 at 11:05 A.M., CMT A said:-Resident #109 told him/her the abuse hotline was not working, and was not sure how long it had been like this; -CMT A did not tell anyone;-CMT A thought the Director of Nursing (DON) and the Administrator already were aware of the phone not working;-He/She should have told the administrator immediately.During an interview on 07/03/25 at 11:18 A.M., the Administrator said:-She was just made aware the abuse hotline was not able to be accessed from the facility phones;-She expected staff to tell her immediately if the abuse hotline was not working;-The resident's should have easy access to the abuse hotline at anytime. During an interview on 7/03/25 at 11:30 A.M., the Administrator and the DON said residents have the right to call the abuse hotline from a facility phone and it should be a successful call. They did not believe that they should have to borrow a phone from another resident to place the call. The Administrator was not sure how long this had been going on. MO256236

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect two resident's (Resident #18 and Resident #7) right to be free from physical abuse. On 6/15/25 LPN A followed Resident #18 into an unoccupied resident room rolled him/her out of the bed onto the floor multiple times and LPN A walked the resident backwards which resulted in the resident falling and sustaining a fracture of the right tibial plateau (a break in the top portion of the shinbone near the knee joint, that often occurs due to high-energy impacts such as falls). The resident was sent to the local hospital and transferred to another hospital for surgical evaluation. In addition, staff failed to protect Resident #7's right to be free from abuse when Resident #27 hit him/her on the back of the head. The facility census was 56. The Administrator was notified on 7/11/2025 at 2:30P.M. of an Immediate Jeopardy (IJ) which began on 6/15/2025. The IJ was removed on 7/14/2025 as confirmed by surveyor onsite verification. Review of the facility's undated Abuse and Neglect policy showed:- Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental, or physical condition cause harm, pain or mental anguish. - Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. - Convivence is defined as the result of any action that has the effect of altering a residents behavior. that is not in the residents best interest. - Manual method means to hold or limit a residents voluntarily movement by using body contact as a method of physical restraint. - Mistreatment means inappropriate treatment of a resident. - Each resident has the right to be free from abuse, neglect and corporal punishment of any type by anyone. -The resident has the right to be free from abuse including freedom from involuntarily seclusion and physical or chemical restraint not required to treat the residents medical symptoms. Review of the facility's undated Resident Rights policy showed:-Residents have the right to be free from all abuse;-Residents shall not be subjected to physical, sexual, or emotional injury or harm.-Residents have a right to care which maintains or enhances the quality of life.Review of the facility's Person-Centered Interventions Behavior Management Program, dated 2022, includes:- When addressing a resident in crisis approach the person with a calm demeanor, avoid getting into a power struggle, utilize empathy and try to understand the residents point of view, respect the residents personal space and stand a little further back than arms reach (if you are too close to the person in crisis, then he/she may believe that you are being aggressive and that could further intensify the escalation of the event, Keep your hands to your side so the resident can see you have nothing you will use against them.- Person Centered Interventions includes guidance for a 2 to 3 person and did not include a physical de-escalation technique that could be used by only one staff member.1. Review of Resident #18's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/21/25, showed:-No cognitive impairment;-The resident had delusions;-The resident received antipsychotics (a class of medications primarily used to treat mental health disorders) daily;-Diagnoses included, schizophrenia, bipolar disorder, anxiety, and depression.Review of the resident's care plan, dated 05/29/25, showed:-The resident is at risk for falls;-The resident has behaviors;-Staff are directed to maintain a safe environment.Review of the nurse progress notes showed:-06/15/2025 at 04:00 A.M., the resident came to nurses station became verbally aggressive to LPN A. The resident said he/she will sleep where he/she chooses and went to room that was not the resident's room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN A went to the other room where the resident was in bed with the covers pulled over his/her head and pulled the covers down to verify it was the resident. The resident sat up in the bed and started grabbing, punching and scratching LPN A. LPN A utilized PCI technique, securing the resident's arms and lowering the resident to the floor onto his/her knees as the resident was kicking and screaming;-06/15/25 at 04:15 A.M., the Assistant Director of Nursing (ADON) went to the resident's room and the resident said his/her right knee hurt. The resident's knee was swollen; -06/15/25 at 05:31 A.M., the resident was sent to the hospital;-06/15/2025 at 08:17 A.M., the resident's guardian called and said resident was being sent to another hospital due to a fractured tibial plateau;-06/18/2025 at 05:47 P.M., the resident was re-admitted to the facility with diagnosis of right tibial plateau fracture.Review of the facility's Event Investigation dated, 06/15/25, showed:-At approximately 04:00 A.M., the resident became physically aggressive toward LPN A;-The resident initiated the altercation by pulling LPN A's hair and punching and scratching LPN A's head and arms;- LPN A implemented PCI technique and brought the resident safely to his/her knees to manage the aggression;- During this time the resident continued to resist by kicking his/her legs; -Certified Medication Technician (CMT) C and Certified Nurses Aide (CNA) A assisted the resident to bed. Observations and interviews with Resident #18 on 07/01/25 at 09:35 A.M. and 7/2/25 at 10:00A.M., showed: -The resident sat in a wheelchair with a brace in place to his/her right leg;-The resident said LPN A had got into it with him/her and broke his/her leg;-The resident said he/she was not usually in a wheelchair, but he/she had to be until the fracture is healed;-The resident said his/her right knee hurts, but pain medications help; -The night before the altercation with staff he/she had slept in a spare room, because his/her roommate snored;-He/she thought it was okay to sleep in another room;-On 06/15/25 at around 04:00 A.M., he/she walked to the empty room and LPN A followed him/her into the empty room;-LPN A told the resident he/she needed to get back into his/her bed;-LPN A went around the bed and started pulling up the sheets that the resident was laying on top of;-LPN A pulled the sheets up and rolled the resident out of bed and he/she got back into the bed and LPN A did it again multiple times; -The last time LPN A rolled him/her off the bed he/she got up and sat up on the bed and LPN A got in his/her face so he/she started punching and scratching LPN A;- He/she said, I should not have done that, but LPN A got in my face and All I wanted to do was sleep;-LPN A went to get CMT C and CNA A, because he/she was not able to stand up and could not put any weight on his/her right foot; - CMT C and CNA A helped him/her back to his/her room and into bed because his/her knees hurt; -He/She went to the hospital for a few days;-The hospital told resident he/she had a broken knee cap;- LPN A apologized and said he/she did not know she hurt him/her; - He/she is afraid of LPN A and a LPN A was still working at the facility. During an interview on 07/02/25 at 01:34 P.M., LPN A said:-On 06/14/25 the resident said he/she wanted to be moved to 400 hall and off the 200 halls, because the resident's roommate snored; -The resident went to an empty room and laid down;-The administrator told LPN A to get the resident to sleep in his/her own bed;-The administrator told LPN A not to let the resident sleep in another bed again;-On 06/15/25 at around 04:00 A.M., the resident came to the nurses station holding a pillow and said he/she could not sleep and he/she started down the hall to an empty room;-The resident went into an empty room and LPN A followed the resident;-The resident got in bed and covered up his/her head;-LPN A took the cover off the resident's head and told the resident he/she had to go back to the other room, because the administrator said he/she needed to sleep in his/her own room;-The resident stood up and started hitting LPN A;-The resident stepped toward LPN A and LPN A grabbed both of the residents' wrists and put them behind his/her back;-LPN A was facing the resident and walked the resident backwards toward the closed bathroom door;-When the resident and LPN A got to the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	closed bathroom door the resident went down to the floor and hit his/her knees and then the resident said ouch and that his/her knee hurt;-LPN A said he/she did not remember exactly how the resident got down to his/her knees;-The resident did not specify which knee was hurt at this time;-He/She did not pull the covers up and roll the resident out of the bed on to the floor at any time;-CNA A came down to the resident's room, because he/she said he/she heard some noise and the resident was setting on the floor at this time with his/her legs out in front of him/her.-CMT C came to the room and CNA A and CMT C assisted the resident back to bed;-The resident was complaining of knee pain;-The ADON had arrived at the facility and came to assess the resident;-He/She did not intentionally hurt the resident;-He/She did not want the resident to hurt himself/herself or others;-He/She should have left the room to get help and not try to de-escalate the resident alone;-The resident had a right to be safe at the facility. During an interview on 07/02/25 at 02:30 P.M., the Administrator said:-LPN A called the night that the incident happened and said the staff had dealt with the behavior;-He/She told LPN A to try to keep the resident in his/her own bed because that was the resident's bed;-LPN A said the resident had been up at the nurse's desk throughout the night;-The resident went into an empty room and LPN A followed/her;-The resident got in the room before LPN A did and had been covered up from head to toe;-LPN A took the covers down from the resident's head and the resident jumped up and went toward LPN A;-The resident started hitting/smacking LPN A;-LPN A said she used PCI training, but LPN A did not give any details;-LPN A said he/she got the resident to calm down by using PCI training;-LPN A said the resident fell down while the PCI technique was being administered and the resident complained of knee pain; -He/She did not feel this was abuse;-LPN A tried to keep the resident from harming himself/herself or others;-It was an unfortunate accident with no intent of abuse;-The resident had the right to be safe and free from accidents.During an interview on 07/02/25 at 03:47 P.M., CNA A said:-On 06/15/25 at around 04:00 A.M., LPN A did not call for help while he/she was in the resident's room;-He/She went to the resident's room, because he/she heard a sound like a trash can fell over;-When he/she got the resident's room the resident was sitting on the floor in front of the bed;-He/She has not seen LPN A be rude or rough with the residents;-The resident can be combative at times.During an interview on 07/02/25 at 04:12 P.M., CMT C said:-On 06/15/25 at around 04:00 A.M., LPN A did not call for help while he/she was in the resident's room;-CNA C told him/her to come to the resident's room;-The resident was sitting on the floor next to the bed;-The resident said LPN A hurt him/her;-He/she did not report the incident to anyone;-He/She had not seen LPN A be rude or rough with the residents;-The resident can be combative at times;-After CMT C entered the resident's room the resident told him/her LPN A hurt him/her;-The resident did not say how LPN A hurt him/her.During an interview on 07/02/25 at 04:43 P.M., the resident's physician said:-He was aware of the situation leading up to the fall;-The resident was combative with cares;-The resident was sent to the hospital for knee pain and found to have a right tibial plateau fracture.During an interview on 07/02/25 at 04:55 P.M., the resident's guardian said:-She was aware of the of situation;-The resident was combative with cares;-The facility did not report the resident was in pain;-She expects the resident to be safe and pain free.During an interview on 6/27/25 at 11:30 and 7/10/25 at 2:18P.M. the Ombudsman said:-The resident told her a staff member broke his/her knee;-The resident said he/she went to the hospital;-The resident did not say he/she was in pain at the time of the incident.2. Review Resident #7's Quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Diagnoses included: stroke, dementia and seizure disorder.Review of the resident's care plan, updated 06/22/25, showed staff educated the resident on not moving other residents' wheelchairs and to ask for staff assistance.Review of Resident #27's Annual MDS, dated [DATE], showed:-Severe cognitive (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	impairment;-Verbal behaviors directed toward others;-Independent with the use of a wheelchair for mobility;-Diagnosis included, multiple sclerosis, thyroid disorder and high cholesterol.Review of the resident's care plan, dated 06/27/25, showed:-Used a wheelchair for mobility;-Impaired decision making.Review of the facility's investigation, dated 06/22/25, showed:-Resident #7 asked Resident #27 to move so he/she could get around him/her;-Both residents sat in wheelchairs;-Resident #7 moved Resident #27's wheelchair and went around him/her in the hall;-Resident #27 hit resident #7 with an open hand in the back of the head.Review of Licensed Practical Nurse (LPN) B written statement, dated 06/22/25, showed:-He/She sat at the nurses desk;-He/She observed Resident #7 go around Resident #27 in the hall;-Resident #27 reached out and slapped resident #7 with an open hand on the back of the head;-Resident #27 told Resident #7 to not come around him/her on this hall.Review of Resident #27 nurse's notes, dated 6/22/25 at 06:30 P.M., showed:-LPN B witnessed Resident #27 reach out and slap Resident #7 in the back of the head;- Resident #27 told Resident #7 do not come around him/her on this hall;-Resident #27 said Resident #7 was a [NAME].During an interview on 07/02/25 at 08:21 A.M., LPN B said:-He/she was at the nurse's desk on 06/22/25;-Resident #7 moved Resident #27's wheelchair and went around Resident #27:-Resident #27 reached out and slapped Resident #7 in the back of the head after he/she got around him/her;-Resident #27 told Resident #7 to not come around him/her on this hall;-Resident #27 said Resident #7 was a [NAME];-Resident #7 did not complain of pain;-Resident #7 did not say he/she was afraid of Resident #27.During an interview on 07/03/25 at 08:55 A.M., the Administrator said: -Resident #27 hit Resident #7 on the back of the head;-Resident #27 hit Resident #7, because Resident #7 moved his/her wheelchair;-Resident #27 told Resident #7 to stay off his/her hall;-Abuse is willful and intended;-Hitting is considered a form of abuse;-Resident #7 did not complain of pain;-Resident #7 did not say he/she was afraid of Resident #27;-He/She expected Resident #7 to be free from abuse;-He/She expected all residents to be free form abuse.During an interview on 07/03/25 at 08:58 A.M., the DON said:-Resident #27 hit Resident #7 on the back of the head;-Resident #27 hit Resident #7, because Resident #7 moved his/her wheelchair;-Resident #27 told Resident #7 to stay off his/her hall;-Abuse is willful and intended;-Hitting is considered a form of abuse;-He/She expected Resident #7 to be free from abuse;-He/She expected all residents to be free form abuse.MO256314At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.At the time of exit, the severity of the deficiency was lowered to the G level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).