STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265472	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brent B Tinnin Manor	220 Euel Polk Drive Ellington, MO 63638

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751 Based on record review and interview the facility failed to thoroughly investigate a resident to resident abuse allegation for two residents (Residents #1 and #2) out of a sample of four residents when Licensed Practical Nurse (LPN) A failed to report allegations of Resident #2 hitting Resident #1 to the Administrator for investigation. This deficient practice had the potential to effect all residents. The facility census was 52. Review of the Facility's Abuse and Neglect Policy dated September 2021 showed: - The Facility will not tolerate verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property, by employees, family members, visitors, or other residents; - Establish an atmosphere conducive to reporting any indications of abuse, neglect, mistreatment, or misappropriation of resident property; - To develop and implement a system for identifying, investigating, preventing and reporting any incident, or suspected incident, of abuse, neglect, mistreatment, or misappropriation of resident property. 1. 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 the 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 physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 1. Review of Resident #1's medical record showed: - admitted on [DATE]; - Diagnoses of Congestive Heart Failure (CHF) (a chronic disorder in which the heart does not pump effectively), anxiety and Schizophrenia (a mental disease causing disconnection from reality). (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At risk of impaired communication: - At risk for undesirable behaviors. - No documentation of an abuse allegation investigation. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 09/10/24, showed: - The resident was moderately cognitively impaired; - The resident required maximum assist with personal care. During an interview on 11/18/24, at 10:00 A.M., Resident #1 said he/she was in the room with Resident #2. The volume of the television was too high and he/she had asked Resident #2 to turn it down. They argued, then Resident #2 turned the volume up and down repeatedly. Resident #1 said he/she had to turn the volume down at the television and that's where he/she was when Resident #2 approached and said I am gonna get you. Resident #2 hit Resident #1 in the chest, both shoulders and head. Resident #1 indicated by showing the spots on his/her body as to where the punches landed. Resident #1 then said he/she fell forward out of the wheelchair from being hit by Resident #2. He/She stayed in the floor until staff came and assisted. Resident #1 said Certified Nurse Aide (CNA) C and Nurse Aide (NA) D approached the room and assisted him/her into the chair. The resident said he/she was not hurt and Resident #2 was moved to a new room. 2. Review of Resident #2's medical record showed: - admitted on [DATE]; - Diagnosis of depression and respiratory failure; - No documentation of an abuse allegation. Review of Resident #2's quarterly MDS dated [DATE], showed: - The resident is cognitively intact; - The resident requires minimal assist with ADLs. During an interview on 11/18/24 at 10:10 A.M., Resident #2 said he/she and Resident #1 argued over the television volume often. Resident #2 said Resident #1 is rude to staff. Resident #2 said he/she did hit Resident #1 and then continued to whoop his/her ass. Resident #2 said it had been a long time coming. The resident said he told anyone who asked he hit Resident #1. Resident #2 said the staff relocated him/her afterward to a new room and everything is going well for him/her. Review of the Facility Reported Incident, dated 11/16/24, showed: - On 11/15/24, Resident #1 and Resident #2 were in their room and were arguing over the volume of the television; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Licensed Practical Nurse (LPN) A was told there had been a verbal altercation with no injuries; - The Director of Nurses (DON) was notified and called the Administrator (ADM) and reported there had been a verbal altercation; - Resident #2 was relocated to another room; - There was no information on who reported the incident to LPN A; - There was no information documented regarding any physical altercation; During an interview on 11/18/24 at 10:45 A.M., NA D said while passing ice on 11/15/24, he/she and CNA C were told by a resident in the hallway, Resident #1 was in the floor. Upon entering the room, Resident #1 was in the floor in front of the television. The resident said Resident #2 had hit him/her. Resident #2, who was also in the room, confirmed this information and NA D informed LPN A of the physical altercation. LPN A entered the room and assessed the resident for injury. The facility Security Officer (SO) also entered the room and questioned Resident #2 who admitted again to striking Resident #1 a few times. During an interview on 11/18/24 at 12:15 P.M., the SO said on 11/15/24 CNA C had motioned to him to come to the residents' room. When he entered the room, staff were assisting Resident #1 from the floor to the wheelchair. Resident #1 said Resident #2 had hit him/her. Resident #2 confirmed this and said he/she hit Resident #1 and he/she fell to the floor. The SO said LPN A was in the room and was aware of the situation. During an interview on 11/18/24 at 12:30 P.M., LPN A said on 11/15/24 he/she was called to the room to assess Resident #1. LPN A observed NA D and CNA C assisting Resident #1 in the floor. LPN A said there was no indication of any physical abuse and she believed the resident had fallen from the chair. LPN A said later in the day, Resident #2 told him/her that he/she had beat the shit out of Resident #1. LPN A said he/she notified the ADM at that time, but did not recall if he/she reported a verbal or physical altercation between the residents. LPN A did not provide any information as to why he/she told the ADM there was only a verbal altercation. LPN A said that it had just been a crazy day and he/she had been very busy. LPN A denied being told prior to being called to Resident #1's room about any altercation between the residents. LPN A denied hearing or being made aware of a physical altercation while he/she was in the room with Residents #1 and #2. During an interview on 11/18/24 at 12:45 P.M., CNA C said he/she was passing ice in the room of Resident #1 and #2 on 11/15/24. They were arguing over the television. CNA C said he/she continued to pass ice down the hall, and stopped by the nurse's station to let LPN A know the residents were arguing. Approximately 15 minutes later, a resident informed him/her of Resident #1 being in the floor. CNA C and NA D responded and found Resident #1 on the floor. NA D called for LPN A. LPN A came to the room to assess Resident #1. CNA C said he/she, NA D, the SO and LPN A were all in the room when Resident #1 said Resident #2 had hit him/her and Resident #2 confirmed doing so. While in the room, LPN A and SO were made aware of the physical altercation. Resident #1 told them all that Resident #2 had hit him/her. (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 11/18/24 at 9:00 A.M. Registered Nurse (RN) B said on 11/16/24 he/she received a call from the Administrator requesting him/her to take the lead on a report LPN A had just made regarding Residents #1 and #2 as the ADM was on vacation. RN B said he/she contacted LPN A who said Resident #1 had been found in the floor and had been arguing with Resident #2. RN B said LPN A reported neither resident was injured, and the only allegation had been an argument. Based on that information from LPN A, RN B said he/she felt the situation had been handled and no abuse occurred. Resident #2 had already agreed to move to another room and the situation seemed resolved. RN B said if LPN A had reported physical abuse the facility would have done an investigation as per protocol. RN B said he/she is the previous director of nursing for the facility and was acting as the designated representative of the administrator. During an interview on 11/18/24 at 1:45 P.M., the ADM said LPN A contacted her while she was on vacation and unable to help in the situation. She contacted RN B and asked him/her to look into it and investigate as necessary. Regardless of what type of abuse it was, facility staff should have followed protocol and interviewed those involved to verify what exactly happened.