STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265494	A. Building B. Wing	12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Ridge Manor	3111 Highway A Mansfield, MO 65704

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48187 Based on interviews and record review, the facility staff failed ensure all allegations of possible abuse were reported timely when staff did not report an allegation of employee to resident abuse involving one resident (Resident #1) immediately to administration and within two hours of staff becoming aware of the allegation to the state survey agency (Department of Health and Senior Services - DHSS). The facility census was 32. Review of the facility policy titled Abuse Prohibition Protocol Manual, revised 11/28/16, showed the following: -Educate all staff to report to the Administrator and/or designees any alleged violations involving abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property; -The Administrator or designee must report to the State Survey Agency no later than two hours after the allegation is made if the event involved abuse or resulted in injury. Review of the facility policy titled Reporting, revised 11/2017, showed the following: -All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property will be reported immediately; -Allegations of abuse must be reported within two hours after the allegation was made; -All employees of the facility are mandated reporters. 1. Review of Resident #1's face sheet (brief resident profile sheet) showed the following information: -admitted [DATE]; -Diagnoses included pervasive development disorder (delays of social and communication skills), epilepsy (seizures), anxiety, and bipolar disorder (mood swings ranging from depressive lows to manic highs). (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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(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	Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/16/23, showed the following information: -Severe cognitive impairment; -Required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene; -Sometimes incontinent of bowel and bladder. Review of the resident's care plan, revised 11/16/23, showed the following information: -Provide resident with supportive care and services; -Staff will anticipate needs and ensure needs are met; -Staff will keep area around resident calm and quiet with minimal stimulation. Record review of the facility's initial facility reported incident to the Abuse and Neglect Hotline, dated 12/10/23, at 7:01 A.M., showed the following: -The Administrator reported to the Director of Nursing (DON) at 8:24 p.m. on 12/09/23 that the Dietary Manager had received a text message from Dietary Aide (DA G) that he/she believed Certified Nurse Aide (CNA) J had restrained the resident while taking him/her out of the dining room at supper time; -Later, the DA said he/she and cook, (DA H) seen this same CNA yelling at this same resident, and aggressively putting him/her to bed. Review of the facility's follow-up investigation report, dated 12/12/23, showed the following: -The victim was Resident #1 and the alleged perpetrator was CNA J; -DA G reported to his/her supervisor that he/she witnessed staff member CNA J wrap his/her arms around the resident from behind when the resident was screaming in the dining room at 6:00 P.M. Friday evening (12/08/23). CNA J quickly released the resident and then wheeled his/her wheelchair out of the dining room. DA G then witnessed CNA J helping the resident into bed at around 7:40 P.M. He/she claimed he/she felt that CNA J was being a little rough with the resident and that the resident hit his/her knee on the wall, but could not be sure; -The resident's guardian and physician were notified; -The allegation was reported to the facility Adminstrator at 8:30 P.M. on 12/09/23 (the day after the alleged abuse occurred). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/23, at 11:30 A.M., DA G said that he/she saw CNA J restraining the resident while in the dining room on Friday, 12/08/23, at approximately 5:30 P.M. CNA J was holding down the resident's arms while he/she was sitting in his/her wheelchair while in the dining room. Later that evening he/she witnessed CNA J aggressively throw the resident into the bed and yell at the resident to stay in the bed. DA G said that he/she did not report this to anyone until the next evening, Saturday, 12/09/23, at approximately 8:00 P.M. He/she notified his/her manager via text message. He/she said he/she was not aware that it should have been reported immediately. During an interview on 12/18/23, at 12:50 P.M., DA H said he/she was with DA G on 12/08/23, gathering trays from residents' rooms, when he/she heard CNA J yell at the resident to lay down and stay in bed. He/she did not see any abusive behavior in the room, stating he/she only heard the yelling from the resident's room then saw a CNA J leave the room and slam the door. He/she said he/she did not report it because he/she did not see anything to report. Abuse or neglect should be reported to the manager or the Administrator immediately. During an interview on 12/18/23, at 1:25 P.M., Dietary Manager I said that he/she received a text message from DA G on Saturday, 12/09/23, at approximately 8:09 P.M., regarding alleged abuse that had occurred the previous day. He/she immediately called the Administrator to report the allegation and forwarded him the text message. Dietary Manager I said that he/she has educated his/her staff on multiple occasions to notify him/her immediately of any abuse or neglect that is seen or heard. During an interview on 12/18/23, at 10:57 A.M., Housekeeper A said he/she was not aware of any recent allegations of abuse and has not had any recent abuse and neglect trainings or in-services. If he/she witnessed any abuse, he/she would report it immediately to his/her supervisor so that it could be reported to the state within two hours. During an interview on 12/18/23, at 10:59 A.M., Housekeeper B said that he/she has not witnessed any abuse including yelling or cussing or seen any staff being rough with the residents. He/she would report those things immediately to his/her supervisor. During an interview on 12/18/23, at 11:04 A.M., Housekeeper C said that he/she has not seen any abuse. He/she said that any abuse should be reported to all administration, including his/her Manager, Director of Nursing (DON) and the Administrator immediately. During an interview on 12/18/23, at 11:06 A.M., Registered Nurse (RN) D said that he/she has not seen any recent abuse. He/she would report any abuse immediately to the Director of Nursing and the Administrator. During an interview on 12/18/23, at 11:10 A.M., Nurses Assistant (NA) E said that if he/she witnessed any kind of abuse he/she would notify the charge nurse immediately. He/she said that the facility has two hours to report alleged abuse to the state. During an interview on 12/18/23, at 11:15 A.M., Certified Nurse's Assistant (CNA) F said that he/she has not witnessed any abuse from staff and if he/she does he/she will notify his/her charge nurse, DON, and Administrator immediately. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/23, at 1:30 P.M., the Director of Nursing (DON) said the Administrator had called him/her on Saturday, 12/09/23, at approximately 8:30 P.M., regarding alleged abuse that had occurred the previous day. The DON said that he/she lived close to the facility and came to the facility to immediately report the alleged abuse to DHSS. During an interview on 12/18/23, at 1:38 P.M., the Administrator said that he received a phone call from the Dietary Manager I on Saturday, 12/09/23, at approximately 8:25 P.M., regarding alleged abuse that had occurred the previous day. The Administrator said that he called the DON to report the abuse and the Administrator immediately started his/her investigation. He/she expects staff to notify him/her and the DON immediately of any allegations of abuse or neglect. The facility has two hours to report the allegations to DHSS. MO00228554

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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 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** 48187 Based on interviews and record review, the facility failed to ensure that an allegation of possible abuse was immediately investigated with immediate steps taken to protect all residents during the investigation when staff failed to immediately report an allegation of abuse involving one resident (Resident #1) and a staff member. The facility census was 32. Review of the facility policy titled Abuse Prohibition Protocol Manual, revised 11/28/16, showed the following: -Educate all staff to report to the Administrator and/or designees any alleged violations involving abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property. Review of the facility policy titled Reporting, revised 11/2017, showed the following: -All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property will be reported immediately; -All employees who have been alleged to commit abuse will be suspended immediately pending investigation. 1. Review of Resident #1's face sheet (brief resident profile sheet) showed the following information: -admitted [DATE]; -Diagnoses included pervasive development disorder (delays of social and communication skills), epilepsy (seizures), anxiety, and bipolar disorder (mood swings ranging from depressive lows to manic highs). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/16/23, showed the following information: -Severe cognitive impairment; -Required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene; -Sometimes incontinent of bowel and bladder. Review of the resident's care plan, revised 11/16/23, showed the following information: -Provide resident with supportive care and services; -Staff will anticipate needs and ensure needs are met; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff will keep area around resident calm and quiet with minimal stimulation. Review of the facility's initial facility reported incident to the Abuse and Neglect Hotline dated 12/10/23, at 7:01 A.M., showed the following: -The Administrator reported to the Director of Nursing at 8:24 P.M. on 12/9/23 that the Dietary Manager had received a text message from DA G that he/she believed CNA J had restrained the resident while taking him/her out of the dining room at supper time. Later, the DA said he/she and cook (DA H) seen this same CNA yelling at this same resident, and aggressively putting him/her to bed. Review of the facility's follow-up investigation report, dated 12/12/23, showed the following: -The allegation was reported to the facility admnistrator at 8:30 P.M. on 12/9/23 (the day after the alleged abuse occurred); -The victim was Resident #1 and the alleged perpetrator was Certified Nurse Assistant (CNA) J; -DA G reported to his/her supervisor that he/she witnessed staff member CNA J wrap his/her arms around the resident from behind when the resident was screaming in the dining room at 6:00 P.M. Friday (12/08/23) evening. CNA J quickly released the resident and then wheeled his/her wheelchair out of the dining room. DA G then witnessed CNA J helping the resident into bed at around 7:40 P.M. He/she claimed he/she felt that CNA J was being a little rough with Resident #1 and that the resident hit his/her knee on the wall, but could not be sure; -The resident's guardian and physician were notified; -The Administrator was responsible for completing the investigation. During an interview on 12/18/23, at 11:30 A.M., Dietary Aide (DA) G said that he/she saw CNA J restraining the resident while in the dining room on Friday, 12/08/23, at approximately 5:30 P.M. CNA J was holding down the resident's arms while he/she was sitting in his/her wheelchair while in the dining room. Later that evening he/she witnessed CNA J aggressively throw the resident into the bed and yell at the resident to stay in the bed. DA G said that he/she did not report this to anyone until the next evening, Saturday, 12/09/23, at approximately 8:00 P.M. He/she notified his/her manager via text message. During an interview on 12/18/23, at 12:50 P.M., DA H said he/she was with DA G on 12/08/23, gathering trays from residents' rooms when he/she heard CNA J yell at the resident to lay down and stay in bed. He/she did not see any abusive behavior in the room, stating he/she only heard the yelling from the resident's room then seen CNA J leave the room and slam the door. He/she said he/she did not report it because he/she did not see anything to report. During an interview on 12/18/23, at 1:25 P.M., Dietary Manager I said that he/she received a text message from DA G on Saturday, 12/09/23, at approximately 8:09 P.M., regarding alleged abuse that had occurred the previous day. He/she immediately called the Administrator to report the allegation and forwarded him the text message. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/23, at 1:30 P.M., the Director of Nursing (DON) said the Administrator had called him/her on Saturday, 12/09/23, at approximately 8:30 P.M., regarding alleged abuse that had occurred the previous day. The DON said that he/she lived close to the facility and came to the facility to immediately report the alleged abuse to DHSS. The DON said that CNA J was not on the schedule to work and would not be allowed to work during the investigation. During an interview on 12/18/23, at 1:38 P.M., the Administrator said that he received a phone call from the Dietary Manager I on Saturday, 12/09/23, at approximately 8:25 P.M., regarding alleged abuse that had occurred the previous day. The Administrator said that he called the DON to report the abuse and the Administrator immediately started his/her investigation. He/she said that CNA J was suspended until after the investigation was completed. The Administrator said that the facility must ensure resident safety and start an investigation. MO00228554