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M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CIs), MS #29468 and CI MS #29581 at the facility from 8/14/25 through 8/15/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. CI MS #29581 was investigated related to accidents/incidents regarding an unwitnessed fall and there were no citations related to the CI. CI MS #29468 was investigated related to resident rights and M500 was cited. The facility held a license for 100 beds, with a census of 96.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate	M 500		

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medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion,

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M 500	Continued From page 2 discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500		

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M 500	Continued From page 3 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500		

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M 500	Continued From page 4 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be treated with respect and dignity for one (1) of four (4) sampled residents, Resident #1. Findings include: Record review of the facility provided "Resident's Rights" with Revision date 9/97 (September 1997) stated, "Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs". On 8/14/25 at 11:00 AM, an observation and interview with Resident #1 revealed the resident was seated on his bed in his room with fair to good posture, eating a snack without assistance. He was well-groomed and appropriately dressed and wearing non-skin (gripper) socks. Resident #1 was alert and able to answer simple questions with one-word answers. He confirmed he was well and had everything he needed. He indicated the staff treated him well and said "no" when asked if he recalled an incident with staff on 6/29/25. On 8/14/25 at 1:52 PM, an interview with CNA#3 revealed that on 6/29/25 at approximately 5:50 PM, she observed Resident had exited his room and had entered the room of Resident #4. She said she heard Resident #4 tell Resident #1 to go back to his own room. CNA #3 said that CNA #1 had approached Resident #1, grasp his right arm with her right hand and tried to get Resident #1 exit Resident #4's room. She said she didn't observe either swing, strike or hit the other. She said she didn't hear Resident #1 say anything.	M 500		

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M 500	Continued From page 5 She said she heard CNA #1 yelling at Resident #1 to stop and not hit her. CNA#3 said she thought that based on her training CNA#1 should not have approached the resident from behind, grasped his arm or yelled at him. She said her training for assisting a resident with dementia included approaching residents face to face in a calm manner and speaking with a calm voice, and providing redirection and/or summoning assistance from other staff and/or giving the resident space and time to calm down. She said she had not noted any change in the resident's functional or psychosocial wellbeing since the incident. On 8/14/25 at 2:00 PM, during an interview Licensed Practical Nurse (LPN) #1 said that on 6/29/25 at approximately 5:50 PM, she heard an indiscernible sound and went to investigate. She said that she observed CNA #1 standing face to face with Resident #1 in the hallway outside his room. She said she couldn't see exactly what happened but saw Resident #1 swinging his hands/fists at CNA #1. She said she saw CNA #1 throw her arms up but not strike out at the resident. She demonstrated a defensive posture assumed by CNA #1 at the time. LPN #1 said she repeatedly instructed CNA #1 to "Step back", but CNA #1 ignored her and was speaking rudely and loudly to Resident #1. She said that as CNA #3 assisted Resident #1 back to his room she had escorted CNA #1 to the front of the building and CNA #1 kept walking out the front entrance. She said she had not noted any change in the resident's functional or psychosocial wellbeing since the incident. On 8/15/25 at 10:50 AM, during a telephone interview with Agency Staffing Agent #1 confirmed that the facility Staffing Coordinator had notified	M 500		

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her on 6/30/25 that CNA #1 had been involved in an incident on 6/29/25 and was not allowed to return to the facility. She stated that the staffing agency had not been able to contact CNA #1 since before 6/29/25.

On 8/15/25 at 12:35 PM, during a telephone interview, CNA #1 denied any abusive or aggressive behavior toward Resident #1. She explained that she observed Resident #1 wander into Resident #4's room, heard Resident #4 yelling at Resident #1 to go back to his own room. She said Resident #1 was resistant to leave Resident #4's room and became combative and hit her when she attempted to assist him back to his room. She said Resident #1 hit her and confirmed she had reflexively thrown her arms up in a defensive manner to prevent him from hitting her face. She said the incident occurred very quickly and she had not heard LPN #1's instructions to step away from Resident #1. She confirmed she had received training related to the care of residents with dementia and difficult behavior that included instructions to approach residents in a calm manner and leave the resident alone and give them time/space to calm down and de-escalate tense situations. She confirmed that LPN #1 escorted her to the front of the building following the incident and that she had kept walking out of the main entrance. She confirmed she left the facility because she was upset and had not worked since. She explained that she had insisted Resident #1 leave Resident #4's room with her because Resident #4 was yelling at Resident #1 to get out of his room.

On 8/15/25 at 12:50, an interview with the Director of Nurses (DON) revealed she was notified of the 6/29/25 incident between Resident #1 and CNA #1 who reported allegation of

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disrespectful and possible abusive treatment of Resident #1 by CNA #1, an agency nurse. She confirmed that the facility had conducted a thorough investigation, reported the incident to State Agency, and that the incident was reported to the agency that CNA#1 was affiliated with, along with instructions that CNA#1 could not return to the facility.

Record review of the "Demographics" for Resident #1 revealed the facility admitted the resident on 4/09/25 and the resident had diagnoses that included severe Dementia with agitation, Schizoaffective disorder and Mood disorder.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/25 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment.

Record review of the Facility Investigation dated 6/29/25 and Incident Report dated 6/29/25 revealed the facility conducted a thorough investigation, assessed Resident #1 to have no physical or psychosocial injuries as a result, ensured resident's safety and provided psychosocial services and counseling following the incident. The Facility Investigation and Incident Report documented undignified and disrespectful treatment of Resident #1 as evidenced by CNA #1 was observed approaching Resident #1 in an unprofessional manner, grasped his arm and engaged in mistreatment of the resident as she yelled at him and failed to provide appropriate interventions or distraction or provision of space and time to regain his calm and de-escalate a situation.

MSDH - Health Facilities Licensure and Certification

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