STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER Twin Pines Adult Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 S Jamison Kirksville, MO 63501	

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 - Some	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, facility staff failed to treat three residents (Resident #5, #7, and #8) in a review of ten sampled residents, with respect and in a manner that maintained their dignity. The facility census was 73.Review of the facility's Dignity and Respect policy, undated, showed the following:-Every resident has a right to be treated with dignity and respect;-All staff will speak to and treat all residents with dignity and respect. 1. Review of Resident #8's Face Sheet, undated, showed the following:-The resident was readmitted on [DATE];-The resident was his/her own responsible party;-Diagnoses included dementia, muscle wasting and atrophy (wasting, shrinkage, or decrease in size of body tissues, muscles, or organs, typically resulting in reduced function), anxiety disorder (fear of or apprehension about real or perceived threats). Review of the resident's Care Plan, dated 10/27/24, showed the following:-The resident had a communication problem/potential for a communication problem related to hearing loss;-Allow adequate time to respond. Repeat as necessary. Do not rush;-Face the resident when speaking, make eye contact;-Use simple, brief, consistent word/cues. Use alternate communication tools as needed;-Encourage the resident to verbalize feelings and fears. Clarify misconceptions;-Establish a trusting relationship with the resident;-The resident had decreased mobility due to weakness;-Physical mobility, ambulation, transfer, bed mobility wheelchair mobility, and balance impaired;-The resident was dependent on the staff for bed mobility, toileting, transfers with mechanical lift, and bathing;-He/She was incontinent of bowel;-Provide peri care after each incontinent episode;-He/She used antidepressant and antianxiety medication;-He/She had chronic pain;-He/She was incontinent of bladder. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Minimal difficulty with hearing, no hearing aid;-Usually understood. Difficulty communicating some words or finishing thoughts but was able if prompted or given time;-Usually understands. Misses some part/intent of message but comprehends most conversations;-Adequate vision-saw fine detail, such as regular print in newspapers/books;-Moderate cognitive impairment;-No behaviors;-Dependent on staff for toileting hygiene, bathing, bed mobility, and transfers;-Always incontinent of bladder and bowel. Observation on 2/19/26 at 9:00 A.M., showed the following:-Certified Nurse Assistant (CNA) C and CNA D transferred the resident from the wheelchair to the bed using a mechanical lift, but had the resident positioned with his/her head touching the headboard of the bed;-The staff used the reuseable incontinence pad to pull the resident down in the bed;-The top of the resident's incontinence brief did not move with the resident, but stayed with the bottom of the bed, causing the brief between his/her legs to pinch the resident's groin;-The resident yelled out, Stop, you're hurting me!;-Resident D said, hold on, you're fine, then continued to provide care without stopping to make the resident comfortable or acknowledge the resident's discomfort;-Staff completed the resident's peri care and positioned the resident in bed;-CNA D said the resident always complained while standing beside the resident. During an interview on 2/19/26 at 9:30 A.M., Resident (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#8 said the staff needed to be gentle when moving him/her. During an interview on 2/19/26 at 2:05 P.M., Resident #8's spouse said the following:-CNA D was rough with the resident and was always in a hurry;-A week or two ago, CNA D was rough with the resident during a transfer to the shower chair;-CNA D positioned the resident in the shower chair, while the resident yelled out that CNA D was hurting him/her;-CNA D told the resident to hold on a minute then finished getting him/her positioned in the shower chair;-The resident was mad about what happened;-If it hadn't hurt, the resident wouldn't have yelled out that it hurt;-The staff were unprofessional in front of residents, their family members, and other staff in the dining room recently which was upsetting to the resident;-The resident became upset and anxious easily;-The Director of Quality Assurance Performance Improvement (QAPI) was in the dining room, put his/her hands on his/her hips and told CNA F to get back to work;-CNA F was on a lunch break, eating with the residents, but it didn't matter to the Director of QAPI, because he/she told CNA F to get back to work again;-Another issue occurred when staff were squirting each other with water in the dining room on a different day;-The resident was usually quiet and laid back, but became upset and told staff to stop;-Certified Medication Technician (CMT) I approached the resident, gave him/her a squirter, and told the resident to shoot someone with it but the resident was not happy and did not participate. During an interview on 2/19/26 at 2:25 P.M., CNA D said the following:-He/She knew about the staff squirting each other with water;-It happened on a busy, stressful day when CMT I decided to cheer people up by squirting water. During an interview on 2/19/26 at 9:00 A.M., CNA D said the following:-He/She knew about the incident in the dining room related to a staff member being yelled at in front of the whole dining room;-The incident occurred about a week and half to two weeks ago;-Nursing administration told CNA F to help the other unit, but CNA F didn't want to because he/she had showers to complete on this unit;-CNA F ate lunch in the dining room with the residents, the facility encouraged staff to eat with the residents to engage them in conversations;-The Director of QAPI told CNA F to get back to work because there was too much left to do;-CNA F told the Director of QAPI that he/she had ten minutes left on lunch break, but the Director of QAPI told CNA F to get back to work anyway;-The interaction upset Resident #8 and the spouse;-Residents and family members were in the dining room when it happened, and they looked surprised. 2. Review of Resident 7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, complete by facility staff, dated 11/23/25, showed the following:-Cognitively intact;-Understands others;-Made self-understood;-No behaviors. Review of the resident's Care Plan, dated 9/15/25, showed the following:-The resident had an impaired communication/a potential for communication impairment due to hearing deficit;-Communication: Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternate communication tools as needed. During an interview on 2/13/26 at 2:50 P.M. and 2/19/26 at 8:55 A.M. the resident said the following:-The staff didn't treat the resident with respect;-At night, the staff played music loud enough to keep him/her awake;-The night shift staff told him/her it couldn't be turned down because other residents enjoyed it;-The resident couldn't remember the night staff member's name;-He/She told the nurse on the next shift after it happened. 4. During an interview on 2/24/26 at 9:36 A.M., the Director of Nursing said the following:-Her expectation was for staff to treat all residents with dignity and respect;-The facility was the residents' home and staff should treat it as such;-Her expectation was nursing administration disciplined staff members away from residents, families, and visitors;-She was unaware the night shift was playing music at night;-She was unaware the staff were squirting each other with water in (continued on next page)

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	265198	A. Building B. Wing	02/24/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	front of residents;-Her expectation was staff to not be rushed when caring for residents and to not be unnecessarily rough. No one had reported anything about that to her. During an interview on 2/24/26 at 1:22 P.M., the Administrator said the following:-His expectation was for staff to treat all residents with dignity and respect and not be rough when providing care;-The staff should treat the residents like a loved one. #2744230

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the responsible party when one resident (Resident #9) of ten sampled residents, had medication changes and transfer to a hospital. The facility census was 73.Review of the facility's Notification of Changes Policy, dated 5/2021, showed the following:-It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority;-Notification is provided to residents and/or the resident representative(s) to promote the resident's right to make choices about care and treatment and to keep them informed of the resident's current health status. Review of the facility's Procedure for Notification of Changes for Resident policy, updated 2017, showed the following:-The nurse will immediately notify the resident and/or the resident representative(s) for a decision to transfer or discharge the resident from the facility;-The nurse will notify the resident and/or resident representative(s) for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician;-Educate the resident and/or resident representative about the risks and benefits of the proposed treatment change and provide an opportunity for the resident to make an informed choice of the treatment or alternate that they prefer. Review of Resident #9's Face Sheet, undated, showed the following:-The resident was admitted to the facility on [DATE];-He/She was his/her own responsible party;-The staff listed emergency contact #1 with phone number;-The staff listed emergency contact #2 with phone number;-Diagnoses included dementia (general, umbrella term for a decline in mental abilities-including memory, thinking, reasoning, and language-severe enough to interfere with daily life), and rheumatoid arthritis (chronic disorder where the immune system mistakenly attacks the lining of joints, causing painful inflammation, stiffness, and swelling). Review of the resident's Physician Orders, dated 10/15/25, showed the following:-Colchicine (medication to treat gout) 0.6 milligrams (mg) give one tablet by mouth two times a day related to pericardial effusion (buildup of excess fluid in the sac surrounding the heart, which can compress the heart and restrict its ability to function properly);-Methotrexate (medication to treat rheumatoid arthritis) 2.5 mg give one tablet by mouth every 24 hours as needed for rheumatoid arthritis flare up. Review of the resident's Physician Orders, dated 10/17/25, showed to hold the colchicine 0.6 mg. Review of the resident's Physician Orders, dated 10/20/25, showed to resume the colchicine 0.6 mg two times a day. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/20/25, showed the resident was cognitively intact. Review of the resident's Physician Orders, dated 10/24/25, showed the physician ordered colchicine 0.6 mg give one tablet by mouth one time a day related to pericardial effusion. Review of the resident's Physician Orders, dated 10/25/25, showed the physician discontinued the order for colchicine 0.6 mg daily. Review of the resident's Nurse Notes showed no documentation the nurse notified the resident or emergency contact when the colchicine was restarted on 10/17/25 or when the directions changed on 10/24/25. Review of the resident's Physician Orders, dated 12/5/25, showed methotrexate 2.5 mg give one tablet by mouth one time a day for rheumatoid arthritis. Review of the resident's Nurse Notes showed no documentation the nurse notified the resident or emergency contact when the methotrexate order was changed from as needed to scheduled daily. Review of the resident's Transfer Form, dated 1/14/26, showed the facility transferred the resident to the hospital for abnormal vital signs (low/high blood pressure, high respiratory rate). Review of the resident's Nurse Notes showed no documentation the nurse notified the resident's emergency contact when the facility transferred the resident to the hospital by ambulance. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/18/26 at 10:48 A.M., the resident's emergency contact #1 said the following:-The facility did not contact him/her the methotrexate order was changed from as needed to once a day;-The family asked the nursing staff several times for the medication colchicine to be discontinued, but the facility continued to administer it, even though it was causing the resident nausea and vomiting;-The facility didn't call any family members about sending the resident to the hospital on 1/14/26;-He/She requested staff contact him/her when the resident had any changes, because the resident previously forgotten what was discussed. During an interview on 2/19/26 at 8:49 A.M., Licensed Practical Nurse (LPN) H said the following:-The resident's family member #2 was very involved in the resident's care;-LPN H thought he/she called the resident's family regarding the resident being transferred to the hospital. It should have been documented in the nurse notes;-The nurses were supposed to call the resident's family when sending a resident to the hospital and when there was a significant change in physical or mental status;-If a family member had a problem with a resident's medication, the nurse was supposed to contact the physician and follow up with the family member. During an interview on 2/20/26 at 12:48 P.M., the resident's emergency contact #2 said the following:-On 1/14/26, the facility sent the resident to the hospital but did not contact any of the family;-A friend saw the resident going into the hospital's emergency department and called family member #1 to ask what was happening to the resident;-That was how the family found out the resident was in the hospital. Review of the resident's Nurse Notes showed no documentation of the resident or family being notified when colchicine medication was started or when the instruction was changed. No documentation of the resident or family being notified when the methotrexate was changed from as needed to scheduled daily. There was no documentation staff notified the resident's family when the resident transferred to the hospital. During an interview on 2/24/26 at 1:22 P.M., the Director of Nursing said the following:-Her expectation was the nurse notify the resident's family when the resident was sent to the emergency department;-Since the resident was his/her own responsible party, the nursing staff was not required to notify the family when a medication hanged, unless the family requested to be informed. 2725731

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide each resident with meals served at an appetizing temperature for four residents (Residents #2, 3, 4, and 7) out of ten sampled residents. The facility census was 73. Review of the facility's Monitoring Food Temperatures for Meal Service policy, dated 2016, showed the following:-Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures;-Food temperatures of hot foods on a room tray at the point of service are preferred to be at 120 degrees Fahrenheit or greater to promote palatability for the resident;-Any complaint regarding food temperatures by residents will be documented on the Food Temperature Log;-Complaints will be investigated by conducting a test tray for that meal to determine if foods are remaining above 120 degrees Fahrenheit;-The investigation is recommended to be completed with 72 hours of the complaint. 1. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, complete by facility staff, dated 11/23/25, showed the following:-The resident was cognitively intact;-Setup assistance required from the staff with eating. Review of the resident's Care Plan, updated 2/26/25, showed the following:-The resident's meal trays were to be the first served;- Before taking the tray to him/her, the meal trays were to be heated in the microwave for 30 seconds to one minute;-He/She required set up assistance for eating. Review of the resident's Physician Orders, dated February 2026, showed regular diet, regular texture, and regular consistency (started 11/27/25). During an interview on 2/13/26 at 2:50 P.M., the resident said the following:-The facility had a problem with the food being cold;-There was a staff member that microwaved the food before serving it because the staff member knew the resident did not like cold food;-Sometimes when the resident was in the bathroom, the staff brought in the meal tray, took the cover off the food and walked away;-By the time he/she was done in the restroom and back to her chair, the food was already cold. 2. Review of Resident #2's annual MDS, dated [DATE], showed the following:-The resident was cognitively intact;-Setup assistance required from the staff with eating. Review of the resident's Care Plan, updated 1/26/26, showed the following:-The resident preferred to eat in his/her room;-He/She required assist with tray set up by one staff member. Review of the resident's Physician Orders, dated February 2026, showed regular diet, regular texture, regular consistency, and small portions per his/her request (started 11/11/23). During interview on 2/13/26 at 10:15 A.M., the resident said the following:-He/She ate meals in his/her room;-He/She ordered soup off the menu several times throughout the week, and it was always cold. 3. Review of Resident #3's Care Plan, dated 4/14/25, showed the following:-Provide the resident with as much control as possible in routines, food preferences, etc.;-Provide, serve diet: no added salt, regular texture, as ordered;-The resident required setup assistance by staff to eat. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident had moderate cognitive impairment;-Setup assistance required from the staff with eating. Review of the resident's Physician Orders, dated February 2026, showed no added salt diet, regular texture, and regular consistency (started 12/27/24). During interview on 2/13/26 at 10:30 A.M., the resident said the following:-The food was frequently cold when served;-That morning, the eggs were too cold to eat. 4. Review of Resident #4's quarterly MDS, dated [DATE], showed the following:-The resident had moderate cognitive impairment;-Setup assistance required from the staff with eating. Review of the resident's Care Plan, updated 1/19/26, showed the following:-Monitor and encourage good consumption of food and fluids. Offer substitutions as needed or requested;-Provide the resident with as much control as possible in routines, food preferences, etc.;-Serve diet: low concentrated sweets, regular consistency;-He/She required set up assistance by one staff (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to eat. Review of the resident's Physician Orders, dated February 2026, showed low concentrated sweet diet, regular texture, and regular consistency. During interview on 2/13/26 at 10:40 A.M., the resident said the following:-He/She ate in the dining room;-Sometimes the food was cold. 5. During an interview on 2/13/26 at 11:42 A.M., Certified Nurse Aide (CNA) C said the following:-The residents complained about the temperature of the food being too cold;-He/She knew Resident #7 frequently complained of his/her food being cold; therefore, CNA C microwaved the resident's food prior to taking it to the resident's room;-The process of delivering meal trays had changed;-In the past, the kitchen plated the food, covered it, then gave it to nursing staff to take to the resident;-Now the kitchen plated the food, covered it, and placed it in a cart for the staff to deliver to the resident rooms;-If nursing staff was busy, the food sat until someone was available to pass out the trays. During interview on 2/13/26 at 11:42 A.M., CNA D said the following:-Nursing staff was supposed to clock in at 6:45 A.M., and received report from the off going staff;-The kitchen staff had the breakfast trays plated and in the cart at 7:00 A.M.,-It took longer than 15 minutes to get everything done with the off going staff and getting the remainder of residents ready for the day;-By the time the nursing staff were available to pass out trays, the food was room temperature. During interview on 2/13/26 at 11:55 A.M., Licensed Practical Nurse (LPN) E saidresidents complained about the food being cold. Observation of the test tray, the last tray served after all the resident had been served on 2/13/26 at 12:45 P.M., showed the following: - The fried chicken thigh was 116 degrees Fahrenheit;-The green beans were 112 degrees Fahrenheit. During interview on 2/18/26 at 8:02 A.M., the Dietary Manager said the following:-His expectation was the kitchen staff checked the temperature of the food before it left the kitchen and again before the trays were served to residents;-He was not aware of any resident complaints about cold food;-His expectation was the food was maintained at the temperature per policy at a minimum of 120 degrees Fahrenheit by the time the resident received the meal tray. During interview on 2/24/26 at 1:22 P.M., the Administrator said the following:-His expectation was the residents' food reached and were maintained at the temperature per the regulations;-If the food was not at the correct temperature, then there needed to be an investigation to determine why food temperatures were not appropriate. #2722550