STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265251	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Blue Ridge, The	701 Blue Ridge Road Columbia, MO 65201

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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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interview and record review, facility staff failed to ensure the facility did not employ or engage one of four sampled employees prior to employment who had a class A Felony First Degree Assault - Serious Physical Injury or Special Victim which is a disqualifying factor for employment in a long term care facility. The facility census was 84. 1. Review of the facility's Abuse Prohibition Protocol Policy , dated 2017, showed the facility cannot employ individuals who have been found guilty of abuse or have an abuse violation against their professional license. Abuse is defined as willful infliction of injury with resulting harm, pain or mental anguish. Review of facility's Hiring Process Policy, undated, directs staff to conduct an Employee Disqualification List (EDL) and a Family Safe Care Registry check (FSCR) on any potential newly hired staff. 2. Review of CNA A's personnel file showed a hire date of 06/20/2023. Review of the CNA's CBC, dated 04/22/25, showed a Class A Felony in the First Degree Assault - Serious Physical Injury or Special Victim. During an interview on 04/24/2025 at 9:40 P.M., the receptionist said he/she is responsible for conducting CBC's on all prospective employees prior to employment. He/She said at the time of CNA A's employment the facility used a private investigation firm for conducting CBC's and they did not identify any disqualifying crimes. The receptionist said when he/she submitted a request on 04/22/25, he/she learned CNA A did have a disqualifying crime and should not have been employed by the facility. During an interview on 04/24/2025 at 10:30 A.M., the Administrator said CBC's are conducted by the receptionist on behalf of the Business Manager. He/She stated CNA A's employment occurred prior to his/her employment October, 2024, so he/she was not aware the Family Safe Care Registry was not used to conduct the CBC. He/She was informed a CBC was conducted on 4/22/25 and CNA A flagged with a disqualifying crime on the report. MO00252853

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide written notification to the resident and/or the resident's representative of the facility bed hold policy at the time of transfer to the hospital for three residents (Resident #2, #3, and #4) out of four sampled residents. The facility's census was 88. 1. Review of the facility's Bed Hold Policy Guidelines, undated, showed the facility will notify all residents, and/or their representative of the bed hold policy guidelines. This notification shall be given upon admission to the facility, at the time of transfer to the hospital or leave, and at the time of non-covered therapeutic leave. 2. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 01/20/25, showed staff assessed the resident as cognitively intact. Review of resident's medical record showed staff documented the resident: -discharged from the facility on 04/11/25 and readmitted to the facility on [DATE]; -discharged from the facility on 04/26/25 and readmitted to the facility on [DATE]; -Voluntarily agreed to transfer to the hospital for psychological evaluation on 05/01/25 and returned to the facility on [DATE]; -The medical record did not contain documentation staff issued a bed hold notice upon discharge with the resident on 04/11/25, 04/26/25, or 05/01/25. During an interview on 05/07/25 at 12:42 P.M., the resident said staff did not provide him/her with a bed hold notice when he/she was transferred or discharged to the hospital on [DATE], 04/26/25, or 05/01/25. 3. Review of Resident #3's quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Review of resident's medical record showed the resident discharged from the facility on 04/19/25 and readmitted to the facility on [DATE]. The medical record did not contain documentation staff issued a bed hold notice upon discharge with the resident and/or the resident's responsible party. During an interview on 05/07/25 at 11:24 A.M., the resident said staff did not provide him/her with a bed hold notice when he/she was discharged to the hospital on [DATE]. 4. Review of Resident #4's quarterly MDS, dated [DATE], showed staff assessed the resident as cognition not assessed. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record showed the resident with a responsible party, the resident discharged from the facility on 04/24/25 and readmitted to the facility on [DATE]. The medical record did not contain documentation staff issued a bed hold notice upon discharge with the resident's responsible party. 5. During an interview on 05/07/25 at 12:37 P.M., the Assistant Director of Nursing (ADON) said the nurse who does the discharge is responsible to give the bed hold notice to the resident, have him/her sign the written notice if able, or call the resident's representative to discuss and obtain a verbal consent. He/She said he/she was not aware the nurses had not issued some of the bed hold notices. During an interview on 05/07/25 at 12:55 P.M., the Social Services Director (SSD) said the nurse is responsible to issue the bed hold policy to the resident or the resident's representative at the time of each hospital transfer or discharge, and eventually he/she verifies that a written notice was issued. He/She said he/she checks the bed hold notices monthly but had not yet checked the discharges for April. During an interview on 05/07/25 at 2:23 P.M., the Director of Nursing (DON) said the charge nurse is responsible to issue the bed hold policy to the resident or the resident's representative at the time of each hospital transfer or discharge and place the signed notice in either the DON or SSD's inbox. The DON said he/she gives any notices placed in his/her inbox to the SSD who follows up with filing the notice. During an interview on 05/07/25 at 2:30 P.M., the administrator said the charge nurse is responsible to issue the bed hold policy to the resident or the resident's representative at the time of each hospital transfer or discharge, and the SSD follows up with filing the notice. The administrator said he/she was not sure if anyone double checks that the bed hold notices are issued to residents or their representatives upon each discharge to the hospital. MO00253604

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review facility staff failed to ensure one resident (Resident #1) received his/her pain medications as ordered when staff failed to obtain a physician's order to resume medications that were on hold for surgery after notification of surgery cancellation, and failed to administer his/her pain medication as ordered when staff documented the medication as not available. Facility staff failed to complete smoking risk assessments to re-assess smoking privileges for two residents (Resident #2 and #4), of two sampled residents who smoke. The facility census was 84. 1. Review of the Medication Administration policy, revised 02/07/2013, showed medications are given to benefit the resident's health as ordered by the physician. The policy did not address medication holds or unavailable medications. Review of Medication, Holding policy, dated March 2012, showed staff are directed as follows: -The resident's medical record must indicate that medications are being held and the entry must be signed and dated by the staff/charge nurse entering the data; -Staff/charge nurse record the following data in the resident's medical record: name and strength of the medication, reason the medication is being held, when the thirty day period will expire, and other information as necessary or appropriate. 2. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/07/2025, showed staff assessed the resident as follows: -Cognitively intact; -Diagnosed with Parkinson's Disease; -Received scheduled and prn (as needed) pain medication; -Pain assessment interview should be conducted; -Pain frequency was Frequently, pain intensity over the past five days rated seven; -Opioids given since admission. Review of the resident's care plan, dated 11/19/2024, showed staff assessed the resident as diagnosis of left knee replacement related to osteoporosis, (a disease of progressive bone loss associated with an increased risk of fractures) and staff directed to assess, monitor and record pain. Review of the resident's Physician Order Sheets' (POS'), dated 4/23/25, showed staff did not document an order for medication holds due to surgery scheduled 04/21/25 or an order to resume previously held medications due to postponement of surgery on 04/11/25. Review of the resident's electronic Medication Administration Record (eMAR), dated 04/22/25 at 3:40 P.M., showed staff documented the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Tizanidine two milligram (mg) three times per day as needed. Staff documented the medication as not administered on 04/20 for day or night shift -Hydrocodone/acetaminophen 5/325 mg every six hours. Staff documented the medication as not administered on 04/18/25 at 4 P.M. and 10 P.M. due to not available; -Hydrocodone/acetaminophen 5/325 mg every six hours. Staff documented the medication as not administered on 04/19/25 at 10 A.M., due to unavailable; -Folic acid one mg, one tab daily. Staff documented on 04/20/25 not administered on hold; -Cyanocobalamin (B-12) 1000 mcg one tab daily. Staff documented not administered on 4/13/25 through 4/21/25 due to on hold; -Losartan 50 mg daily. Staff documented not administered on 04/20/25 due to on hold. Review of the resident's eMAR, dated 04/22/25 at 4:00 P.M. showed staff assessed the resident's pain scores as follows: -4/17/25 Day 0/10; Night 9/10; -4/18/25 Day 5/10; Night 2/10; -4/19/25 Day 9/10; Night 0/10; -4/20/25 Day 0/10; Night 0/10; -4/21/25-Day 7/10; Night 0/10. During an interview on 04/22/25 at 1:00 P.M., resident said he/she was scheduled for knee surgery on 04/21/25 and received a schedule of medication holds from the anesthesiologist. The schedule included a hold on day of surgery for Tizanidine (muscle relaxant) 2 mg, two tabs three times per day as needed, and hydrocodone/ acetaminophen (narcotic analgesic used for pain) 325 mg/5 mg one tab every six hours was to continue as scheduled. The surgery was postponed on 04/11/25 pending cardiac clearance. The resident said he/she talked to the charge nurses on 04/18 and 04/19 to ensure his/her medications would not be stopped after cancellation of the procedure. The resident said he/she feared having to play catch up on pain management due to an interruption in his/her pain medications as he/she had experienced in the past. He/She was assured by the two charge nurses there were no medications on hold. On 4/18 the resident's family also called the charge nurse on duty and was told there were no medications on hold for the resident. The resident said her pain baseline is eight out of 10 before medication and five out of 10 after medication. The resident said he/she was told on night of 04/20 by the Certified Medication Technician (CMT) administering medications that his/her Tizanidine was on hold. The resident said he/she woke up in pain that night and could not get back to sleep. The resident became increasingly concerned that staff were unaware of the procedure cancellation when he/she was reminded on the evening of 04/20/25 to take a pre-operative shower. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/25 at 2:10 P.M., the resident said he/she thought he/she had received Hydrocodone/Acetaminophen and Tizanidine on 04/18. He/She reported only requesting Tizanidine in the morning and at night. The resident said he/she was not told the hydrocodone was not available on 04/18 and 04/19, that she assumed it was in the cup of medications given to her. He/She said the CMT's don't tell him/her she is getting and get annoyed or don't respond when asked. The resident said he/she is asked to rate her pain every 7-10 days and he/she would never rate his/her pain zero out of 10 on the scale. He/She said sometimes he/she cannot stay awake late enough to ask for Tizanidine since staff pass medications between 9:30 P.M. and 10:00 P.M. Staff do not want to make extra trips for prn (as needed) medication requests. 3. During an interview on 04/22/25 at 2:25 P.M., CMT B said he/she only works two shifts per week and does not recall if the resident had medications on hold for surgery, he/she would have to check the eMAR. He/She did recall hearing the resident's surgery had been canceled. During an interview on 04/22/25 at 3:40 P.M., the Assistant Director of Nursing (ADON) said the resident must not have asked for Tizanidine on the opportunities it was available since it is a prn order. He/She said the pain score documentation is concerning since the resident's unmedicated baseline is eight out of 10 and that staff are probably not waking her up for medications. He/She said she did not understand why the daytime pain score on 04/17 and 04/20 would be zero. The ADON did not know why medication holds had not been resumed after surgery cancellation. He/She said the nurse who entered the holds no longer works at the facility and that is why it was missed. The ADON said he/she does not know why Hydrocodone/Acetaminophen was not available on 04/18 and 04/19 for the resident since it could have been obtained from the STAT box (a box of emergency medications) that all nursing staff can access. During an interview on 04/23/25 at 2:26 P.M., Licensed Practical Nurse (LPN) C said changes to medication holds are communicated during shift report. He/She said the nurse who put the resident's medications on hold no longer works at the facility and he/she would not think to see if the holds or continuations were correct. LPN C said residents should be asked their pain levels every shift or as directed and the eMAR requires documentation of a pain score prior to administration of pain medications. During an interview on 04/23/25 at 3:00 P.M., the Director of Nursing (DON) said when he/she was passing medications on the morning of 04/21/25 the resident requested Tizanidine, he/she realized there were holds on her medications that should have been removed after surgery cancellation. He/She fixed the eMAR so all medications were released from hold. The DON said they do not require a physician order for medications holds prior to surgery or to resume them if the procedure is canceled. He/She stated the information is usually passed on during sift change report or communicated in a note. He/She said if hydrocodone/acetaminophen is not available for residents in the medication cart, they can be obtain doses from the STAT box. During an interview on 04/24/25 at 10:30 A.M., the Administrator stated there should be a physician order to hold medications and an order should be obtained to resume held medications after hold is lifted. He/She said the Transporter is very good about communicating procedure changes and the information could be found in progress notes and communicated during report. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the facility's Smoking-Residents policy, undated, showed the facility shall establish and maintain safe resident smoking practices, and staff will review the status of a resident's smoking privileges periodically, and consult as needed with the DON and the attending physician. 5. Review of Resident #2's annual MDS, dated [DATE], showed staff assessed the resident as cognitively intact, and did not use tobacco products. Review of resident's smoking assessment, dated 03/29/25, showed staff documented the resident as a safe smoker. Review of resident's nurses' notes, dated 04/26/25 at 11:31 A.M., showed staff documented the resident lit a cigarette in the dining room, and was observed with smoke coming from his/her mouth. Review of resident's nurses' notes, dated 04/30/25 at 9:31 P.M., showed staff documented the resident yelled at Resident #4 to return his/her cigarette from earlier, and snatched a cigarette from Resident #4's hand. Review of resident's electronic medical record (EMR), dated 04/26/25 through 05/07/25, showed the EMR did not contain documentation staff reviewed or re-assessed the resident's smoking privileges. During an interview on 05/09/25 at 12:31 P.M., the Care Plan Coordinator (CPC) said the nurse who documented he/she observed the resident smoking inside the building should have completed a new smoking assessment for the resident or notify the CPC to assist with the assessment. During an interview on 05/09/25 at 1:10 P.M., the administrator said he/she would expect the nurse who documented he/she observed the resident smoking in the building, to re-assess the resident and complete a new smoking assessment. 6. Review of Resident #4's annual MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, and did not use tobacco products. Review of resident's smoking assessment, dated 01/22/25, showed staff documented the resident as a safe smoker. Review of resident's nurses notes, dated 04/30/25 at 9:31 P.M., showed staff documented the resident was advised not to go outside to smoke when Resident #2 was outside smoking. Review of residents EMR dated 01/23/25 through 05/07/25, showed the EMR did not contain documentation staff reviewed or re-assessed the resident's smoking privileges. 7. During an interview on 05/07/25 at 2:30 P.M., the DON said the nurses are responsible to complete smoking assessments on admission and quarterly. During an interview on 05/09/25 at 5:58 A.M., Registered Nurse (RN) D said he/she was unsure, but thinks either the SSD or the CPC is responsible to complete smoking assessments for residents who smoke. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/25 at 8:51 A.M., the SSD said the CPC is responsible to complete smoking assessments on admission and quarterly for residents who smoke. During an interview on 05/09/25 at 12:31 P.M., the CPC said the nurses are responsible to complete smoking assessments on admission and quarterly for residents who smoke, but they have not been completing the assessments, so he/she has completed some assessments if he/she notices one missing. During an interview on 05/09/25 at 1:10 P.M., the administrator said the nurses are responsible to complete smoking assessments on admission and quarterly, and the CPC and DON should double check they are completed. MO00253049/MO00253882

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, facility staff failed to ensure residents' environment remained free of accident hazards, when staff failed to ensure residents did not retain smoking materials while in the facility for two residents (Resident #2 and #4) of two sampled residents. The facility's census was 88. 1. Review of the facility's admission Packet, Resident Rules and Regulations, showed residents may not retain matches or lighters. Review of the facility's Smoking-Residents policy, undated, showed staff are directed as follows: -The facility shall establish and maintain safe resident smoking practices; -Any smoking related privileges, restrictions, and concerns (example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues; -Smoking shall not be permitted in living/sleeping area; -This facility may check periodically to determine if residents have smoking articles in violation of our smoking policies. Staff shall confiscate any such articles and shall notify the charge nurse. 2. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 01/20/25, showed staff assessed the resident as cognitively intact. Review of the resident's smoking assessment, dated 03/29/25, showed staff documented the resident as a safe smoker. Review of the resident's care plan, updated 04/14/25, showed staff did not document any interventions for smoking privileges, restrictions, or concerns. Review of the resident's nurses' note, dated 04/26/25 at 11:31 A.M., showed staff documented the resident lit a cigarette in the dining room, and was observed with smoke coming from his/her mouth, tried to educate him/her on the smoking policy, took the two lighters he/she had, checked his/her room for more lighters and did not see any. Review of the resident's nurses' note, dated 04/27/25 at 2:11 A.M., showed staff documented the resident was a direct threat to his/her own safety and other residents because he/she lit cigarettes in public gathering such as dining room and activity, knowing that there are multiple peers using oxygen around him/her. During an interview on 05/09/25 at 6:08 A.M., Certified Medication Technician (CMT) F said the resident was allowed to keep his/her cigarettes and lighter, but should not be allowed anymore for safety reasons. He/She said he/she did not know if the resident still had his/her cigarettes and lighter with him/her because the management staff takes care of that. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/25 at 8:04 A.M., the resident said he/she kept his/her cigarettes and lighter in his/her room. During an interview on 05/09/25 at 8:51 A.M., the Social Services Director (SSD) said he/she reviewed the smoking rules with the resident on admission, the resident was assessed as a safe smoker by the nursing staff and was allowed to keep his/her smoking materials. He/She said he/she was aware the resident was observed smoking in the building, which is not safe, and the resident should no longer be allowed to keep cigarettes or a lighter with him/her in the building. He/She said staff had removed the smoking supplies from the resident's room after he/she lit the cigarette in the building, and the resident did not have money to buy more smoking supplies, but he/she would check the resident's room to see if he/she had any smoking supplies inside the room. During an interview on 05/09/25 at 12:31 P.M., the Care Plan Coordinator (CPC) said he/she is responsible to ensure interventions for smoking are included on the resident's care plan, update the care plan quarterly or with changes to the resident's health conditions, and was not sure how he/she missed the smoking interventions. He/She said he/she was not aware the resident was observed smoking in the building, which is a risk for fire and potential injury to the resident and other residents in the facility. He/She said the resident was previously assessed as a safe smoker and was allowed to keep his/her smoking materials. During an interview on 05/09/25 at 1:10 P.M., the administrator said the CPC is responsible to ensure the resident has appropriate interventions for smoking on his/her care plan, and the interdisciplinary team (CPC, SSD, Director of Nursing, etc.) should have identified at each care plan meeting that smoking interventions were missing from the resident's care plan. He/She said the resident was previously assessed as a safe smoker and was allowed to keep his/her smoking materials. The administrator said he/she was not aware the resident was observed smoking in the building which is a safety risk for all residents, and the resident should no longer be allowed to keep his/her cigarettes and lighter inside his/her room. The administrator said she was not aware of the incident prior to this interview, or what staff did. 3. Review of Resident #4's quarterly MDS, dated [DATE], showed staff assessed the resident as cognition not assessed. Review of the resident's smoking assessment, dated 01/22/25, showed staff documented the resident as a safe smoker. Review of the resident's care plan, updated 04/14/25, showed the resident will have supervised smoking in designated areas, will smoke safely, cigarettes and lighters are kept at nursing station. Observation on 05/09/25 at 12:47 P.M., showed the resident in his/her wheelchair in the dining room with a pack of cigarettes and a lighter protruding from his/her opened waist pouch. During an interview on 05/09/25 at 12:47 P.M., the resident said he/she kept his/her cigarettes and lighter in his/her room but needed assistance to go outside to smoke. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/25 at 1:15 P.M., the administrator said the resident is a safe smoker, but if his/her care plan directs that cigarettes and lighters are to be kept at the nursing station, then the resident should probably not retain his/her cigarettes inside his/her room for safety reasons. 4. During an interview on 05/09/25 at 5:58 A.M., Registered Nurse (RN) D said residents who are assessed by staff as safe smokers are allowed to keep their cigarettes and lighter with them, and some residents are required to keep their smoking supplies at the nurses' station, but he/she did not know all the residents who are required to leave their smoking supplies at the nurses' station. During an interview on 05/09/25 at 6:08 A.M., CMT F cigarettes and lighters are kept for some residents at the nurses' station, but he/she did not know the exact residents who are required to leave their cigarettes and lighters at the nurses' station. During an interview on 05/09/25 at 1:10 P.M., the administrator said residents who are assessed by staff as safe smokers are allowed to keep their cigarettes and lighter with them, but if the resident violates the smoking policy, then he/she should not be allowed to retain his/her cigarettes and lighter. He/She said residents with cognitive impairments, could potentially smoke in their rooms, and place other residents and staff at risk from fire hazards or an explosion in the facility. MO00253882