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	01/15/2026

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

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 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, facility staff failed to notify the physician for three resident's (Resident #1, #2 and #3) out of three sampled residents when medications were not available. The facility census was 90. 1. Review of the facility's Medication Orders policy, dated 04/2017, showed the prescriber is contacted by nursing for direction when delivery of a medication will be delayed, or the medication is not or will not be available.2. Review of Resident #1's quarterly MDS, dated [DATE], showed staff assessed the resident as moderately cognitively impaired.Review of the resident's Physician Order Summary (POS), dated 09/01/25 through 09/30/25, showed the physician directed staff to administer hydrochlorothiazide (to treat essential hypertension) 25 milligrams (mg) once a day by mouth and MiraLAX (to treat constipation) 17 grams once a day by mouth.Review of the resident's Medication Administration Record (MAR), dated 09/01/25 through 09/30/25 showed staff documented the following as not available:-9/1/25 Hydrochlorothiazide;-9/2/25 Hydrochlorothiazide;-9/24/25 MiraLax;-9/29/25 MiraLax.Review of the nurse notes, dated 09/01/25 through 09/30/25, did not contain documentation staff contacted the physician or the pharmacy when the resident medication was not available to administer. 3. Review of Resident #2's quarterly MDS dated [DATE], showed staff assessed the resident as cognitively intact.Review of the resident's POS, dated 12/01/25 through 12/31/25, showed the physician directed staff to administer:-Hydrochlorothiazide 25 mg once a day by mouth;-Cyclobenzaprine (to treat muscle spasms) 5 mg one time a day by mouth;-Boost (to treat weight loss) three times a day by mouth:-Lemon drops (to treat localized enlarged lymph nodes) three times a day by mouth;-Ferrous Gluconate (to treat anemia) 324 mg one time a day by mouth:-Rosuvastatin (to treat long term drug therapy) 10 mg one time a day by mouth;-Mecobalamin (Vitamin B 12) (to treat a vitamin deficiently) 5000 mcg (microgram) one time a day by mouth.Review of the resident's MAR, dated 12/01/25 through 12/31/25 showed staff documented the following medications as not available:-On 12/02/25 Ferrous Gluconate 324 and Vitamin B12;-On 12/22/25, Cyclobenzaprine;-On 12/24/25 Lemon drops and Rosuvastatin;-On 12/25/25 Rosuvastatin and Cyclobenzaprine;-On 12/26/25 Cyclobenzaprine, Boost, Vitamin B12 and Rosuvastatin;-On 12/27/25 Vitamin B.Review of the nurse notes, dated 12/01/25 through 12/31/25, did not contain documentation staff contacted the physician when the resident medication was not available. 4. Review of Resident #3's quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired.Review of the resident's POS, dated 12/01/25 through 12/31/25, showed the physician directed staff to administer:-Colestipol (used to treat hyperlipidemia) 1 gram two times a day by mouth;-Donepezil (to treat unspecified dementia) 10 mg one time a day by mouth;-Eliquis (to treat acute embolism and thrombosis of unspecified deep veins of lower extremities) 5 mg two times a day by mouth;-Potassium Chloride (to treat hypokalemia) 40 mEq (milliequivalent) one time a day by mouth;-Methenamine Hippurate (used to treat acute cystitis with hematuria) 1 gram twice a day by mouth;-Ascorbic Acid (Vitamin C) (to treat a vitamin deficiency) two times a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day by mouth.Review of the resident's MAR, dated 12/01/25 through 12/31/25, showed staff documented the following medications as not available:-On 12/02/25 Methenamine Hippurate;-On 12/03/25 Colestipol and Methenamine Hippurate;-On 12/04/25 Methenamine Hippurate and Potassium Chloride;-On 12/05/25 Methenamine Hippurate and Potassium Chloride;-On 12/06/25 Methenamine Hippurate and Potassium Chloride;-On 12/07/25 Methenamine Hippurate;-On 12/08/25 Methenamine Hippurate and Potassium Chloride;-On 12/09/25 Methenamine Hippurate and Potassium Chloride;-On 12/10/25 Methenamine Hippurate;-On 12/11/25 Methenamine Hippurate;-On 12/12/25 Methenamine Hippurate;-On 12/13/25 Methenamine Hippurate and Potassium Chloride;-On 12/14/25 Potassium Chloride;-On12/15/25 Eliquis;-On 12/16/25 Eliquis;-On 12/17/25 Eliquis and Ascorbic Acid;-On 12/18/25 Eliquis;-On 12/19/25 Eliquis;-On 12/20/25 Eliquis and Potassium Chloride;-On 12/21/25 Ascorbic Acid, Potassium Chloride and Eliquis;-On 12/22/25 Eliquis and Potassium Chloride;-On 12/23/25 Eliquis;-On 12/25/25 Donepezil;-On 12/26/25 Donepezil;-On 12/29/25 Potassium Chloride;-On 12/30/25 Potassium Chloride;-On 12/31/25 Potassium Chloride.Review of the nurse notes, dated 12/01/25 through 12/31/25, did not contain documentation staff contacted the physician when the resident did not receive his/her medication.5. During an interview on 01/08/25 at 10:11 AM, Certified Medication Technician (CMT) B said staff would report to the charge nurse if a resident did not receive his/her medication.During an interview on 1/16/26 at 9:49 AM, the ADON said the nurse should contact the physician and pharmacy if a resident's medication is not available to see if there is an alternative medication to administer. During an interview on 1/16/26 at 9:50 A.M., the DON said staff should contact the physician and pharmacy to see if another medication could be used to replace the missing medication.#2709624

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NAME OF PROVIDER OR SUPPLIER Villa at Blue Ridge, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, facility staff failed to prevent misappropriation of resident funds for one resident (Resident #4) out of six sampled residents. The facility census was 90.1. Review of the facility's, Abuse Prohibition Protocol Manual, undated, showed the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident' medical symptoms. The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation or mistreatment to thoroughly investigate the alleged violations and take appropriate corrective action, as a result of investigation findings. The facility must have evident (documentation forms) of a thorough investigation including resident statements, witness statement, staff statements, environmental review, resident physical assessment, etc., including a timeline of events.2. Review of Resident #4's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's funds account showed it did not contain a deposit of $1700 between the dates of 1/23/25 and 1/10/26. Review of the facility's investigation, dated 01/10/26, showed staff reported to the Director of Operations (DOP) Resident #4 missing $1700.00, and he/she began an investigation. Staff documented staff initially reported to the facility administrator in September 2025 the resident was missing $1700. Staff documented Registered Nurse (RN) A who completed the resident's admission to the facility confirmed the resident had $1700.00. RN A said he/she witnessed the resident give the $1700 to facility staff but was unable to recall who the staff member was. Police report made for the missing money by staff. Facility requested a replacement check to return the money to the resident. During an interview on 01/15/26 at 8:30 A.M., the DOP said the administrator was on vacation 01/05/26 through 01/09/26 so when he/she returned they started the investigation, suspended him/her, and terminated him/her. and he/she was at the facility overseeing it. The DOP said during the week Department of Health and Senior Services (DHSS) investigated a complaint which then stemmed him/her to speak with all the residents to ensure there were no further concerns. The DOP said he/she completed resident interviews on 01/10/26 as part of the investigation because the administrator never did when it was first reported in September 2025. and he/she was approached by Social Service Director (SSD) D in regard to the resident's missing money. The DOP said SSD D reported to him/her the resident and his/her family had reported to him/her on more than one occasion the resident was missing $1700.00 in cash. The DOP said SSD D reported to him/her that he/she had previously told the administrator about the missing money, but nothing had been done about it. The DOP said he/she immediately started an investigation for the missing money and notified DHSS the same day. The DOP said he/she has determined through his/her investigation the resident did have $1700.00 in cash when he/she admitted to the facility, and the resident did give the cash to a staff member and the date of his/her admission. The DOP said he/she notified the police of the missing money, and their report will be ready in seven business days. The DOP said he/she expects the facility to complete a detailed investigation if they receive a report of missing money. The DOP said the administrator did not complete an investigation at the time he/she was notified of the missing money and should have. The DOP said he/she expects the administrator to notify DHSS of any missing money. The DOP said the administrator did not notify DHSS of the missing money and should have. During an interview on 01/15/26 at 12:45 P.M., the corporate financial representative said he/she along with the Business Office Manager (BOM) spoke with the resident regarding his/her missing money. The corporate financial representative said the resident reported he/she had $1700.00 in cash when he/she was admitted to (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. The corporate financial representative said the resident reported he/she took the money to the office and gave it to a staff member but did not recall his/her name. The corporate financial representative said the resident provide a description of the staff member and based on that he/she showed the resident pictures of staff to assist and identify who it may have been. The corporate financial representative said the resident was not able to identify the staff member. The corporate financial representative said the BOM took the resident and had him/her point out the office the resident took the money to. The corporate financial representative said the resident was able to identify the office. During an interview on 01/15/26 at12:58 P.M., the Assistant Director of Nursing (ADON) said he/she was aware the resident had reported missing money several months ago. The ADON said he/she asked the administrator at that time if there was anything he/she needed to do to assist with the missing money and the administrator told him/her no, the less you know the better. The ADON said he/she thought the administrator was completing an investigation at that time and he/she did not hear anything else about the missing money. The ADON said all staff are educated upon hire and annually to report any abuse, neglect, and misappropriation immediately. The ADON said if something is reported the facility is expected notify DHSS within two hours for abuse and complete an investigation. The ADON said the administrator is responsible to complete the investigation. During an interview on 01/15/26 at 1:12 P.M., SSD D said he/she started at the facility in September 2025. SSD D said right after he/she started the resident's family member came to him/her and inquired about the $1700.00 that was missing. SSD d said because he/she was new and not aware of this he/she spoke with a former staff member who told him/her and the resident's family member the facility was investigating it. SSD D said the resident's family member inquired about the missing money again in October 2025. SSD D said at that time he/she and the resident's family member spoke with the administrator in front of the receptionist about it. SSD D said he/she assumed the administrator would complete and investigation, but he/she does not know if the administrator did. SSD D said he/she received abuse, neglect, misappropriation education and knows if missing money is reported to him/her he must report it to the administrator immediately. During an interview on 01/15/26 at 1:24 P.M., the receptionist said he/she witnessed the SSD and resident's family member tell the administrator about the resident's missing money in October 2025. The receptionist said the administrator had been made aware of the missing money prior to that but he/she did not recall the timeframe. The receptionist said he/she does not know if the administrator completed an investigation or who the money was given to. The receptionist said an investigation should have been completed. The receptionist said he/she received abuse, neglect, misappropriation education and knows if missing money is reported to him/her he must report it to the administrator immediately. During an interview on 01/15/26 at 2:05 P.M. RN A said he/she was the nurse who admitted the resident. RN A said the day of admission the resident told him/her of the money, and it was $100 bills in cash. RN A said he/she took the resident to the BOM office but does not recall the staff member's name. RN A said he/she was a new employee and did not know everyone yet. RN A said he/she witnessed the resident give the staff member the money. RN A said the staff member told the resident he/she would put it in an account for him/her to use when he/she wanted it. RN A said the resident agreed to that. RN A said he/she is no longer an employee at the facility and does not know anything about the money missing. During an interview on 01/15/26 at 2:30 P.M., the administrator said he/she was told about the missing money but was not told how much was missing. The administrator did not recall the date he/she was told. The administrator said he/she did not speak with the resident's family about the missing money. The administrator said he/she did not do an investigation for the missing money or report it to DHSS when it was reported to him/her in September (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2025. The administrator said he/she should have completed an investigation and notified DHSS of the missing money when he/she learned about it. The administrator said he/she did not do an investigation in September 2025 because he/she did not know how much money was missing. During an interview on 01/15/26 at 4:10 P.M., the Activity Director (AD) said he/she was gone on medical leave when the resident was admitted in July 2025. The AD said he/she returned to work the first week in August 2025. The AD said he/she was completing his/her admission activity assessment with the resident and inquired how the resident would like to pay for haircuts. The AD said the resident told him/her about giving the staff member $1700.00 in cash the day he/she was admitted to the facility, and he/she did not know what happened to the money after. The AD said the resident expressed he/she wanted to use that money for haircuts. The AD said he/she spoke with the administrator about the money and informed him/her the resident was concerned that he/she did not know what happened to his/her money at that time. The AD said he/she does not know if the administrator completed an investigation or not. During an interview on 01/15/26 at 4:33 P.M., SSD E said he/she left the facility around the end of September 2025. SSD E said he/she does not remember the resident and did not receive any cash from the resident that he/she recalls. SSD E said if he/she had received any money from a resident he/she would have got a witness and made sure it was locked up in the facility safe. Complaint #2713313

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, and record review, facility staff failed to report an allegation of misappropriation of property for one resident (Resident #1) within 24 hours to the state agency Department of Health and Senior Services (DHSS). The facility census was 90.1. Review of the facility's, Abuse Prohibition Protocol Manual, undated, showed the Administrator or designee must report to the State Survey agency no later than two hours after the allegation is made if the event that caused the allegation involved abuse or resulted in serious bodily injury, or not later than twenty four hours if the event that caused the allegation did not involve abuse and did not result in serious bodily injury. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident' medical symptoms. The intent is for the facility to develop and implement policies and procedures that ensure reporting of crimes against a resident or individual receiving care from the facility occurring in nursing homes within prescribed timeframes to the appropriate entities, consistent with Section 1150B of the Act;2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/25/25, showed staff assessed the resident as:-Moderately cognitively impaired;-Received a pain medication as needed during the seven day look back period;-Used an opioid medication.Review of the resident's Physician Order Summary (POS), dated 10/01/25 through 10/31/25, showed an order for 100 milligram(mg)/5 milliliter (ml) Morphine concentrate solution administered every four hours as needed for pain.During an interview on 01/08/26 at 1:11 P.M., License Practical Nurse (LPN) C said he/she staff are directed to report missing narcotic medications to the charge nurse or upper management. He/She said upper management would investigate the missing narcotics. He/She said he/she was completing a narcotic count in October and discovered the resident's liquid Morphine medication seal was broken and the liquid appeared to be clear in color, even though it should have been a pink color, and believed the bottle was full of water. He/She said the medication was received in June. He/She said the seal should not have been broken, since it was not administered from June until October. He/She said he/she reported the incident to the Assistant Director of Nursing (ADON).During an interview on 01/08/26 at 2:39 P.M., the pharmacist said the facility did contact him/her about the potential of missing doses of the resident's liquid morphine. He/She said the color of the liquid morphine was pink. He/She said even if the morphine solution was not used for a long period of time, the color would not change to clear, so shaking the morphine solution wouldn't change the color. He/She said If water got into the bottle, it would dilute the color.During an interview on 01/08/26 at 3:13 P.M., the administrator said he/she and the Assistant Director of Nursing (ADON) would be responsible to complete an investigation of misappropriation of property and report the allegation to DHSS within 24 hours. He/She said he/she did not remember if DHSS was contacted.During an interview on 01/16/26 at 9:49 A.M., the ADON said staff are directed to report abuse and neglect immediately to the supervisor or administrator. He/She said the administrator would be responsible to report an allegation of misappropriation of property to DHSS within 24 hours. He/She said LPN C reported to him/her the resident's liquid Morphine was potentially missing doses. He/She said he/she reported to the administrator the potential of misappropriation on the resident's liquid morphine. He/She said he/she did not know if the administrator reported the allegation to DHSS.During an interview on 01/16/26 at 9:50 A.M., the Director of Nursing (DON) said staff are directed to report abuse and neglect immediately to the supervisor or administrator. He/She said the administrator would be responsible to report an allegation of misappropriation of property to DHSS within 24 hours. He/She said he/she was not employed (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the facility when the incident occurred.#2709624

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record reviews, facility staff failed to initiate and complete a thorough investigation of alleged misappropriation of one resident (Resident #1) narcotic medication. The facility census was 90.1. Review of the facility's, Abuse Prohibition Protocol Manual, undated, showed the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident' medical symptoms. The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation or mistreatment to thoroughly investigate the alleged violations and take appropriate corrective action, as a result of investigation findings. The facility must have evident (documentation forms) of a thorough investigation including resident statements, witness statement, staff statements, environmental review, resident physical assessment, etc., including a timeline of events.Review of the facility's Narcotic Count policy, undated, showed if the count is not accurate, the nurse going off duty is to remain on duty unto the count is reconciled and the Director of Nursing (DON) must be notified for further instruction. The Director of Nursing will initiate an investigation to determine the cause of the discrepancy and contact the pharmacist for assistance as needed.2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/25/25, showed staff assessed the resident as:-Moderately cognitively impaired;-Received a pain medication as needed during the seven day look back period;-Used an opioid medication.Review of the resident's Physician Order Summary (POS), dated 10/01/25 through 10/31/25, showed an order for 100 milligram(mg)/5 milliliter (ml) Morphine concentrate solution administered every four hours as needed for pain. Review of the resident's medical record, dated 09/01/25 through 10/31/25, showed it did not contain documentation the facility investigated the allegation of misappropriation of the resident's liquid Morphine.3. During an interview on 01/08/26 at 1:11 P.M., License Practical Nurse (LPN) C said he/she staff are directed to report missing narcotic medications to the charge nurse or upper management. He/She said upper management would investigate the missing narcotics. He/She said he/she was completing a narcotic count in October and discovered the resident's liquid Morphine medication seal was broken and the liquid appeared to be clear in color, even though it should have been a pink color and believed the bottle was full of water. He/She said the medication was received in June. He/She said the seal should not have been broken, since it was never administered from June until October. He/She said he/she reported the incident to the Assistant Director of Nursing (ADON).During an interview on 01/08/26 at 2:39 P.M., the pharmacist said the facility did contact him/her about the potential of missing doses of the resident's liquid morphine. He/She said the color of the liquid morphine was pink. He/She said even if the morphine solution was not used for a long period of time, the color would not change to clear, so shaking the morphine solution wouldn't change the color. He/She said If water got into the bottle, it would dilute the color.During an interview on 01/08/26 at 3:13 P.M., the administrator said he/she and the ADON were responsible to complete a thorough investigation after an allegation of misappropriation of property. He/She said the ADON conducted the investigation related to resident's missing medication and unsubstantiated the allegation.During an interview on 01/16/26 at 9:49 A.M., the ADON said staff are directed to report abuse and neglect immediately to the supervisor or administrator. He/She said he/she would conduct a thorough investigation. He/She said LPN C reported to him/her the resident's liquid Morphine was potentially missing doses. He/She said he/she did complete an investigation but was unable to locate the paperwork related to the investigation of the potential misappropriation of the resident's liquid Morphine.Complaint #2709624

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, facility staff failed to maintain professional standards of practice when staff failed to complete shiftily controlled drug counts with two staff members and administer medications as ordered, when medications were unavailable for three residents (Residents #1 #2 and #3) out of three sampled residents. The facility census was 90.1. Review of the facility's Narcotic Count policy, undated, showed staff are directed to complete a physical inventory of narcotics at each shift change to identify discrepancies.-Narcotic records are reconciled by a physical count of the remaining narcotic supply at each shift change by the incoming and outgoing licensed nurse.-After the supply is counted and justified, the nurse/Certified Medication Technician (CMT) records the date and his/her signature, verifying that the count is correct.Review of the facility's Medication Ordering and Receiving from Pharmacy policy, dated 04/2017, showed staff are directed to reorder medication four days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing, such as VA medications or specialty medications, order at least seven days in advance of need.Review of the facility's Medication, Administration Guidelines policy, undated, showed-It is the purpose of this facility that residents receive their medications on a timely basis and in accordance with established policies.-Each facility should institute and follow a policy and procedure for regular counting of Class III and IV drugs. 2. Review of the Shift Verification of Controlled Substance Count, dated 12/08/25 through 12/31/25 showed the control substance count did not contain documentation of two staff signatures:-On 12/08/25, one staff signature for 10:00 P.M.;-On 12/13/25, one staff signature for 6:00 A.M. and 2:00 P.M.;-On 12/15/25, one staff signature for 10:00 P.M.;-On 12/16/25, one staff signature for 6:00 A.M. and 2:00 P.M.;-On 12/17/25, one staff signature for 6:00 A.M.;-On 12/18/25, one staff signature for 6:00 A.M. and 2:00 P.M.;-On 12/19/25, one staff signature for 10:00 P.M.;-On 12/20/25, one staff signature for 7:00 A.M.;-On 12/21/25, one staff signature for 10:00 P.M.;-On 12/22/25, one staff signature for 6:00 A.M., no signatures at 7:00 P.M. and one signature at 10: P.M.;-On 12/23/25, one staff signature for 10:00 P.M.;-On 12/25/25, one staff signature for 6:00 P.M.;-12/27/25, one staff signature for 2:00 P.M, and 6:00 P.M.;-On 12/28/25, one staff signature for 6:00 A.M. no signature at 2:00 P.M and one signature at 10:00 P.M.;-On 12/29/25, no staff signatures for 6:00 A.M.;-On 12/30/25, one staff signature for 10:00 P.M.;-On 12/31/25, one staff signature for 6:00 A.M., 2:00 P.M. and 10:00 P.M. During an interview on 01/08/26 at 12:12 P.M., Licensed Practical Nurse (LPN) A said staff are directed to count narcotic medication when coming on shift and off shift by two staff members and document on the form. He/She said the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were responsible to ensure staff documented they counted narcotic medication each shift. He/She said the concern with not completing a narcotic medication count each shift was the potential someone was stealing the medication.During an interview on 01/08/25 at 3:13 P.M., the administrator said staff are required to count narcotics at the beginning of each shift by two staff. He/She said staff should be documenting the narcotics count on the narcotics count form and signed off by both staff showing they completed the count. He/She said the Assistant Director of Nursing (ADON) or Director of Nursing (DON) were responsible to audit the form to verify staff are counting the narcotics. He/She said the concern with staff not completing the narcotic count on each shift, was the potential for the medication count to be off and unable to determine who could be responsible for the missing medication. During an interview on 1/16/26 at 9:49 AM, the ADON said staff are directed to complete count of the narcotic medication at the beginning and end of shift, or when another staff takes over the cart, by two staff members. He/She said staff would document in on the Shift Verifcation of Controlled Substance (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026

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

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Count sheet once the count is completed by two staff members. He/She said the concern if staff did not count the narcotic medication on each shift, would make it more difficult to determine why the medication count was not corrected.During an interview on 01/16/26 at 9:50 A.M., the DON said the narcotic medications should be counted at the beginning and end of each shift or before another staff takes over the cart and should be counted by two staff members. He/She said staff are directed to document a count was completed by two staff member on the Shift Verifcation of Controlled Substance Count form. He/She said if the narcotic medications were not counted each shift, it would make it difficult for staff to determine why the narcotic medication count was not correct. #2709624