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	03/04/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record review, facility staff failed to ensure one resident (Resident #1) remained free from verbal abuse when Certified Nursing Assistant (CNA) A verbally abused the resident and repeatedly yelled at the resident. The facility census was 90.The administrator was notified on 03/04/26 of past Non-Compliance, which occurred on 03/01/25 when the resident's family reported to facility staff that CNA A was observed on camera as he/she yelled and verbally abused the resident by mocking and ridiculing the resident. Staff immediately started an investigation, suspended CNA A pending the results of the investigation, assessed the resident for physical and psychological harm, notified the required state agency, re-educated staff on the abuse and neglect policy, and terminated CNA A on 03/02/26. Staff completed an additional in-service on communication with residents with a diagnosis of Dementia on 03/04/26. 1. Review of the facility's Abuse Prohibition Protocol Manual, undated, showed it is the policy of the facility that each resident will be free from abuse. Abuse can include verbal, mental, sexual, physical abuse, misappropriation of resident property and exploitation, corporal punishment and involuntary seclusion. Review of the facility's investigation, dated 03/01/26, showed Resident #1's responsible party reported to facility staff he/she watched a video footage, dated 03/01/26, and heard CNA A verbally abuse by mocking and ridiculing the resident. The administrator reported the allegations of verbal abuse to the required agencies and suspended CNA A. The administrator documented CNA A was terminated on 03/02/26 an employee handbook violation of failure to maintain care of residents on 03/01/26. 2. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment, dated 12/11/25, showed staff assessed the resident with moderate cognitive impairment, diagnoses to include Unspecified dementia, unspecified severity, without behavioral disturbance, Psychotic Disturbance (symptoms of hallucinations, delusions, disorganized thoughts), and anxiety. Review of the resident's care plan, dated 02/11/26, showed staff assessed the resident has impaired decision making related to dementia, and staff were directed to calm the resident if signs of distress develop during the decision making process by giving him/her time to make the decisions, talk slower and calmer, offer to call family if needs their support, ask him/her what he/she needs to calm down. Review of the video footage, dated 03/01/26 at 1:27 A.M., showed CNA A entered the resident's room, CNA A is heard yelling at the resident I wish you would really leave stuff alone, what are you in here doing? The resident said, we are fixing to go kill an animal. CNA A yelled, aint no animal in here to kill, give it here as he/she pulled something from the resident's hand. The resident pointed across the room and said, you better quit acting dumb now, the animal is laying right there watching you, and CNA A yelled aint no animal in here, leave stuff alone! You need to leave stuff alone. The resident said what? and CNA A said, because, you have no freaking clue what you're doing, where are you at right now? The resident said, what are you talking about? Where am I at right now? CNA A said yes, exactly, aint no animal in here. The resident said, tell me what's gonna happen in the morning when all this, and CNA A yelled NOTHING! You need to leave drawers alone .followed by inaudible words CNA A then yelled Go to sleep! and slammed the door shut as he/she exited the room. During an interview on 03/04/26 at 9:15 A.M., the administrator said after staff reported the allegations to him/her, he/she immediately (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspended CNA A pending the investigation. The administrator said after he/she reviewed the video footage, he/she determined CNA A verbally abused the resident, and he/she terminated CNA A. During an interview on 03/04/26 at 12:32 P.M., CNA A said his/her voice is naturally loud, and he/she only told the resident to go to sleep, but did not think he/she yelled at the resident and was not mean towards the resident. CNA A said he/she received in-services on abuse and neglect and denied any verbal abuse towards the resident. CNA A said there were no witnesses to his/her interaction with the resident inside the room. During an interview on 03/04/26 at 3:42 P.M., the DON said after he/she reviewed the video footage, he/she determined CNA A verbally abused the resident. During an interview on 03/05/26 at 11:48 A.M., Police Officer E said he/she received a report from the facility on 03/01/26 with allegations that CNA A had verbally abused the resident. He/She said CNA A was arrested on 03/04/26 on one charge relating to Elder Abuse and Neglect. During an interview on 03/05/26 at 12:18 P.M., the resident's responsible party said he/she reviewed the video footage in real time and did not appreciate how CNA A yelled at the resident and was demeaning towards the resident. The resident's responsible party said he/she watched the video again, then went to the facility later that morning and showed the video to facility staff. The resident's responsible party said after he/she spoke to the administrator, he/she agreed that CNA A was verbally abusive to the resident. Intake# 2791204 and complaint # 2791413

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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. Based on interviews and record review, facility staff failed to meet professional standards of care when licensed staff failed to complete and document a fall assessment as directed by the facility policy for one resident (Resident #1) out of three sampled residents, after staff reported the resident had an unwitnessed fall. The facility census was 90. 1. Review of the facility's Event Investigation policy, undated, showed the purpose is to identify any injuries after a resident sustains an event, and staff were directed:-Complete a Report of Event Form as soon as possible whenever there is an unexpected and/or unintended event that is not consistent with the routine operation of the facility, the routine care of the resident and/or adversely affects or has the potential to adversely affect a resident or visitor;-An example of when a form should be completed includes a fall or person found on the floor;-Document the location and type of event, such as a fall, complete vital signs (heart rate, blood pressure, respirations, body temperature), a mental/neurological status, range of motion (how far and in what direction you can move a joint or muscle), and pain assessment after the event. 2. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment, dated 12/11/25, showed staff assessed the resident with moderate cognitive impairment, and had two or more non-injury falls since admission. Review of the video footage from the resident's room, dated 03/01/26 showed Certified Nursing Assistant (CNA) A entered the resident's room twice at approximately 1:21 A.M. and 1:27 A.M., both times with the resident's lower body on the fall mat/mattress next to his/her bed. Review of the resident's Electronic Medical Record (EMR), dated 03/01/26, did not contain documentation Licensed Practical Nurse (LPN) B completed a Report of Event Form or assessed the resident's vital signs, mental/neurological status, range of motion, and pain as directed by the facility policy. During an interview on 03/04/26 at 12:32 P.M., CNA A said he/she reported to the nurse twice that the resident was seated on the fall mat/mattress next to his her/her bed. During an interview on 03/04/26 at 12:52 P.M., LPN B said CNA A reported to him/her the resident was on the fall mat/mattress in his/her room, but he/she was busy and did not immediately go to assess the resident. The LPN said about 10 minutes after CNA A made the report of the unwitnessed fall to him/her, the resident's family arrived at facility, went to the resident's room, and assisted the resident back to his/her bed. The LPN said he/she did not enter the resident's room until after the resident's family left over an hour later. The LPN said when he/she went to the resident's room, the resident was asleep in bed and he/she obtained the resident's vital signs, but did not initiate any neurological checks or range of motion checks and thought he/she documented his/her assessment in a progress note. During an interview on 03/04/26 at 1:57 P.M., the administrator said since the resident had an unwitnessed fall, he/she expected the nurse to complete an event form and post-fall assessments per the facility policy, and document a progress note regarding the incident.During an interview on 03/04/26 at 3:42 P.M., the DON said if a resident has an unwitnessed fall, he/she expects the nurse to assess the resident's vital signs, neurological status (on paper), range of motion, pain, apply first aid if needed, and document a progress note in the computer, along with an event form.During an interview on 03/05/26 at 12:18 P.M., the resident's responsible party said he/she arrived at the resident's room on 03/01/26 at approximately 1:45 A.M., assisted the resident from the fall mat/mattress to bed, stayed with the resident for about an hour and a half and did not see any facility staff enter the resident's room or assess the resident. Intake# 2791204 and complaint # 2791413