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	05/05/2026

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 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. Based on observation, interview, and record review, facility staff failed to ensure the safety of one resident (Resident #8) when facility staff turned off door alarm to exit door located on 200 hall and resident exited the facility. Staff failed to notify the physician and/or hospice to inform them resident found outside unattended. The resident was outside unattended for approximately one hour and 49 minutes. The facility census was 88.The administrator was notified on 05/05/26 of past noncompliance that occurred on 04/23/26 when resident's family contacted RN K to report the resident had not been seen in his/her room for a while on his/her camera. Registered Nurse (RN) K and Certified Medication Technician (CMT) M found the resident outside, assessed for injuries, and brought him/her back inside. Administrator began an investigation and identified the door alarm had been turned off by staff. Staff in-serviced staff to not turn the door alarm off.1. Review of the facility's Elopement, Missing Resident policy, undated, showed it did not provide direction for staff in regard to what to do when an alarm sounds. Staff are directed to notify the physician and once the resident is located, notify all appropriate agencies/people.2. Review of the facility investigation, dated 04/23/26, showed RN K reported to the administrator the resident got out of the building and he/she and CMT M assisted the resident back in the building and assessed for injuries, and no injuries identified. RN K informed administrator the door alarm was not working. The administrator checked and the alarms were turned off at the nurse station. RN K said he/she did not know the alarms could be turned off.Review of the facility's video footage without sound, dated 04/23/26, showed the resident left his/her room at 8:24 P.M. Review showed at 9:09 P.M., staff looked in the resident's room and down the hall for the resident. Reviewed showed at 10:13 P.M. the resident found and taken to his/her room.3. Review of Resident #8's annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/20/26, showed staff assessed the resident as severely cognitively impaired and did not exhibit behaviors of wandering.Review of the resident's progress notes, dated 04/23/26 at 10:12 P.M., showed RN K documented resident's family contacted the facility when they did not see the resident on the camera and he/she said he/she would check on the resident and call them back. He/She documented he/she checked the resident's room and hall, but the resident was not in either location. He/She documented he/she saw the door alarm on short wing was blinking and apparently the resident had gone out the door. He/She documented he/she did not realize it was an alarm as it was not audible because of the hall lights going off. RN K documented he/she and a Certified Medication Technician (CMT) M assisted the resident back inside the building. Review of the resident's elopement risk assessment, dated 03/20/26, showed the resident at risk for wandering related to cognitive impairment, restlessness, agitation and takes medication that suppress thought process.Observation on 05/05/26 at 11:58 AM, observation showed the door by the resident's room opened after fifteen seconds and the alarm sounded. The alarm continued until the code was entered at the nurse station.During an interview on 05/05/26 at 9:21 A.M., the administrator said the family contacted the facility after the resident was not in his/her room for about thirty to forty-five minutes. He/She said RN K went to check on the resident in his/her room, but he/she was not in the room. He/She said the resident was located outside. He/She said the resident got out the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side door for about thirty to forty-five minutes. He/She said he/she did not know if the alarm on the door went off. He/She said RN K said he/she thought the alarm was not working. He/She said on 04/24/26 between 7:00 A.M. and 8:00 A.M. he/she went to check the alarms at the nurse station and found the alarm for the hall had been turned off. He/She said he/she did not know how long the alarm was turned off or by who. The administrator said he/she expected staff to notify the hospice agency and the resident's physician after a resident was found outside. He/She couldn't find documentation the nurse notified the physician or hospice agency.During an interview on 05/05/26 at 10:16 A.M., the hospice nurse said staff did not contact him/her after the resident was found outside unattended. He/She said he/she visited the resident on 04/24/26 and was told the resident was found outside the facility, so he/she completed a physical assessment and found bruising on the bottom right part of his/her right foot, most likely from standing for a long period of time. He/She said he/she could not confirm the bruise was or was not there prior to the resident being found outside by staff.During an interview on 05/05/26 at 1:56 P.M., RN L said if the door was opened, an alarm at the nurse station would blink, so staff would be notified. He/She said there have been no issues with the alarm system. He/She said staff reported the resident had gone out the door located by his/her room. He/She said the area where the resident was located was not enclosed. RN L said if a resident was located outside, staff should complete an assessment and contact the family, physician and hospice.During an interview on 05/06/26 at 7:31 A.M., Certified Nurse Aide (CNA) N said CMT M told him/her the resident was found outside. He/She said RN K had informed CMT M that he/she turned off the alarm because his/her child was bringing him/her food and did not want the alarm to go off.During an interview on 05/06/26 at 8:59 A.M., CMT M said RN K walked past him/her and said the family called him/her to let staff know the resident had not been in his/her room for a while. He/She said he/she looked down the hall and in the resident's room but did not see him/her. He/She said RN K looked up, the light above the exit door was blinking, but there was no sound, so they looked outside and found the resident down the sidewalk. He/She said the resident was down past the door, with his/her walker stuck in the mud and the resident couldn't get the walker out of the mud. He/She said there was no alarm sound at the nurse station and assumed the alarm was turned off because there was a loud noise when the alarms went off. He/She said RN K said the alarm was turned off and he/she didn't know by who.29988342994176

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interviews and record review, facility staff failed to ensure five Nurse Aides (Na's) (NA C, NA D, NA E, NA F, and NA G) out of five NA's completed the nurse aide training program within four months (120 days) of their employment in the facility. The facility's census was 91.1. Review of the facility's policies showed staff did not provide a policy for NA training and requirements.Review of the facility's Job Description for Certified Nursing Assistant (CNA), undated, showed a minimum qualification is to be licensed as a CNA in accordance with the requirements of the state governing the facility.2. Review of NA C's personnel file showed a hire date of 04/02/25, and he/she began work as an NA in 09/2025. The file did not contain documentation he/she completed the NA training program.During an interview on 04/22/26 at 11:53 A.M., NA C said he/she started working on the floor as an aide in 10/2025, but he/she has not been able to pass all the testing required to become certified.NA C said he/she was told he/she had 120 days to become certified, or he/she would not be able to continue to work the floor, and he/she passed the skills test, so is still allowed to work the floor but is usually paired with a CNA when working. NA C said he/she is scheduled to retake the written test on 04/28/26.During an interview on 04/22/26 at 10:05 A.M., the ADON said NA C transferred from another department to the nursing department in 09/2025.3. Review of NA D's personnel file showed a hire date of 07/29/25. The file did not contain documentation that the NA completed an NA training program.During an interview on 04/22/26 at 1:52 P.M., NA D said he/she started working on the floor as an aide in 08/2025, completed the NA classwork back in 01/2026 and passed the written test, but he/she does not have a date scheduled to take the required skills test to become certified, and did not provide a reason as to why it was not scheduled4. Review of NA E's personnel file showed a hire date of 10/03/25. The file did not contain documentation the NA completed the NA training program.During an interview on 04/22/26 at 10:05 A.M., the ADON said the NA had just completed the classes in the past week and is scheduled to take the written test 05/04/26. The ADON said a few months ago, NA E had a delay getting his/her pink sheets which is a requirement for the classes signed off timely. 5. Review of NA F's personnel file showed a hire date of 10/20/25. The file did not contain documentation the NA completed the NA training program.During an interview on 04/22/26 at 10:05 A.M., the ADON said NA F was scheduled to take the written test 04/22/26 and should have the results by the end of day.6. Review of NA G's personnel file showed a hire date of 12/02/25. The file did not contain documentation the NA completed an NA training program.During an interview on 04/22/26 at 10:05 A.M., the ADON said NA G failed the written test about a week prior and is scheduled to retake the test on 05/01/26.7. During an interview on 04/22/26 at 10:05 A.M., the ADON said the five NAs are on the current schedule to assist residents with care needs and are allowed to perform the skills they have been signed off for competency, but they are usually scheduled to work with a CNA.During an interview on 04/22/26 at 3:45 P.M., the administrator said NAs should be certified within 120 days of hire, and if not certified in the timeframe, they should be removed from the floor and offered to work in a different department, or perform duties like passing ice water, making beds, etc. The administrator said he/she, the DON and ADON share the responsibility to monitor the NAs for compliance, but they have faced several challenges to have the NAs certified timely. The administrator said he/she is aware the NAs are still scheduled to work the floor to assist with resident care. He/She said the facility had started to wait for NAs to work at least 30 days before paying for them to attend the classes. He/She said the testing sites they previously used are not currently allowed/able to facilitate the skills test/evaluations, the NAs are having difficulty finding a testing site closer than one to two hours from the facility to test, and with transportation to the available sites, so some have just have not scheduled the skills test in fear of not making it to the testing site.Complaint #2963123

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, facility staff failed to update the Facility Assessment (a facility-wide assessment completed by facility staff to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies) at least annually. The facility's census was 91. 1. Review of the facility's Sample Process for Conducting the Facility Assessment, dated 09/18/17, showed staff were directed to review the facility assessment requirements and guidance at F838 (a federal regulation), and establish a process for updating the assessment in one year or earlier if there are substantive changes.2. Review of the facility's Facility Assessment, dated 08/12/24, showed:-The assessment was reviewed with the Quality Assurance and Performance Improvement (QAPI) committee at the January 31st Quality Assurance (QA) meeting;-The facility is licensed to provide care for 97 residents;-The average daily census is 80-90;-The staffing plan identified the total number of staff needed or average is based on 70 residents;-The assessment did not contain documentation staff updated the Facility Assessment at least annually and did not contain staffing data to reflect the total number of staff needed to care for the average daily census of 80-90 residents.During an interview on 04/22/26 at 3:45 P.M., the Administrator said the facility assessment should be reviewed quarterly by facility staff at QAPI meetings and updated at least annually. He/She said the facility assessment should be updated if there is a change in administration and should reflect staffing requirements for resident acuity and average census. He/She said the administrator listed on the facility assessment left the facility in 10/2024, so he/she does not know why the facility assessment had not been updated since 08/2024. The administrator said he/she assumed the role on 03/01/26 and has it on his/her list to complete the facility assessment at the next QAPI meeting.Complaint # 2963123

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to perform hand hygiene and/or wash hands to prevent the spread of infection during incontinence care for three residents (Resident #1, # 2 and #3) out of three sampled residents. Facility staff failed to wear appropriate personal protective equipment (PPE) during care or place appropriate PPE within proximity of the rooms for two residents (Resident #1 and #2) out of two sampled residents with wounds, who required Enhanced Barrier Precautions (EBP) (an infection control intervention). The facility's census was 91. 1. Review of the facility's Hand Cleanser policy, undated, showed the purpose is to cleanse the hands between resident contacts during care and to prevent the spread of infection.Review of the facility's Handwashing policy, undated, showed the purpose of handwashing is to reduce transmission of organisms from resident to resident, nursing staff to resident, and resident to nursing staff.Review of the facility's policy, Perineal Care, undated, showed the purpose is to cleanse the perineum (area between genitals and anus), and to prevent infection and odor. Staff were directed to provide male and female perineal care, put on disposable gloves, remove gloves and wash hands.Review of the facility's policy, Gloves, undated, showed it did not contain direction for staff to perform hand hygiene between glove changes.Review of the facility's policy, Enhanced Barrier Precautions to Infection Control Guidance, dated 03/2024, showed:-The purpose is to prevent broader transmission of MDRO (multidrug-resistance organisms) and to help protect patients with chronic wounds and indwelling devices. EBP should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed;-Use EBP when providing high-contact resident care activities such as when transferring resident from one position to another, providing hygiene, changing bed linens, changing briefs or assisting with toileting, and performing wound care;-Staff should use gown and gloves;-Residents that are placed on EBP should have PPE in close proximity outside the door and a trash can in resident's room for disposal prior to leaving the room.2. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/26/26, showed staff assessed the resident as severely cognitively impaired and dependent on staff with transfers, personal hygiene and toileting.Review of the resident's weekly skin assessment completed by a nurse, dated 04/22/26 at 3:08 A.M., showed staff documented skin breakdown to coccyx and surrounding skin.Observation on 04/22/26 at 1:26 P.M., showed a medical sign outside the room to alert staff EBP required. The resident's room did not have PPE within proximity. Nursing Assistant (NA) D and Certified Nursing Assistant (CNA) H entered the resident's room, applied gloves, transferred the resident by mechanical lift from his/her chair to bed to perform incontinence care, and Licensed Practical Nurse (LPN) I entered the room to assess the resident's buttock. CNA H assisted with turning and removing the resident's clothing, while NA D performed incontinence care, and LPN I applied gloves and assessed a wound to the resident's left buttock and right gluteal fold (below the buttock). NA D, CNA H and LPN I did not wear a gown. NA D did not perform hand hygiene between gloves changes during peri-care or after providing peri-care to prevent the spread of infection.During an interview on 04/22/26 at 1:52 P.M., NA D said he/she was aware the resident had a small open area to his/her buttock, and the EBP sign meant staff should wear gown and gloves for transfers and incontinence care. NA D said gowns were on a bedside table down the hall, and other PPE might be on the linen cart or at a station somewhere in the hallway, but he/she does not always have time to search for PPE to use and just forgot to grab a gown. NA D said he/she should have used hand sanitizer or washed his/her hands after glove changes and before he/she left the room, but he/she was busy, felt overwhelmed and forgot.During an interview on 04/22/26 at 2:11 P.M., LPN I said he/she should have worn a gown to perform the wound assessment, but the aides did not have to wear a gown since they did not know the resident had the new open areas to his/her buttock.3. Review of Resident #2's annual MDS, dated [DATE], showed staff assessed the resident as requiring (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	setup or clean-up assistance from staff with lower body dressing and putting on/taking off footwear and did not have any other ulcers, wounds or skin problems.Review of the resident's Physician Order Summary (POS), dated 01/01/26 through 04/23/26, showed an order to apply barrier cream to coccyx every shift and as needed and an order to cleanse the left shin with wound cleanser, pat dry, apply a sterile, non-adherent, petrolatum-based wound dressing to base of wound, cover with medical dressing and wrap daily.Observation on 04/22/26 at 1:58 P.M., showed CNA A entered the resident's room to provide care. CNA A put on gloves, without performing hand hygiene, and did not put on a gown. CNA A dressed the resident in his/her underwear and pants up to his/her buttocks and then put his/her shoes (touching the bottom of the shoes). CNA A assisted the resident with repositioning and put on his/her shirt with the same gloves. CNA A attempted to transfer the resident, but was unable to, so he/she left the room to find assistance. CNA A did not perform hand hygiene before leaving the room. CNA A and CNA B entered the resident's room. CNA A and CNA B did not perform hand hygiene upon entering the resident's room or put on a gown. CNA B applied gloves out of his/her pocket and gave CNA A a pair of gloves from his/her pocket. CNA B removed the resident's dirty clothing and incontinence pad, bagged up the items, then removed gloves. CNA B removed new gloves from his/her pocket and put on gloves without performing hand hygiene and assisted CNA A with pulling up the residents pants and underwear. CNA A and CNA B left the resident's room without performing hand hygiene.Observation on 04/22/26 at 2:17 P.M., showed a sticker on the resident's door to let staff know the resident on EBP and PPE not in proximity of the resident's room.3. Review of Resident #3's annual MDS, dated [DATE], showed staff assessed the residents as cognitively intact and required substantial to maximal assistance from staff with toilet transfers;Observation on 04/22/26 at 11:06 A.M., showed CNA A and CNA B entered the resident's room to provide care. CNA A and CNA B put on gloves, without performing hand hygiene and assisted the resident to the toilet. CNA A removed the resident's brief and assisted the resident to sit on the toilet. CNA A grabbed a clean brief with the same gloves and brought it into the bathroom. CNA B wiped the resident's buttock with a disposable wipe, then grabbed the clean brief before removing gloves and putting on new gloves without performing hand hygiene. CNA A and CNA B assisted with putting on a new brief. CNA A and CNA B put on put on the resident's pants and slippers and transferred the resident to the wheelchair with the same gloves. CNA B removed his/her gloves and left the resident's room without performing hand hygiene.4. During an interview on 04/22/26 at 2:19 P.M., CNA A said staff are directed to perform hand hygiene any time they are putting on/off or changing gloves. He/She said he/she did miss hand hygiene opportunity. He/She said he/she did not know why he/she did not perform hand hygiene between glove changes or why he/she did not wear a gown when providing care to a resident who is on EBP. He/She said staff identify resident's on EBP by a sticker on the resident's door.During an interview on 04/22/26 at 2:19 P.M., CNA B said staff are educated to use hand hygiene when entering the resident room, between going through clean and dirty task and upon exiting the room. He/She said he/she did know he/she missed a hand hygiene opportunity. He/She said a resident on EBP had a sticker on the door letting staff know to wear a gown and gloves. He/She said he/she was not thinking about hand hygiene between changing gloves or wearing a gown when providing care. He/She said there was not a set spot for staff to get PPE and it was not convenient.During an interview on 04/22/26 at 2:11 P.M., LPN I, the facility's Infection Preventionist (IP), said staff are educated on the EBP policy/process during orientation and staff meetings, and PPE are stored in credenzas in the hallways. LPN I said the medical symbol next to a residents name is to alert staff to wear at least gown and gloves for EBP during cares to prevent the spread of infection.During an interview on 04/22/26 at 3:09 P.M., the assistant Director of Nursing (ADON) said he/she expects staff to wash hands before and after care, when soiled, and after glove changes. The ADON said the nurses should spot check the NAs and CNAs for proper hand hygiene during cares. The ADON said staff are educated on the EBP policy during orientation and in-services, the medical sign by a resident's name indicates EBP is required for transfers, incontinence care and wound care, PPE are (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stored in the utility room cabinets, and the aides are expected to place PPE on the linen carts to use on the halls.During an interview on 04/22/26 at 3:45 P.M., the administrator said he/she expects staff to wear gloves during resident care, change gloves between dirty & clean tasks, and when switching residents. The administrator said staff should wash hands before and after cares, after they remove gloves, and when hands are visibly soiled to prevent infection. He/She said staff are educated on EBP during orientation and in-services, the medical sign by a resident's name indicates EBP is required for transfers, incontinence care and wound care. He/She said PPE should be stored in the credenzas and on linen carts on each hall, and should be within proximity to residents that require EBP. The administrator said the IP has only been in the role for about two weeks, but he/she will be responsible to ensure PPE is available and within proximity to the rooms of residents who require EBP.Complaint # 2963123