

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 10/10/2024
NAME OF PROVIDER OR SUPPLIER Villa at Blue Ridge, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>47193</p> <p>Based on interview and record review, facility staff failed to check the Certified Nurse Assistant (CNA) Registry for employee prior to hire to ensure they did not have a Federal Indicator (a marker given by the federal government to individuals who have committed abuse and/or neglect) for five employees (Dietary Aide D, Nurse Aide E, Housekeeping F, Dietary [NAME] G, and Registered Nurse H) out of a sample of ten employees. Facility staff failed to complete a thorough investigate of an injury of unknown origin for one resident (Resident #61) out of one sampled resident. The facility census was 83.</p> <p>1. Review of the Facility's Screening Abuse and Neglect Manual, undated, showed:</p> <ul style="list-style-type: none"> -The facility will not hire an employee or engage an individual who was found guilty of abuse, neglect, exploitation, or mistreatment or misappropriation of property by a court of law; or who has a finding in the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, or has had a disciplinary action in effect taken against his/her professional license; -The Certified Nurse Assistant (CNA) Registry- ALL applicants must be checked before hire; -Keep a copy of the result page in the employee's personnel file. <p>2. Review of Dietary Aide D's employee file showed a hire date of 01/05/24. The employee file did not contain documentation of the Dietary Aide's CNA's registry check.</p> <p>3. Review of Nurse Aide E's employee file showed a hire date of 08/26/24. The employee file did not contain documentation of the Nurse Aide's CNA's registry check.</p> <p>4. Review of Housekeeping F's employee file showed a hire date of 10/01/24. The employee file did not contain documentation of the Housekeeping's CNA's registry check.</p> <p>5. Review of Dietary [NAME] G's employee file showed a hire date of 11/19/23. The employee file did not contain documentation of the Dietary Cook's CNA's registry check.</p> <p>6. Review of Registered Nurse H's employee file showed a hire date of 05/20/24. The employee file did not contain documentation of the Registered Nurse's CNA's registry check.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/10/24 at 10:05 A.M., the assistant business office manager (ABOM) said it is his/her responsibility to do background checks prior to hiring. He/She said he/she was not aware he/she should be running the nurse aide registry checks on all staff. He/She said he/she was recently educated on the CNA registry checks and he/she was only running them on CNA's to check for certification.</p> <p>During an interview on 10/10/24 at 4:36 P.M., the Assistant Director of Nursing (ADON) said it is the responsibility of the ABOM to run all background checks prior to hire including nurse aide registry. He/She said the nurse aide registry should be done prior to hire and quarterly. He/She was not aware they were not being done. He/She said he/she recently educated the ABOM and he/she must have only ran the CNA's instead of all staff. He/She said they should be done so the facility can ensure no one is hired who has charges against them.</p> <p>During an interview on 10/10/24 at 5:19 P.M., the Administrator said it is the responsibility of the ABOM to run all background checks prior to hire including nurse aide registry. He/She was not aware they were not being done. He/She said they should be ran prior to hire and quarterly. He/She is not sure why he/she was not doing them. He/She said it is important for the CNA registry checks to be completed to ensure all employees hired are free from charges of abuse and neglect.</p> <p>7. Review of the Facility's Reporting Abuse and Neglect Manual, undated, showed:</p> <p>-All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source and misappropriation of resident property by facility employees, contracted employees, volunteers, contract services, consultants, physicians, visitors, family members, or other individuals will be reported immediately but no later than the following timeframes. If the abuse is alleged or the allegation results in serious bodily injury, the allegation must be reported within 2 hours after the allegation was made. If the allegation does not allege abuse or result in serious bodily injury, the report must be made within 24 hours after the allegation was made.</p> <p>Review of the Facility's Event Investigation, undated, showed:</p> <p>-To investigate the cause of all marks, discolorations, skin breaks and injuries which have not been witnessed. To identify any injuries after a resident sustains an event;</p> <p>-Complete a Report of Event Form as soon as possible whenever there is an unusual, unexpected and/or unidentified event that si not consistent with the routine operation of the facility, the routine care of the resident and/or adversely effects or has the potential to adversely affect a resident or visitor. Examples of when a form should be completed:</p> <p>-Bruises/skin tear of unknown origin;</p> <p>-The charge nurse is responsible for completion of the Report of Event form and forwarding to the Director of Nursing (DON) as soon as possible.</p> <p>8. Review of Resident #61's Annual Minimum Data Set (MDS), a federally mandated assessment tool used by staff, dated 06/15/24, showed staff assessed the resident as follows:</p> <p>-Cognition intact;</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Substantial assistance with lower body dressing;</p> <p>-Upper extremity impairment on one side;</p> <p>-Diagnoses of Parkinson's disease;</p> <p>-Used wheelchair.</p> <p>Observation on 10/08/24 at 9:24 A.M., showed the resident in his/her recliner. He/She had a red left cheek, small amount of swelling under the left eye and on his/her left brow, laceration to the right forehead in his/her hairline, and resident's left wrist and hand appeared swollen. Resident was unable to answer questions, but grimaced and guarded left wrist when touched.</p> <p>Review of the resident's medical record, showed the record did not contain documentation staff investigated the injuries to the resident.</p> <p>During an interview on 10/10/24 at 4:36 P.M., the Assistant Director of Nursing (ADON) said he/she was called to the resident's room because the resident had a reddened cheek, scratch to his/her forehead and a swollen wrist. He/She said when he/she asked the resident if he/she fell the resident nodded yes but was unable to answer any other questions. He/She said he/she asked dayshift staff if they knew where the resident got the injuries and staff were unsure. He/She said he/she never contacted night shift about the injuries. He/She said he/she told the charge nurse to contact the doctor and get an order for an X-ray, which came back clear. He/She said he/she is supposed to investigate when there is an injury of unknown origin. He/She said there was no proof that there was an injury, and that the resident didn't injure himself/herself. He/She said he/she did not do a formal investigation or fill out a report on the situation.</p> <p>During an interview on 10/10/24 at 5:19 P.M., the administrator said he/she expects the charge nurse who finds an injury of unknown origin to initiate the investigation, notify the physician, notify the responsible party, notify the ADON or DON and then he/she should notify the administrator. He/She would expect there to be an investigation that narrows down time frames and has staff interviews. He/She said he/she would expect there to be documentation of what was investigated. He/She was not made aware of the injury of unknown origin and he/she is not sure why it was not investigated and documented.</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644</p> <p>Based on interview and record review, facility staff failed to assess residents using the quarterly Minimum Data Set (MDS), a federally mandated assessment completed by staff, no less frequently than once every 92 days as directed by the Resident Assessment Instrument (RAI) manual for 19 residents (Resident #6, #9, #12, #20, #26, #28, #29, #31, #32, #33, #41, #44, #46, #51, #57, #63, #69, #70, and #71) out of 20 sampled. The facility census was 83.</p> <p>1. Review of the Resident Assessment Manual (RAI), dated 10/1/17, showed the Quarterly assessment is an Omnibus Budget Reconciliation Act of 1987 (OBRA) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The Assessment Reference Date (ARD) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.</p> <p>1. Review of Resident #6's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>2. Review of Resident #9's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>3. Review of Resident #12's medical record showed a admission MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>4. Review of Resident #20's medical record showed a admission MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>5. Review of Resident #26's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>6. Review of Resident #28's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in July 2024.</p> <p>7. Review of Resident #29's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>8. Review of Resident #31's medical record showed a admission MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>9. Review of Resident #32's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>10. Review of Resident #33's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>(continued on next page)</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>11. Review of Resident #41's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>12. Review of Resident #44's medical record showed a quarterly MDS dated [DATE]. Staff did not document an annual MDS in August 2024.</p> <p>13. Review of Resident #46's medical record showed an annual MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>14. Review of Resident #51's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>15. Review of Resident #57's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>16. Review of Resident #63's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>17. Review of Resident #69's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>18. Review of Resident #70's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in July 2024.</p> <p>19. Review of Resident #71's medical record showed a quarterly MDS dated [DATE]. Staff did not document a quarterly MDS in August 2024.</p> <p>20. During an interview on 10/10/24 at 2:52 P.M., the MDS Coordinator said the previous MDS Coordinator was gone a lot and got behind on MDS's so he/she is now trying to catch up. He/She said if the MDS says In progress that means it is one he/she is actively working on.</p> <p>During an interview on 10/10/24 at 4:37 P.M., the Assistant Director of Nursing (ADON) said the previous MDS Coordinator was supposed to have them completed, but they were not, so the current MDS trying to get caught up. The ADON said the Director of Nursing (DON) is responsible for oversight on MDS.</p> <p>During an interview on 10/10/24 at 5:19 P.M., the administrator said she would expect the DON to help MDS if needed. The DON however has had to work the floor to cover RN hours, so he/she has not been available much. The administrator said she was not aware they were far behind and the corporate who oversees the facility hasn't reported anything about this to her.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644</p> <p>Based on observation, interview, and record review, facility staff failed to meet professional standards of care one resident (Resident #31) , when staff failed to provided the resident's treatment as ordered and facility staff failed to provide consistent documentation in regard to choice of code status (the level of medical interventions a resident wishes to have if their heart or breathing stops) for two resident's (#3 and #30) out of three sampled resident. The facility census was 83.</p> <p>1. Review of the facility's Physician Orders Policy, undated, showed a current lists of orders must be maintained in the clinical record of each resident to avoid confusion and errors.</p> <p>2. Review of Resident #31's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> -Moderate cognitive impairment; -Lower extremity impairment on one side; -Dependent on staff for lower body dressing; -Diagnosis of Parkinson's and Diabetes. <p>Review of the resident's Physician Order Sheet (POS), dated [DATE], showed an order dated [DATE], for Tubi grip (a tubular bandage that provides support and compression for a variety of injuries and conditions) to bilateral lower extremity every shift, off at bedtime for generalized edema.</p> <p>Observation on [DATE] at 3:30 P.M., showed the resident in his/her wheelchair without Tubi grips on his/her legs.</p> <p>Observations on [DATE] at 1:25 P.M., showed the resident in his/her wheelchair without Tubi grips on his/her legs.</p> <p>Observations on [DATE] at 10:00 A.M., showed the resident in his/ her wheelchair without Tubi grips on his/her legs.</p> <p>During an interview on [DATE] at 2:45 P.M., Licensed Practical Nurse (LPN) A said he/she expects staff to carry out orders as prescribed by the physician. He/She said it is okay to use nursing judgement in certain cases, but nurses should document the reason for not carrying out the order and should notify the physician. He/She said if a resident refuses care or treatments nurses should make more than one attempt and should document the refusals and notify the physician of the situation.</p> <p>During an interview on [DATE] at 3:02 P.M., LPN R said the resident often refuses to wear his/her tubi grips. LPN R said the tubi grips were on him/her this morning, and it is the nurses responsibility to put them to the resident. LPN R said he/she does not know why they are not on her currently. LPN R said if a resident refuses a treatment it should be documented on the Treatment Administration Record.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 4:37 P.M., the Assistant Director of Nursing (ADON) said if a resident has an order for a treatment, the expectation is for it to be followed. If a resident refuses, try a different staff but if not done it should be documented.</p> <p>During an interview on [DATE] at 5:19 P.M., the administrator said all physician orders should be followed and if resident refuses any order or treatment, it should be documented in progress notes each time.</p> <p>3. Review of the facility's policies showed staff did not provide a documentation of advance directives policy.</p> <p>4. Review of Resident #3's Quarterly MDS, dated [DATE], showed facility staff assessed the resident as moderate cognitive impairment.</p> <p>Review of the resident's care plan, dated [DATE], showed staff documented the resident as a full code status.</p> <p>Review of the resident's POS, dated [DATE], showed a physician order for full code status.</p> <p>Review of the resident's face sheet, showed the resident's code status as do not resuscitate (DNR).</p> <p>Review of the resident's advance directive, dated [DATE], showed the resident had a signed DNR.</p> <p>Observation on [DATE] at 1:35 P.M., showed the resident's door had a red sticker next to his/her name.</p> <p>5. Review of Resident #30's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact.</p> <p>Review of the resident's care plan, dated [DATE], showed staff documented the resident as a full code status.</p> <p>Review of the resident's facesheet showed staff documented the resident as a full code status.</p> <p>Review of the resident's POS, [DATE], showed an order for a DNR status.</p> <p>Observation on [DATE] at 5:06 P.M., showed the resident's door with a red dot on it.</p> <p>6. During an interview on [DATE] at 1:37 P.M., housekeeper B said he/she is not sure what the colored stickers meant next to the resident's names on their door. He/She said he/she thinks they signify which bed each resident is in. He/She said he/she works in housekeeping and had not received an education on the meaning of the door stickers.</p> <p>During an interview on [DATE] at 1:39 P.M., nurse aide (NA) C said the red dot next the residents name on his/her door indicates DNR and green sticker indicates full code.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] 02:45 P.M., LPN A said the red sticker on the resident's door means they are a DNR and the green means they are a full code. He/She said he/she would expect the advance directives placed in the resident charts to match their orders, what the resident has signed off on, the face sheet, and what is marked on the resident's door. He/She said having them not match or be incorrect could cause a full code to get missed and not be resuscitated and a DNR could be resuscitated against their choice. He/She said the Social Services director oversees obtaining and maintaining resident code statuses. He/She said he/she was not aware some residents had code statuses that did not match.</p> <p>During an interview on [DATE] at 3:22 P.M., the social services director said he/she is responsible for obtaining and maintain resident code statuses. He/She said he/she obtains the residents code status upon admission and keeps them up to date as they change. He/She said he/she oversees making sure code status changes are updated by the physician as they change. He/She said he/she does quarterly audits to make sure resident code status match records. He/She said there are five areas he/she checks during audits. He/She checks the resident's face sheet, care plan, the resident's door, orders, and make sure there is an updated copy at the nurse's station. He/She said he/she was not aware there were some residents whose code status didn't match. He/She said he/she did an audit last July and it is time for another audit.</p> <p>During an interview on [DATE] at 4:36 P.M., the assistant director of nursing (ADON) said the social services director is responsible for maintaining and updating advance directives. He/She said it is his/her expectation that resident code statuses are accurate and consistently match all areas of their medical record. He/She said he/she was not aware there were some residents whose medical records had inconsistent code statuses. He/She said the concern with the inconsistency is that the resident may not get their wishes carried out if something were to happen.</p> <p>During an interview on [DATE] at 5:10 P.M. CNA I said the dots on the door are there so you know the code status of the residents. Red is DNR and [NAME] is revive them.</p> <p>During an interview on [DATE] at 5:15 P.M. Charge Nurse J said the dots on the door show the code status. Red is DNR and green is full code. He/She said it is the responsibility of someone in administration to make sure the dots are on the door. Social Services usually comes around and checks them.</p> <p>During an interview on [DATE] at 5:19 P.M., the administrator said the social services director is responsible for maintaining and ensuring each resident's advanced directives are correct and consistent throughout their medical record. He/She said he/she was not aware there were some residents whose records were not consistent. He/She said the concern is that in the event of an emergency staff would not know which is correct and the residents wishes would not be upheld. He/She said code statuses can be found on the resident's face sheet, orders, care plan, color codes dots on the doors and in a advance directive binder.</p> <p>47193</p> <p>50432</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644</p> <p>Based on interview and record review, facility staff failed to complete a comprehensive discharge summary or post discharge plan of care form for one resident (Resident #77) of two discharged residents. The facility census was 83.</p> <p>1. Review of the facility's Discharge/Transfer of Resident Policy, undated, showed to provide a safe departure from the facility and to provide sufficient information for aftercare of the resident staff will complete a discharge summary and post discharge plan of care form.</p> <p>2. Review of Resident #77s medical record, showed the resident discharged on [DATE]. The record did not contain a comprehensive discharge summary or post discharge plan of care of the resident's stay in the facility.</p> <p>During an interview on 10/10/24 at 10:00 A.M., the Social Services Director (SSD) said he/she is responsible for resident discharges. The SSD said he/she should have put a discharge summary and other discharge information in the resident's medical record, but just didn't do it.</p> <p>During an interview on 10/10/24 at 4:37 P.M., the Assistant Director of Nursing (ADON) said when a resident is discharged the SSD is made aware, and they are responsible to set up home health, or therapy if needed. The SSD would do discharge education and put the discharge summary in the medical record.</p> <p>During an interview on 10/10/24 at 5:19 P.M., the administrator said when a resident discharges from the facility she would expect there to be a doctor's order, Home Health set up if needed, and verify they have a safe place to go after they leave the facility. The administrator said SSD is responsible for putting the discharge information into the resident's medical record.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>47193</p> <p>Based on interview and record review, facility staff failed to ensure one (Resident #55) of one sampled residents received care and services for the provision of hemodialysis (the clinical purification of blood by dialysis, as a substitute for the normal function of the kidney) consistent with professional standards of practice when staff failed to provide orders, ongoing assessments of the resident's condition, and monitoring for complications after dialysis treatments. The facility census was 83.</p> <p>1. Review of the Facility's Care of a Resident Receiving Dialysis policy, undated, showed staff are directed to:</p> <ul style="list-style-type: none"> -Feel for thrill (vibration that is felt on the skin overlying an dialysis shunt (connection from a hemodialysis access point to a major artery)) sensation daily; -Inspect access site for redness, swelling, or warmth; -Watch for bleeding after dialysis; -Monitor for signs of infection; -Nurse will maintain dressing to access site at all times. Site to be checked every shift and dressing reapplied or reinforced as needed; -Nurses will check the thrill daily and document daily. This will be documented on the resident's treatment record; -Communication between the Facility and Dialysis unit; -The Dialysis Communication Record will be sent with the resident on each dialysis visit; -All care concerns in the last 24 hours will be addressed, including last medications given and facility contact person; -The dialysis unit will complete the lower portion of the report to include weight prior to and after dialysis, any labs completed, medication given, follow up information and any new physician orders; -The lower portion will be signed by the dialysis nurse and returned to the facility; -These records will be maintained in the medical record. <p>2. Review of Resident #55's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/20/24, showed facility staff assessed the resident as:</p> <ul style="list-style-type: none"> -Cognitively intact; <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses of End Stage Renal Disease, Type 2 Diabetes Mellitus and Congestive Heart Failure;</p> <p>-Received dialysis.</p> <p>Review of the resident's care plan, dated 08/21/24, showed staff assessed the resident with right-sided dialysis shunt. Review showed staff documented:</p> <p>-The resident will not have signs or symptoms of infection;</p> <p>-Staff will check for thrill over shunt once daily;</p> <p>-Staff will not take blood pressure or blood from the right-side extremity;</p> <p>-The plan of care did not direct staff on monitoring or care of a resident on dialysis.</p> <p>Review of the resident's physician's order sheet (POS), dated October 2024, showed the POS did not contain an order for dialysis or care of the right-side shunt.</p> <p>Review of the resident's medical record, from January 2024-October 2024, showed the record it did not contain documentation staff assessed the resident prior to or upon return from dialysis appointments, monitored daily vital signs, monitored risk for infection, monitored the resident's shunt, monitored intake, and output, monitored daily weights, and the record did not contain completed communication forms.</p> <p>During an interview on 10/09/24 at 2:49 P.M., Charge Nurse L said he/she only puts documentation in the residents chart if the dialysis clinic calls to say there are issues. He/She said he/she will add a note in progress notes or if he/she sees any issues. He/She said there are no other documentation that is required for them to do with residents on dialysis. He/She said the facility only has one dialysis resident.</p> <p>During an interview on 10/10/24 at 2:45 P.M., Licensed Practical Nurse (LPN) A said he/she is not sure what the policy says about dialysis. He/She said staff should be assessing the resident before and after dialysis. He/She said some of the assessments would be checking vitals, weights and blood sugars. He/She said he/she was not aware of a dialysis communication for until today.</p> <p>During an interview 10/10/24 at 9:13 A.M., the Assistant Director of Nursing (ADON) said he/she would expect there to be an order for dialysis and assessing the shunt site. He/She said staff should be doing the assessments and vital signs on the resident monthly. He/She said they do not do assessments before or after dialysis, but staff should be doing them because the resident could have blood sugars that are too high or too low and they would not know if they didn't do assessments. He/She said they have a communication form staff have not been using. He/She said he/she the new hires were not educated on them when they started. He/She said the DON is responsible for ensuring these are getting done, but the DON has been staffing the night shift as the charge nurse.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/10/24 at 5:19 P.M., the administrator said they only have one resident on dialysis. He/She said he/she would expect there to be orders for dialysis and taking care of the shunt, He/She said staff should be assessing at the shunt daily. He/She said he/she expects staff to be using the communication form before the resident leaves for dialysis, he/she should take the form to the dialysis clinic and then facility staff should be filling it out when he/she returns. He/She said he/she was not aware staff were not using the communication forms and that there were not orders in for dialysis and assessments of the shunt.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>47193</p> <p>Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN), for at least eight consecutive hours per day, seven days a week. The facility census was 83.</p> <p>1. Review of the facility's policies showed the facility did not provide a policy for RN coverage.</p> <p>2. Review of the facility's RN staff schedule, dated July 2024, showed the facility did not have an RN in the building for the dates of:</p> <p>-Thursday 07/04/24;</p> <p>-Friday 07/05/24;</p> <p>-Sunday 07/07/24;</p> <p>-Saturday 07/13/24;</p> <p>-Sunday 07/14/24;</p> <p>-Saturday 07/20/24;</p> <p>-Sunday 07/21/24;</p> <p>-Friday 07/26/24;</p> <p>-Saturday 07/27/24;</p> <p>-Sunday 07/28/24;</p> <p>-Monday 07/29/24;</p> <p>-Tuesday 07/30/24.</p> <p>3. Review of the facility's RN staff schedule, dated August 2024, showed the facility did not have an RN in the building for the dates of 08/03/24 through 08/31/24.</p> <p>4. Review of the facility's RN staff schedule, dated September 2024, showed the facility did not have an RN in the building for eight consecutive hours per day for the month of September.</p> <p>5. Review of the facility's RN staff schedule, dated October 2024, showed the facility did not have an RN in the building for the dates of 10/01/24 through 10/08/24.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. During an interview 10/10/24 at 9:13 A.M., the Director of Nursing (DON) said he/she works 12-hour shifts on nights to cover the nursing holes. He/She said he/she is the only RN on staff. He/She said he/she knows the requirement is to have an RN eight hours a day seven days a week. He/She said he/she is on call for them if they need him/her and he/she is not scheduled. He/She said they are currently trying to hire another RN.</p> <p>During an interview on 10/10/24 at 4:36 P.M., the Assistant Director of Nursing (ADON) said he/she is responsible for scheduling. He/She said he/she only has one RN on staff full time, and it is the DON. He/She said he/she knows the requirement is to have an RN on staff eight consecutive hours daily. He/She said they have utilized agency in the past, but it costs too much.</p> <p>During an interview on 10/10/24 at 5:19 P.M., the administrator said the ADON does all of their scheduling. He/She said they only have one full time RN and that is the DON. He/She said he/she is aware the requirement is to have an RN eight consecutive hours seven days a week.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50432</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, and record review, facility staff failed to ensure a medication error rate of less than 5% out of 31 opportunities observed. Two errors occurred, resulting in a 6.45% error rate, which affected one resident (Residents #60) of 6 sampled residents. The facility census was 83.</p> <p>1. Review of the facility's policy Medication Administration, revised 2/17/13, showed:</p> <ul style="list-style-type: none"> -The complete act of administration entails removing an individual dose from a previously dispensed, properly labelled container, verifying it with the physician's orders, giving the individual dose to the priper resident, and promptly recording the information; -If there is doubt concerning the administration, the physician's order must be verified before the medication is administered; -Certain medications should never be crushed. Refer to pharmacy manual if you are unsure a medication can be crushed. <p>Review of the website dailymed.nlm.nih.gov, updated 04/18/23, showed Metoprolol succinate extended-release (ER)(used to lower blood pressure), tablets are scored and can be divided; however, do not crush or chew the whole or half tablet.</p> <p>2. Review of Resident #60's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/01/24, showed staff documented the resident diagnosis of Dementia/Alzheimers, hypertension, hip fracture and adequate vision.</p> <p>Review of the the resident's Physician Order Sheet (POS), October 2024, the physician ordered:</p> <ul style="list-style-type: none"> -Latanoprost drops (used to reduce increased pressure in the eye in people with either open-angle glaucoma or ocular hypertension) 0.0005%, one drop to left eye once daily; -Metoprolol Succinate tablet ER 24 hr; 50 mg (milligrams) 1.5 tabs once a day A.M. <p>Observation on 10/10/24 at 6:40 A.M., showed Certified Medical Technician (CMT) K placed Metoprolol Succinate ER in a medicine cup and crushed the tablets.</p> <p>During an interview on 10/10/24 at 6:45 A.M., CMT K said he/she realizes now the metopropol should not have been crushed because it is extended release.</p> <p>During an interview on 10/10/24 at 5:00 P.M., the Assitant Director of Nurses (ADON) said the policy for crushing medications has to have an order and the medication has to be mixed with something. He/She said extended release tablets should not be crushed. He/She said the risk is the full dose would be administered at one time. He/She said if they read the orders, they should know how to administer the medications.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/10/24 at 5:53 P.M., the administrator said extended release medication typically are not crushed because it would not be dispersed properly. He/She said medication errors should be reported to the Charge Nurse. Medication errors are discussed at QAPI meetings.</p> <p>Observation on 10/10/24 at 6:50 A.M., showed CMT K administered one drop of Latanoprost eye drops to the resident's left and right eyes.</p> <p>During an interview on 10/10/24 at 8:36 A.M., CMT K said he/she gave two drops, one in each eye to the resident and afterward noticed the order was changed. The resident used to have a prescription for both eyes. He/She said he/she should have looked at the medication administration record more closely.</p> <p>During an interview on 10/10/24 at 8:29 A.M., Charge nurse L said it is expected that staff follow medication orders as written. The eye drops, for example, are prescribed for the left eye only for a reason.</p> <p>During an interview on 10/10/24 at 5:00 P.M., the ADON said they should know how to administer the medications. A nurse should be notified right away. The charge nurse should fill out a med error form.</p>		

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<p>F 0761</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50432</p> <p>Based on observation, interview and record review, facility staff failed to store medications and biologics in a safe manner when medication and treatment carts were left unlocked in public areas accessible to residents. The census was 83.</p> <p>1. Review of the facility's Storage of Medications Policy, undated, showed:</p> <p>-All medications must be stored at or near the nurse's station in a locked cabinet, a locked medication room, or one or more locked medication carts;</p> <p>-All poisonous substances and other hazardous compounds such as sterilization solutions, irrigation solutions, antiseptics, diagnostic reagents, etch, must be kept in a separate locked container away from medications and may not be accessible to residents.</p> <p>2. Observation at 10/10/24 8:20 A.M., showed the 200 hall medication cart left unlocked and unattended in hall.</p> <p>Observation at 10/10/24 8:33 A.M., showed the 200 hall medication cart unlocked and unattended while staff was in resident room.</p> <p>Observation at 10/10/24 9:15 A.M., showed the 200 hall medication cart unlocked and unattended in hall.</p> <p>During an interview on 10/10/24 at 9:30 A.M., Certified Medication Technician (CMT) K said medication carts are supposed to be locked each time they leave it, but he/she is getting asked for a lot more as needed medications than usual this morning.</p> <p>3. Observation at 10/10/24 9:17 A.M., showed the 300 hall treatment cart unlocked and unattended in the hall.</p> <p>Observation at 10/10/24 11:53 A.M., showed the 300 hall treatment cart unlocked and unattended.</p> <p>4. During an interview on 10/10/24 at 8:29 A.M., Charge Nurse L said the carts are supposed to be locked unless you are right in from of it.</p> <p>During an interview on 10/10/24 at 11:30 A.M., the Assistant Director of Nurses said medication and treatment carts should always be locked or residents could get into them, or there could be misplacement of drugs.</p> <p>During an interview on 10/10/24 at 11:55 A.M., the administrator said it is not ok for medication and treatment carts to be unlocked and unattended. There is the potential for harm to residents.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644</p> <p>Based on interview and record review, facility staff failed to document collaboration of care with hospice providers for development and implementation of a coordinated plan of care and communication between the facility and local hospice provider for two (Resident #49 and #82) out of three sampled residents who received hospice services. The facility census was 83.</p> <p>1. Review of the facility's Nursing Facility Services Agreement, dated October 15, 2009, showed, Coordination of Care:</p> <p>-General. Hospice and facility shall communicate with one another regularly and as needed for each particular hospice patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of hospice patients are met 24 hours per day.</p> <p>-Design of plan of care. In accordance with applicable federal and state laws and regulations, Facility staff shall coordinate with hospice in developing a plan of care for each hospice patient. Hospice retains primary responsibility for development of the Plan of Care.</p> <p>2. Review of Resident's #49's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 09/26/24, showed:</p> <p>-Received hospice care;</p> <p>-Diagnosis of Cancer;</p> <p>-The resident has a condition or disease may result in a life expectancy of less than six months.</p> <p>Review of the facility matrix list, dated 10/2024, showed staff identified the resident received hospice services.</p> <p>Review of the facility's hospice binder, showed the binder did not contain a plan of care, or communication documentation for the resident between the facility and the hospice provider.</p> <p>Review of the resident's medical record, showed the record did not contain a plan of care, or communication documentation for the resident between the facility and the hospice provider.</p> <p>3. Review of Resident's #82's Significant change MDS, dated [DATE], showed:</p> <p>-Received hospice care;</p> <p>-Diagnosis of Kidney Disease.</p> <p>Review of the facility matrix list, dated 10/2024, showed staff identified the resident received hospice services.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's hospice binder, showed the binder did not contain a plan of care, or communication documentation for the resident between the facility and the hospice provider.</p> <p>Review of the resident's medical record, showed the record did not contain a plan of care, or communication documentation for the resident between the facility and the hospice provider.</p> <p>4. During an interview on 10/10/24 at 2:54 P.M., Licensed practical nurse (LPN) A said the expectation would be the binder kept at the nurses station would have hospice communication and a plan of care. He/She is not sure why there is not documentation in the hospice binder.</p> <p>During an interview on 10/10/24 at 4:37 P.M., the Assistant Director of Nursing (ADON) said he/she would expect there to be an order for Hospice, a care plan, and communication between the hospice provider and the facility. He/She said they are not sure why this does not get done, and that the facility has met and spoken with hospice about this in the past, but not sure why it hasn't changed.</p> <p>During an interview on 10/10/24 at 5:19 P.M., the administrator said the expectation is that there be documentation when hospice comes in the building to see the resident, any change in condition and a plan of care should be documented and in the hospice binder at the nurses station.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45564</p> <p>Based on observation, interview and record review, facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD- a serious type of pneumonia (lung infection) caused by Legionella bacteria, which places all residents of the facility at risk of exposure which could lead to illness. The facility census was 84.</p> <p>1. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed:</p> <ul style="list-style-type: none"> -The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains; -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water; -CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the Centers for Disease Control and Prevention (CDC) and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit; -Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities: -Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; -Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens; -Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility's Water Management Program, showed the program did not contain policies related to water management. Review showed the program did not contain control measures or corrective actions. Review showed the facility will not test the water or the resident's water unless there is a positive case of Legionnaire's disease within the facility.</p> <p>Review of the facility's water system description showed eight water heaters were identified as temperature permissive areas where Legionella could grow and special considerations for healthcare. Review of the annual water management checklist showed the monitoring procedure for water heaters was to maintain temperatures at 110-120 degrees Fahrenheit (F) and observe for signs of biofilm or sediment. Review showed the water heaters were cleaned on 12/12/23.</p> <p>Review of the facility's water system description showed sinks and showers were identified as areas of possible stagnation. Review showed the system description did not identify system dead legs (areas where water may pool). Review showed the water management plan did not include policies, control measures or corrective actions related to areas of possible stagnation.</p> <p>Review of Water Management Program Meeting minutes for June, July, August and September of 2024 showed the minutes included educational topics monthly. Review showed the minutes did not include information related to facility specific water systems or facility specific monitoring.</p> <p>Review of the Bureau of Environmental Health Services Sanitation Observation, dated 10/10/24, showed the facility does not have a water management plan specific to the facility addressing the facility's water distribution system and controls. The water temperature at the water heaters were approximately 117 degrees F. Thermometers at water heaters were observed to be nonfunctional and/or painted to cover the face. Cold water lines were run to resident rooms and capped and not actively in use which result in multiple dead leg cold water lines throughout the facility.</p> <p>During an interview on 10/08/24 at 3:15 P.M. the administrator said he/she was just notified the resident in room [ROOM NUMBER], who was sent to the hospital on 10/06/24 with respiratory distress, tested positive for Legionella.</p> <p>During an interview On 10/08/24 at 2:45 P.M., the maintenance director said he/she tested the facility water for coliform every March. The maintenance director said he/she did not document the results of the March 2024 test. The maintenance director said he/she never tested the water for Legionella. The maintenance director said he/she checked water temperatures weekly to ensure the temperature was kept between 105 and 120 degrees Fahrenheit (F).</p> <p>During an interview on 10/10/24 at 9:20 A.M., Housekeeper Q said housekeepers clean the bathrooms daily and run water for about 15 seconds every other day. Housekeeper Q said when he/she cleaned a shower head he/she would hang the head up which created a hanging loop in the shower hose. Housekeeper Q said he/she never performed water flushing beyond routine daily cleaning.</p> <p>(continued on next page)</p>		

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 10/10/2024
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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/10/24 at 2:00 P.M., the maintenance director said the administrator or corporate staff were responsible for writing policy. The maintenance director said he/she was not aware of any specific water management policies. The maintenance director said he/she cleaned the exterior and flushed the water heaters annually. The maintenance director said housekeeping staff runs the water in resident rooms but he/she did not know how long. The maintenance director said the facility did not have a policy related to flushing resident use sinks or showers. The maintenance director said he/she created the facility's water system description on his own based on a model in the CDC Toolkit. The maintenance director said he/she did not know what the term temperature permissive meant. The maintenance director said he was unsure what special consideration for healthcare facilities meant. The maintenance director said the facilities water management control measures were water temperature and visual inspections. The maintenance director said he/she did not document corrective actions.</p> <p>During an interview on 10/10/24 at 3:00 P.M., the Infection Preventionist (IP) said he/she was not really familiar with the water management program but there should be policies. The IP said water management education was reviewed during monthly department head meetings. The IP said he/she thought the water heaters were repaired in the previous month but he/she did not know what work was done.</p> <p>During an interview on 10/10/24 at 4:45 P.M., the administrator said he/she was aware of the requirements for a water management program. The administrator said the facility's control measures included water temperatures and he/she could not think of anything else. The administrator said maintenance and housekeeping flush sinks for three to five minutes every couple of weeks but he/she had never seen documentation of flushing. The administrator said he/she had not looked in depth at the water management program. The administrator said he/she was not aware the water management plan did not include facility specific policies, control measures or corrective actions.</p> <p>50432</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50432</p> <p>Based on interview and record review, facility staff failed to follow policies and procedures for immunization of residents against Pneumococcal disease in accordance with national standards of practice and/or failed to assess and vaccinate two residents (Resident's #73 and # 92) of five sampled residents (over [AGE] years old) with doses of the Pneumococcal and/or influenza vaccine, as recommended by the Center for Disease control and prevention. Facility census was 83.</p> <p>1. Review of the facility policy, Immunizations, undated, shows the following:</p> <p>-The resident's physician will be consulted and determine the level of risk and need for the vaccinations. A physician order is required to administer any medication/vaccination;</p> <p>-Pneumococcal vaccinations in Persons aged 65 and older years, unless contraindicated, will be administered according to the following guidelines when determining vaccination status:</p> <p>-Adults [AGE] years or older who have not received any pneumococcal vaccination should receive Pneumococcal Conjugate Vaccine (PCV) 15 followed by a dose of pneumococcal polysaccharide vaccine (PPSV) 23 (one year later, or a single dose of PCV 20). If PCV 20 is administered, a dose of PPSV 23 is not indicated.</p> <p>Review of Centers for Disease Control (CDC) Vaccine Guidelines for Adults, 09/12/24, states:</p> <p>-Adults >65 who have not received any pneumococcal vaccine should receive PCV20 or PCV21; or PCV15 followed by a dose of PPSV23 a year later;</p> <p>-Adults >[AGE] years with prior PCV 13 only vaccination should be given the option of PCV 20, PCV 21 or PCV 23;-Adults [AGE] years or older who have not already received a pneumococcal conjugate vaccine may receive either a single dose of PCV 15 followed by a dose of PPSV 23 one year later; or a single dose of PCV 20.</p> <p>2. Review of Resident #73's medical record showed:</p> <p>-admitted [DATE];</p> <p>-Signed pneumococcal vaccination consent on 6/24/24;</p> <p>-Staff did not document the resident offered, received or refused the pneumococcal vaccine.</p> <p>3. Review of Resident #92's medical record showed:</p> <p>-admitted [DATE];</p> <p>-Resident received PCV13 on 5/8/16;</p> <p>-Signed pneumococcal vaccination consent on 8/16/24;</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Staff did not document the resident was offered, recieved or refused the PCV20, PCV21or PCV23 pneumococcal vaccine.</p> <p>4. During an interview on 10/9/24 at 3:30 P.M., the Assistant Director of Nursing (ADON)/ Infection Preventionist (IP) said he/she was responsible for the immunization program, but has not kept up with offering pneumococcal boosters since assuming the role. He/She does not know why some residents did not get an opportunity to be vaccinated.</p> <p>During an interview on 10/9/2024 at 4:00 P.M., the administrator said the IP is responsible for the vaccination program right now. The expectation is the immunization policy would be followed. He/She does not know why PCV20 or PCV21 vaccines have not been offered to eligible residents, but agrees it should be done.</p>