STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265302	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Manor	1201 Hunt Avenue Columbia, MO 65202

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, facility staff failed to maintain resident dignity, when staff entered resident rooms without knocking and/or failed to identify themselves prior to entering the room affecting two sampled residents (Resident #53 and #12), failed to answer a call light in a timely manner which resulted in one of three sampled residents (Resident #12) being incontinent and discussed the bowel habits of one resident (Resident #43) while they provided care for another resident (Resident #12). The facility census was 79.1. Review of the facility's Resident Rights policy, undated, showed each resident shall be treated with consideration, respectfully, and a full recognition of his/her dignity and individuality, including privacy in treatment and care of his/her personal needs. 2. Review of Resident #53's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/09/26, showed staff assessed the resident as cognitively intact. Observation on 06/15/26 at 10:31 A.M., an unknown housekeeper and unknown Certified Nurse Aide (CNA) did not knock or announce themselves before they entered the resident's room. During an interview on 06/15/26 at 10:31 A.M., the resident said staff barge in the room all the time to take care of his/her roommate and do not know. He/She said he/she does not like to complain and most of the time it does not bother him/her.3. Review of Resident #12's Annual MDS, 03/18/26, showed staff assessed the resident as:-Cognitively intact;-Dependent on staff for toileting;-Frequently incontinent;-Diagnosed with Multiple sclerosis (disease of the central nervous system).Observation on 06/16/26 at 8:50 A.M., showed the resident's call light on. At 9:09 A.M., Nurse Aide (NA) N did not knock or announce himself/herself before he/she entered the resident's room. The aide left the room at 9:12 A.M., he/she informed the resident he/she had to obtain a mechanical lift. The aide returned at 9:23 A.M., with CNA E and the mechanical lift. As CNA E entered the room, he/she informed NA N he/she planned to help with Resident #43 because the resident had a bowel movement. NA N used the lift and lifted the resident from his/her wheelchair and as the resident rose a stream of urine flowed from the resident's bottom to the wheelchair cushion, to the floor, and to the bed where the resident had been lowered. During an interview on 06/16/26 at 9:32 A.M., the resident said staff often just come into the room and do not announce themselves. He/She said it's frustrating but you just get used to it. He/She said it when urine falls to the floor it he/she is embarrassed and angry, but it happens all the time. The resident said that's nothing new that staff talk about other residents in front of residents. He/She said he/she knew about a lot of resident's personal stuff. He/She said he/she doesn't care about hearing other residents' toileting problems. The resident said, often staff will come in and complain about the smell of his/her bowel during care. He/She said those comments are hurtful and he/she often feels like a burden.During an interview on 06/16/26 at 9:29 A.M., NA N said he/she is new and is still training but he/she should have knocked and announced himself/herself before going into the room. He/She said he/she just got busy and seen the call light on. The NA said he/she thought when the light was on that was an invitation to come into the room. The NA said he/she would be embarrassed if he/she had been incontinent of urine and it flowed to the floor. During an interview on 06/18/26 at 10:42 A.M., CNA E said he/she should not have talked about Resident #43 in front of Resident #12. That information should have been kept quiet and not said in (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	front of other residents to maintain the residents' dignity. He/She said if he/she had to sit in urine for a long period of time to the point it leaked to the floor, he/she would be embarrassed and ashamed. He/She said if staff go into a resident's room, they should knock and announce themselves because that is how he/she would want it at my house, otherwise I'd feel they were invading my space. 4. During a group interview on 06/16/26 at 11:04 A.M. the residents said the staff make comments when a resident needs help like, It's not my hall. Staff barge into the rooms without knocking and don't introduce themselves. The staff talk about other residents all the time where it can be heard by everyone. This causes anxiety and should be addressed. During an interview on 06/18/26 at 2:05 P.M., the Director of Nursing (DON) said staff are expected to treat residents with dignity and respect by knocking and announcing themselves before going into residents' rooms, not talking about residents in earshot of other residents, and responding to call lights and toileting needs timely. He/She said failing to do so would cause humiliation and embarrassment. During an interview on 06/18/26 at 2:35 P.M., the Interim Administrator said staff are expected to provide privacy and dignity to all residents which would include knocking on the doors, announcing who they are before entering the rooms, toileting residents timely and only discussing resident needs privately and not in front of others. He/She said it is embarrassing to be left wet and talked about in front of others.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interview and record review, facility staff failed to provide transportation to outside activities for one resident (Resident #51) out of one sampled resident whose wheelchair would not fit in transport van. The facility census was 79.1. Review of the facility policy titled Residents Rights, undated, showed each resident shall be permitted to participate, as well as not participate, in activities of social, religious or community groups at his/her discretion, both within the facility, as well as outside the facility, unless contraindicated for reasons documented by the physician in the resident's medical record. 2. Review of Resident #51's Five-Day PPS (Prospective Payment System), Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/27/26, showed staff assessed the resident as cognitively intact, used a motorized wheelchair, had lower extremity impairments on both sides, and was dependent on staff for chair/bed to chair transfers.During an interview on 06/15/26 at 10:36 A.M., the resident said his/her electric wheelchair does not fit in the facility transport van. The resident said he/she does not get to go shopping or go to outside activities like other residents because he/she is unable to get on the facility van. He/She said if he/she was put in a manual wheelchair, the chair still would not fit on the van.During an interview on 06/18/26 at 11:45 A.M., the resident said when he/she does not get to participate in outside activities he/she feels, sad, left out, and segregated. He/She said about a month ago the other residents got to go fishing as an activity, but he/she could not attend because his/her chair does not fit on the transport van. He/She said when the activities director (AD) announced the activity he/she was sad that he/she could not go and the AD said, I know, I'm sorry, I know you love to fish. He/She said the facility should be able to accommodate all residents who live in the facility. During an interview on 06/18/26 at 12:21 P.M., the AD said, We don't have the proper van for some of the residents, I feel bad that they can't go and I know it would help their mental health. He/She said he/she has mentioned it to management, but nothing has been done. During an interview on 06/18/26 at 2:01 P.M., the Director of Nursing (DON) said he/she was not aware of the transportation van issue. He/She said they had borrowed another facility van before for transportation. During an interview on 06/18/26 at 2:41 P.M., the administrator said he/she was not aware until today the facility van did not accommodate the resident for activities. He/She said the facility should be able to figure out a way for every resident to attend activities even if they must borrow a van or use an alternative method of transportation. Complaint #3028502

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to maintain a comfortable and homelike environment. The facility census was 79.1. Review of the facility's policy titled, Environmental, undated, showed floors and tabletops will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 2. Observation on 06/15/26 at 10:20 A.M. and 1:32 P.M., showed the hallway outside the conference room with a strong foul odor. The carpet had an irregularly shaped dark stain. Observation on 06/16/26 at 7:45 A.M. and 4:00 P.M., showed the hallway outside the conference room with a strong foul odor. The carpet had an irregularly shaped dark stain. Observation on 06/17/26 at 8:52 A.M., showed the hallway outside the conference room with a strong foul odor. The carpet had an irregularly shaped dark stain. 3. Observation on 06/15/26 at 10:56 A.M., showed the carpet outside resident occupied room [ROOM NUMBER] with two bleached areas. 4. Observation on 06/15/26 at 12:08 P.M., showed the carpet outside resident occupied room [ROOM NUMBER]'s door with a large orange stain. 5. Observation on 06/15/26 at 2:19 P.M., showed Resident #46's carpet in his/her room with a large brown circular stain beside the bed, two stains by the dresser. The ceiling popcorn spackle bubbled and hung from the ceiling with exposed unpainted drywall. During an interview on 06/15/26 at 2:19 P.M., the resident said he/she does not feel like the stained carpet in his/her room is homelike. 6. During an interview on 06/15/26 at 12:23 P.M., Resident #54 said the carpet needs shampooed but staff said the shampooer is broken and the staff will get to the carpets when they get a new shampooer. During an interview on 06/16/26 at 11:11 A.M., Resident #22 said sometimes when staff open the door to his/her room, he/she gets whiffs of bad odors that come into his/her room from the hallway. The resident said he/she noticed the stains on the carpets. During an interview on 06/18/26 at 10:39 A.M., Certified Nurse Aide (CNA) E said some of the circular stains on the carpets are from spilt drinks, from residents who have accidents. He/She said maintenance cleans the carpets when they can. The CNA said he/she smells urine when walking up and down the halls. The CNA said he/she would feel disgusted if his/her home smelled like the halls in the facility and he/she would not want to live like that. During an interview on 06/18/26 at 11:32 A.M., Certified Medication Technician (CMT) B said he/she would describe the carpet as old and nasty. The CMT said he/she is so used to the smells but sometimes can smell urine when walking in the halls. The CMT said he/she doesn't feel like the carpet is homelike. During an interview on 06/18/26 at 12:03 P.M., Floor Tech C said the stains have been on the carpet for a while because the shampooer and the stain machine do not work. He/She said he/she told the front office, and they said they are waiting for a brush to come in. The machine used on the stains has not worked for at least two months. He/She said he/she notices the odors in the hallway and when the shampooer was working the smell was not so bad. He/She said it's not homelike. During an interview on 06/18/26 at 12:17 P.M., the Activity Director said he/she hates the carpet, it's always stained and keeps the smell in the halls. He/She said the halls smell like urine and even the carpet cleaner doesn't help. The Activity Director said the carpet is not homelike. During an interview on 06/18/26 at 12:50 P.M., Licensed Practical Nurse (LPN) D said the carpet in the halls is stained and the facility smells of urine. The LPN said he/she becomes used to the smell after a while. The LPN said he/she worked last weekend, and the stains were on the carpets, and they have gotten worse. The LPN said the carpet machine does not have proper suction to clean the stains from the carpet. During an interview on 06/18/26 at 1:15 P.M., the Maintenance Director said he/she noticed the stains and odors with the carpet. He/She said the carpet cleaner is broken and he/she has been waiting for parts to fix it. 7. Review of the policies provided by the facility showed the facility did not provide a policy for building maintenance. Review of the facility's two Maintenance Books showed the books did not contain any maintenance requests for the observations below. Review showed the Maintenance Books contained requests dated up to a (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year ago that were not completed or signed.8. Observation on 06/15/26 at 11:01 A.M., showed the 200 hall air vent above nurse's station the ceiling with screws coming out of the drywall. 9. Observation on 06/15/26 at 11:02 A.M., showed the therapy room's door frame skid guard broken and hung off the doorframe. 10. Observation on 06/15/26 at 11:05 A.M., showed the 200 hall lounge chairs by the nurse's station had torn and cracked vinyl the length of the arm rests. 11. Observation on 06/15/26 at 11:26 A.M., showed resident occupied room [ROOM NUMBER]'s bathroom door with large chunks of wood and paint missing. 12. Observation on 06/15/26 at 11:27 A.M., showed resident occupied room [ROOM NUMBER]'s door frame unscrewed from the door with a screw off the frame and the bottom of the door drug the ground. Observation showed the bathroom door with a baseball sized hole. 13. Observation on 06/15/26 at 11:28 A.M., showed the ceiling in resident occupied room [ROOM NUMBER] with removed spackle and exposed unpainted drywall and the wall behind bed A with approximately two feet of exposed unpainted drywall. 14. Observation on 06/15/26 at 11:39 A.M., showed the community sitting area with broken and jagged plastic skid guards along the base of the door frame. 15. Observation on 06/15/26 at 11:42 A.M., showed the armchair rail by resident occupied room [ROOM NUMBER] and between resident occupied rooms [ROOM NUMBERS] loose and hung off the wall. 16. Observation on 06/15/26 at 11:53 A.M., showed the main dining room light frame, spackle and drywall hanging from the ceiling. 17. Observation on 06/15/26 at 11:57 A.M., showed the smaller dining room ceiling with a water stain. 18. Observation on 06/15/26 at 3:10 P.M., showed resident occupied room [ROOM NUMBER]'s call light with light above the door and light on the wall did not work when the call light is pushed. During an interview on 06/18/26 at 12:50 P.M., LPN D said he/she works on the resident's hall and is not aware of his/her call light having issues or not working. The LPN said he/she would expect staff to tell him/her. During an interview on 06/18/26 at 1:15 P.M., the Maintenance Director said staff have not notified him/her the resident's call light is not working. 19. Observation on 06/16/26 at 9:19 A.M., showed a light fixture above the 100 hall nurse's station without a cover and the fixture with only one of four light bulbs. 20. Observation on 06/15/26 at 2:39 P.M., showed the left vinyl armrest of Resident #7's wheelchair cracked and torn. Observation showed a scratch on the resident's left forearm. The vinyl is peeled back with sharp edges. During an interview on 06/15/26 at 2:39 P.M., the resident said his/her left arm got scratched by the wheelchair armrest. The resident said it would be nice to have it fixed. 21. Observation on 06/15/26 at 2:19 P.M., showed around the can light on the ceiling of resident #46's room, the popcorn spackle has bubbled and hung from the ceiling with exposed unpainted drywall. During an interview on 06/15/26 at 2:19 P.M., the resident said he/she does not feel like the condition of his/her room is homelike. 22. During an interview on 06/18/26 at 10:39 A.M., CNA E said there is a book at the nurse's station to put maintenance requests in. Staff leave the maintenance requests in the book, and maintenance checks the requests and documents when the requests are completed. The CNA said when the maintenance request is completed it stays in the book. The CNA said he/she has seen spackling missing off the ceiling and has not reported it, and assumed maintenance knew about the issues. The CNA said the facility is not homelike. The CNA said he/she has noticed some damage to walls and doors or doorframes, and the issues were reported. The CNA said he/she has noticed bulbs not working in the dining room and dayroom but has not personally reported them. During an interview on 06/18/26 at 11:32 A.M., CMT B said he/she has noticed damaged doors, walls and doorframes in residents' rooms and staff are supposed to report these types of concerns to maintenance. The CMT said the previous Maintenance Director, who left a week or two ago, was not responsive to maintenance requests. The CMT said there are issues with spackling missing on the ceilings and he/she did not report it to the old Maintenance Director. The CMT said the maintenance request book is at the nurse's station and the Maintenance Director is supposed to look at the book daily. During an interview on 06/18/26 at 12:50 P.M., LPN D said staff are supposed to put maintenance requests in the maintenance log, but that has been a waste of time because the previous Maintenance Director did not follow up on the requests. The LPN said he/she has noticed the rips in the wheelchair armrests and several other (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chairs need repaired. The LPN said the facility really hasn't had a maintenance person for a long time. During an interview on 06/18/26 at 1:15 P.M., the Maintenance Director said there is a maintenance request book at each of the two nurse's stations that staff are expected to write maintenance requests in. The Maintenance Director said the book is checked daily and there has not been any requests made this week. The Maintenance Director said he/she has not gotten any maintenance requests about the carpet, ceilings, light fixtures, door frames or walls. The Maintenance Director just took over in the last week or two and that is why there is maintenance requests up to a year old in the maintenance books that have not been completed. #3025947#3028948#3046404#3034727

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review and interview, facility staff failed to have systems in place to prevent misappropriation for one resident (Resident #15) of three sampled residents', when the resident's $360.00 cash was not located in the facility safe. The facility census was 79 residents.1. Review of the facility's policy titled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 11/17, showed each resident of the facility would be free from misappropriation of property.2. Review of the facility's policy titled, Protection of Residents Funds, undated, showed the facility shall furnish the Resident with a written receipt for all expenditures and deposits regarding any of the Resident's funds deposited with the Facility. A record of all transactions regarding the Resident's funds shall be maintained by the Facility in accordance with the generally accepted accounting principles. The resident shall have reasonable access, upon request, to the above record and shall receive an itemized quarterly statement of his or her account. 3. Review of the facility's investigation, dated 06/18/26, showed staff documented Resident #1 $360.00 could not be located in the facility safe. Review showed the facility conducted and investigation and determined the resident's $360.00 had been misappropriated by staff.During an interview on 06/16/26 at 1:43 P.M., the Business Office Manager (BOM) said the former administrator, him/her and any past BOMS would have the code to the facility's safe. He/She said the resident's money had been put in the safe because he/she had waved the money around and staff were trying to keep him/her from getting it stolen, so he/she put it in the safe before he/she could get the resident's account set up. During an interview on 06/16/26 at 1:49 P.M., the Corporate Financial Consultant said the only staff with keys to the business office are the BOM, Former Administrator and Social Services Designee (SSD). He/She said the corporate office would like the BOM to take the money to the bank, but he/she wasn't listed on the accounts yet. He/She said the residents' $360.00 went missing between 05/07/26 and 05/22/26. He/She said Certified Medication Technician (CMT) G had been a BOM here as well and the safe code had not been changed after the CMT left the BOM position. He/She said the safe code was only supposed to be shared between the BOM and the administrator. He/She said CMT A had also been a BOM for a short time before he/she returned to work on the floor. He/She said both CMTs would have still had the code to access the safe. He/She said corporate has proof the resident had $360.00 cash in the safe, so the corporate office will refund the money. The BOM is supposed to give the money in the safe to the receptionist and the receptionist deposits in the bank.During an interview on 06/16/26 at 2:22 P.M., the SSD said he/she had been a BOM at the facility. He/She said he/she still has a key to the business office, and he/she knows the code to the safe. The SSD said there are only three staff who have keys to the Business office, the BOM, himself/herself and the administrator. He/She said the Activity Director told him/her on May 22nd, the resident's $360.00 was missing, after the Activity Director had went to the Business Office to get some of the resident's money for cigarettes, so he/she directed the resident and Activity Director to the former administrator and that was the last he/she heard of it. The SSD said he/she did not take the money. During an interview on 06/16/26 at 3:30 P.M., the Corporate Nurse said he/she worked with the Director of Operations (DO) on the investigation. He/She said he/she thinks the SSD, the administrator and the BOM had the code to the safe and he/she thinks the BOM and administrator have a key to the safe. He/She said he/she told the former administrator about the missing money, and he/she put her hands in the air and would not talk about it. The Corporate Nurse said he/she interviewed the Activity Director on 06/04/26 and the Activity Director told him/her staff found out about the resident's missing money on 05/21/26, when the Activity Director went to get some of the resident's money for the resident to use and the money was gone. During an interview on 06/17/26 at 7:46 A.M., CMT A said he/she was the BOM for a short time and the safe was in the business office at that time. The CMT said he/she had the code to the safe and he/she kept it on a piece of tape under the keyboard because he/she could never remember the numbers. The CMT said he/she had a (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	key to the business office. The CMT said the former administrator was the only other person with the code to the safe and maybe previous BOMs that had been in there, like the current SSD.During an interview on 06/17/26 at 8:44 A.M., the Activity Director said he/she is aware of the residents' missing money. The Activity Director said when he/she went to get some of the resident's money for cigarettes, the BOM said the resident's money went missing a month or so ago. The Activity Director said the BOM never gave him/her a receipt for the resident's $360.00 when the BOM put it in the facility safe. The Activity Director knew nothing about how the money was kept or monitored.During an interview on 06/17/26 at 9:52 A.M., the former administrator said the current SSD used to be in the Business Office. The safe has always had the same code through all the BOM changes. He/She said he/she did not know why he/she didn't change the code to the safe. The former administrator said there is a key to the business office on the BOM's keys, administrator's keys, SSD's Keys and Maintenance Director's keys. The former administrator said the money was found to be missing on 05/22/26 and no one was in the office 05/21/26 but the BOM. The former administrator said he/she has not stolen money from any resident. The former administrator said he/she did not know the $360.00 was even in the safe until it was missing. He/She said when he/she was a BOM, he/she would sign money out of trust for the residents. He/She said the SSD has a key to the business office and knows the code to the safe. He/She said he/she doesn't know why the SSD would have a key to the business office, it doesn't make sense, and he/she was a previous BOM and he/she had a code to the safe. He/She said money was constantly missing when SSD was the BOM, the SSD would leave money on the table with the safe open and say the money came up missing. The former administrator said the code to the safe is in the drawer of the business office desk, on a post it note, so if staff can get in the office, they could find it. During an interview on 06/17/26 at 2:01 P.M., the BOM said on 05/22/26 when he/she first noticed the $360.00 missing, he/she did not know he/she was supposed to report missing money. The BOM said he/she guesses he/she should have said something about it then. The BOM said he/she told the Corporate Financial Consultant about the missing $360.00 on 06/04/26.During an interview on 06/17/26 at 2:55 P.M., the SSD said he/she learned about the $360.00 missing the day the Activity Director was supposed to go to the store for the resident, because he/she came and told him/her about it. The SSD said he/she told the Activity Director to go to the former administrator and notify him/her of the missing money. #3034106

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	265302	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Manor	1201 Hunt Avenue Columbia, MO 65202

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, facility staff failed to report an allegation of misappropriation of $360 for one resident (Residents #15) of 39 sampled residents to the State Agency. The facility census was 79.1. Review of the facility's policy titled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 11/17, showed the nursing home administrator or designee will report to the State Agency per state and federal requirements. The facility shall report misappropriation to the State Agency no later than 24 hours after the allegation is made. The facility will comply with the seven-step approach to abuse and neglect, which include: Reporting and Response; Screening; Training; Prevention; Identification; Investigation and Protection. 2. Review of the facility's investigation, dated 06/08/26 through 06/11/26, showed Resident #15's $360.00 had been reported to facility staff as missing the 3rd week of May and had been reported to the State Agency on 06/04/26, by the former administrator. During an interview on 06/16/26 at 1:43 P.M., the Business Office Manager (BOM) said the residents' $360.00 in cash had been in the facility's safe and had been taken. The BOM said he/she first noticed the cash missing on 05/22/26. During an interview on 06/16/26 at 1:49 P.M., the Corporate Financial Consultant said he/she thought the resident's missing $360.00 had been reported to the state agency since it had been reported missing on 05/22/26. During an interview on 06/16/26 at 2:22 P.M., the Social Service Designee (SSD) said he/she did not report the resident's missing money to the State Agency. He/She said he/she assumed the administrator reported the missing money. The SSD said he/she did not have an answer, as to why he/she did not follow up to see if the missing money had been reported. The SSD said he/she knew the money was missing on 5/22 because the Activity Director went to the BOM and asked for some money to get the resident cigarettes. During an interview on 06/16/26 at 3:30 P.M., the Corporate Nurse said the missing $360.00 should have been reported to the State Agency. During an interview on 06/17/26 at 3:19 P.M., the Director of Operations said when residents' money is missing, he/she expects staff to report the missing money to the State Agency within 24 hours, then staff have time to follow up with an investigation. The Director of Operations said he/she found out on 06/04/26 about the missing, $360.00, and he/she was told by the former administrator the missing money had been reported to the State Agency.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to develop and implement a person-centered comprehensive care plan for three (Resident #1, #9 and #58) of five sampled residents. The facility census was 79.1. Review of the facility's policy titled Care Plan Comprehensive, undated, showed an individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental and psychosocial well-being. The care plan will be based on a thorough assessment that includes but is not limited to the Minimum Data Set (MDS), a federally mandated assessment tool.Review of the facility's MDS and Care Planning Guidelines, dated October 2015, showed it is the policy of the facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) manual, any published interim RAI manual errata documents, and applicable federal guidelines as the authoritative guide for completion of the MDS, Care Area Assessments (CAA)'s and resident care planning. 2. Review of Resident #1's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact and felt it is somewhat important to keep up with the news, do activities with groups of people, do favorite activities and get fresh air when the weather is good. Review of the resident's care plan dated 03/17/26, showed the care plan did not contain the resident's activity preferences. 3. Review of Resident #9's admission MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-Felt it was very important to have books/magazines, listen to music he/she enjoys, do activities with pets, keep up with the news, do things with groups of people, do favorite activities, go outside when the weather is good, and participate in religious activities;-Used oxygen;-Used a wheelchair for locomotion;-Smoked;-Used an antidepressant and anticoagulant (blood thinner).Review of the resident's care plan dated 06/01/26, showed the care plan did not contain direction or preferences for activities, wheelchair use, smoking, antidepressant and anticoagulant use, and oxygen use. Observation on 06/15/26 at 2:20 P.M., showed the resident in bed with a wheelchair within proximity of the bed. He/She wore oxygen via nasal cannula. 4. Review of Resident #58's admission MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-Felt it was very important to have books/magazines, listen to music he/she enjoys, do activities with pets, keep up with the news, do things with groups of people, do favorite activities, go outside when the weather is good, and participate in religious activities;-Used a diuretic (pill to pull water from the body).Review of the resident's care plan dated 06/16/26, showed the care plan did not contain activity preferences or direction and guidance for diuretic use. 5. During an interview on 06/18/26 at 10:42 A.M., Certified Nurse Aide (CNA) E said resident preferences are in the care plans, but he/she isn't sure if he/she has access to care plans. He/She said staff can always ask the nurses about resident care needs. During an interview on 06/18/26 at 11:58 A.M., the MDS/Care plan Coordinator said he/she is responsible for creating the care plans. He/She said care plans should be completed upon admission, reviewed quarterly, and should include resident preferences. He/She said he/she uses the Resident Assessment Instrument (RAI) manual to help him/her complete the care plans and his/her work is overseen by the corporate nurse. The facility went for a long period of time without an MDS Coordinator, and he/she is trying to get caught up, but he/she is pulled to the floor to fill in as charge nurse and had to complete all the quarterly assessments and observations in addition to the MDS assessments. He/She said he/she did not think the CNA's had access to the care plans. During an interview on 06/18/25 at 2:05 P.M., the Director of Nursing (DON) said the MDS Coordinator is responsible for updating and completing care plans and a corporate nurse looks oversees the completion. Care plans are discussed in the Quality Assurance and Performance Improvement (QAPI) meeting and weekly care plan meetings and should include resident preferences and care needs.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, facility staff failed to ensure a medication error rate of less than five percent (%) out of 30 opportunities observed, five errors occurred, resulting in a 16.67% error rate, which affected four residents (Resident #32, # 34, #43, and #71) of seven sampled residents. The facility census was 79. 1.Review of the facility's policy titled Medication Errors and Drug Reactions, undated, showed staff are directed to report all medication errors immediately to the physician, Director of Nursing (DON) and administrator. The policy did not contain a medication error definition. Review of the facility's policy titled Medication Administration Guidelines, undated, showed it is important that the residents receive their medication on a timely basis. If there is doubt concerning the administering of medications, the physician's order must be verified before the medication is administered. The policy did not contain a medication error definition.Review of the facility's Medication Administration policy, undated, showed the policy did not contain a medication error definition.Review of the policies provided by the facility showed the facility did not provide a policy for insulin administration via an insulin pen.Review of the Autoshield Safety Duo Pen Needle brochure at Embecta.com, dated 2016, showed dial two units for priming the pen and dispense the two units. It is important to prime the needle successfully before administering the injection. 2. Review of Resident #32's Physician's Order Sheet (POS), dated June 2026, showed an order for a stool softener8.6-50 milligrams (mg), three tablets daily for constipation and an order for sertraline (an antidepressant) 100 mg daily for depression.Observation on 06/17/26 at 7:25 A.M., showed Certified Medication Technician (CMT) H administer one stool softner 8.6-50 mg tablet. He/She documented the medication given as ordered. The CMT omitted the resident's sertraline medication and documented it as unavailable. During an interview on 06/17/26 at 11:32 A.M., CMT H said the medication was not available in the emergency kit and he/she had to tell the nurse. He/She said the resident often will only take one of the Senna Plus tablets so that is all he/she gave. He/She said he/she should have told the nurse he/she did not administer the correct dose. Medication errors would include wrong dose, wrong resident, wrong time and wrong form. He/She said not giving medication would be considered a medication error.During an interview on 06/18/26 at 12:55 A.M., Licensed Practical Nurse (LPN) D said he/she was not informed of any errors with Resident #32. 3. Review of Resident #34's POS, dated June 2026, showed an order for lidocaine (pain reducing) adhesive patch 5 %, topical, place on the resident in the morning and off at bedtime for diagnosis of pain in left shoulder.Observation on 06/17/26 at 7:25 A.M., showed CMT H applied a lidocaine 5% patch to the resident's lower back. During an interview on 06/17/26 at 11:36 A.M., CMT H said staff let the resident tell them where to put the patch on his/her body. He/She said the order probably should say where to put it since the diagnosis is for shoulder pain. 4. Review of Resident #43's POS, dated June 2026, showed an order for Humalog U100 insulin per sliding scale, give two Units (U) for blood sugar between 150 and 250.Observation on 06/17/26 at 11:12 A.M., showed CMT H obtained the resident's blood sugar with a result of 161. The CMT attached a new Autoshield Duo needle pen needle to a Humalog insulin pen, dialed the pen to 2 U of Humalog insulin and administered the medication. He/She did not prime the needle. 5. Review of Resident #71's POS, dated June 2026, showed and order for Novolin R Flexpen100 units/milliliter (ml) per sliding scale, give 6 U for blood sugar 300 to 349. Novolin R U100 insulin, give 7 U between 11:00 A.M. and 12:00 P.M.Observation on 06/17/26 at 11:02 A.M., showed CMT H obtained the resident's blood sugar with a result of 314. The CMT attached a new Autoshield Duo needle pen needle to a Novolin insulin pen, dialed 13 U of Novolin insulin and administered the medication. He/She did not prime the needle. During an interview on 06/17/26 at 11:36 A.M., CMT H said staff do not have to prime the Autoshield Duo pen needles. 6. During an interview on 06/18/26 at 12:55 A.M., LPN D said he/she would expect the CMT's to report medication errors. He/She was not informed of any errors with Resident #32. LPN D said medication errors consist of wrong medication, dose, and time and would need to be reported to the physician. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He/She would expect the CMT's to prime all insulin needles, so the residents get the correct dose and remove air from the needle.During an interview on 06/18/26 at 2:05 P.M., the DON said he/she expects staff to report all medication errors to the DON and the physician. There should be medications in the emergency kit if the resident is out of medication. CMT's should alert the nurse if the resident is out of a medication and/or refuses medication. He/She expects the CMT's to follow the physician orders, so the residents get the correct medication. He/She said he/she is not sure about priming the insulin pens since it has been a while since he/she has administered insulin. During an interview on 06/18/26 at 2:39 P.M., the Interim Administrator said topical patch orders should indicate a location, and insulin pens should be primed before administering the insulin to prevent medication errors. #3028948