STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265381	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwood Hills Care Center	800 N Arthur St Humansville, MO 65674

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to appropriately bill the resident's appropriate Medicare plan during their stay resulting in an overpayment and failed to reimburse the resident 30 days after discharge for the over payment for one resident (Resident #5). The facility census was 82.Review of the facility's policy, Credit Balance and Refund Policy, revised 02/06/26, showed the following:-The purpose of the policy was to provide guidance on managing credit balances efficiently and to ensure accounts with credit balances due to overpayments are refunded in a timely manner and as required by law. These refunds include, but are not limited to, monies due back to federal health care programs, insurance payers, and residents;-Credit Balances may be caused by multiple reasons including, the payer paying more than expected, the resident paying more co-insurance, copay, or deductible than was owed based on the payment received from the payer; duplicate payment of the claim by payers and or resident (e.g., when the primary and secondary insurance companies both pay primary); or an error in the accounts receivable system setup for expected payment andcontractual amount; or an erroneous posting by the facility during payment posting (e.g., payment posted to wrong account);-When an account has a credit balance, it is important to determine the reason, correct any posting errors, and, if applicable, process a refund to the appropriate party in a timely manner;-The facility shall make every reasonable effort to promptly identify and resolve credit balances. If research and analysis confirm the credit balance is in overpayment. Overpayments are returned within 60 days of identification;-For those credit balances confirmed to require refund, the Business Office Manager (BOM) (or designee) should promptly take steps to refund the monies due to the appropriate party. Sometimes the payer will take the refund from future remittances. If not, a refund check must be issued;-Complete the AR Patient Refund form including an explanation of the reason for the refund;-Obtain approval from the Executive Director by them signing the completed form;-The Accounts Payable associate will then enter the invoice into the accounts payable system and scan backup documents;-The treasury department will process the refund and mail to the payee according to the information entered by the facility.-If the credit balance is due to a billing error, an adjustment should be made to the Medicare claim which will cause Medicare to recoup the refund. Open a support ticket with Facility Financial applications if you have any issues with adjusting the claim to return the money;-If the Credit Balance results from overcollection on of a resident's obligation, ensure the refund check is payable to the resident. 1. Review of Resident #5's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 12/23/25;-discharge date of 04/03/26. Review of the resident's discharge Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), date 04/03/26, showed the following:-admission of 12/23/26;-Discharge from facility with return not anticipated on 04/03/26. Review of the resident's eligibility report, dated 01/02/26, showed the following:-The resident's Medicare advantage plan was terminated on 12/31/25;-The resident's Medicare Part A effective date was 11/01/2017;-The resident's plan benefits were Medicare part A first bill, dated 01/01/26. Review of the resident's billing statements showed the facility did not bill Medicare part A for the resident's stay. Review of facility records showed an email to the Business Office Manger (BOM) and (continued on next page)

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

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator from the Regional Field Controller dated 05/28/26, at 9:43 A.M., that indicated the resident overpaid $9266.97 dollars for his/her stay. During an interview on 06/10/26, at 2:50 P.M., the BOM said the following:-The resident moved from out of state. He/she had Medicare advantage plan through the other state and the facility was out of network;-The resident and his/her family agreed for him/her to be private pay and they were going to cancel their advantage plan and get back on Medicare part A;-He/she qualified for a skilled stay as of 01/01/26, however, the facility failed to complete skilled notes/documentation required to qualify for a skilled stay and have it paid for by Medicare;-He/she did not know why staff did not complete the documentation needed;-Medicare A was not billed for the stay that he/she qualified for;-The resident's family came to the facility after the resident was discharged around the middle of May. They were upset and felt they had been overbilled;-The Administrator investigated the concern. They realized that the resident had qualified for Medicare A but the facility did not bill correctly;-The Regional Field Controller sent an email with the amount that Medicare part A would have covered if they had billed them correctly;-He/she thought Administrator was taking care of the resident reimbursement;-The resident has not been refunded timely;-The resident has not been reimbursed yet. During an interview on 06/10/26, at 2:55 P.M. the Regional Field Controller said the following:-He/she sent the amount that needed to be reimbursed to the Administrator and BOM;-They were supposed to get the check ready and send it back to the corporate office to be signed;-The resident had not been reimbursed yet. During an interview on 06/11/26, at 12:45 P.M., the Director of Nursing (DON) said the following:-The resident's family came to the facility sometime in May and were upset about a billing issue;-Corporate said they were owed a refund;-The resident was private pay when he/she admitted and the medical record did not populate skilled notes;-He/she did not know the resident had Medicare so skilled documentation was not completed;-He/she did not know if the resident has been reimbursed. During an interview on 06/11/26, at 1:12 P.M., the Administrator said the following:-The resident was admitted to the facility on [DATE] with insurance that was of network;-He/she was not sure how they missed that the resident qualified for a skilled stay under Medicare part A as of 01/01/26;-The resident started out as private pay. They discontinued the insurance that was out of network but he/she did not think the Medicare would go into effect until February;-If that had occurred the resident would not have qualified for a skilled stay;-The resident's family came to the facility in mid-May. They were upset about the co-pays;-The Administrator investigated and discovered the resident had qualified for a skilled stay and would have qualified for some of it to be covered by Medicare;-The BOM manager should have realized the resident qualified for a skilled stay at of 01/01/26;-He/she worked with the Regional Field Controller to determine how much money Medicare would have covered if the facility had billed them;-He/she was not sure how long the facility had to reimburse the resident;-The resident had not been reimbursed yet. Complaint #3017587

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care per standards of practice when staff failed to document monitoring after a fall for three residents (Resident #2, #3, and #4) and failed to inform management of a fall for one resident (Resident #2) who was later found to have a fracture due to the fall. The facility census was 82.Review of the facility's policy, Incident and Reportable Event Management, revised 02/24/26, showed the following:-A fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (example, resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred;-Event management includes falls;-To help reduce the risk of an event, all residents receive assistance and supervision as addressed in their care plan. In an effort to minimize the potential for recurrence, if an event occurs, the facility will ascertain what happened or was reported to have happened, provide care and document any injuries, interview to find out who saw the resident last and the time of the event, investigate why it happened, and intervention;-The licensed nurse should evaluate the resident and render first aide if needed;-The nurse evaluation should be complete prior to moving a resident who has fallen, to determine presence of an injury;-The licensed nurse should create an event note and include, the assessment details of the resident (including location details of the resident), presence or absence of injury, and any treatments rendered, if resident is able to report what occurred, this should be included in the notes, notification of family or responsible party and notification of physician and any orders received. 1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 04/01/11;-Diagnosis included diabetic nephropathy and polyneuropathy (progressive kidney damage and widespread nerve damage. Both are primarily caused by chronic high blood sugar and oxidative stress), Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), history of falling, osteoarthritis of bilateral knee, Parkinson's disease dyskinesia without mention of fluctuations (a progressive neurological disorder that primarily affects movement), pain in right knee, abnormalities of gait and mobility, unsteadiness on feet, and chronic pain. Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/27/26, showed the following:-The resident is cognitively intact;-The resident is independent with transfers;-The resident had one fall with injury since the last admission. Review of the resident's care plan, updated 05/30/24, showed the following:-The resident needed assistance with activities of daily living (ADLs - grooming, bathing, toileting etc.) as required during activities;-The resident as an ADL self-care performance deficit due to activity Intolerance, dementia, impaired balance, limited mobility and pain;-The resident required assistance of one staff with bathing/showering;-The resident was at risk for falls and had history of falls. He/she had gait/balance problems, psychoactive drug use, muscle weakness, and arthropathy (any disease or abnormal condition affecting the joints);-Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs;-Staff to complete a fall assessment;-Encourage to participate in activities that promote exercise, physical activity for strengthening and to improve mobility;-Staff will provide adaptive equipment or devices as needed and provide appropriate non-skid proper fitting footwear when ambulating in room. Remind resident to ask staff for assistance with water spills. Review of the resident's progress notes showed the following:-On 04/03/26, at 6:35 A.M., Licensed Practical Nurse (LPN) E said the shower aide assisted the resident to the floor in the shower room. The resident hit his/her head on the wall with no pain or discomfort noted. The resident's blood pressure was 160/88 millimeters of Merch (mm/Hg) (normal range is less than (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	120/80 mm/Hg), heart rate 62 beats per minute (bpm) (normal range is 60 to 100 bpm), oxygen saturation of 95% (normal is 95% to 100%), respirations of 18 per minute (normal is 12 to 20 per minute), and temperature of 97 degrees Fahrenheit (F). The resident did not have redness or bruising;-On 04/04/26 to 04/06/26, staff did not document related to the resident's fall and follow-up monitoring;-On 04/07/26, at 3:20 A.M., the resident continued on skilled therapy services. The resident used a walker and knee braces. The resident continued say therapy is too hard on him/her and he/she needed to quit. (Staff did not document related to the resident's fall and follow-up monitoring.);-On 04/08/26 to 04/09/26, staff did not document related to the resident's fall and follow-up monitoring;-On 04/10/26, at 9:32 A.M., the resident refused to go to the dentist and said, I can't go my back hurts. When asked a second time the resident said, I told you I am not going my back hurts. (Staff did not document related to the resident's fall and follow-up monitoring.);-On 04/11/26 to 04/12/26, staff did not document related to the resident's fall and follow-up monitoring;-On 04/13/26, at 8:56 A.M., LPN A said the resident continued to have pain in the lower back and tailbone from falling into a wall. Staff notified the physician and ordered an x-ray;-On 04/13/26, at 3:45 P.M., LPN A said the resident had increased pain to the lower back, coccyx (tailbone) area. An x-ray showed a left pubic rami fracture with mild displacement (a break in one of the bones that make up the front of your pelvic ring). Staff notified the nurse practitioner. During an interview on 06/10/26, at 10:39 A.M., the resident said the following:-He/she fell a few months ago in the shower with a staff member. The staff member tried to help him/her to the floor, but he/she still hit the floor hard;-The facility did an x-ray and he/she had a broken pelvis. During an interview on 06/10/26, at 10:57 A.M., LPN E said the following:-The resident fell in the shower. She was lowered to the floor by a staff member;-He/she came to the shower room, assessed the resident and completed neurological checks on the resident;-The resident did not appear to have any new injuries. The resident complained of back pain, however, that was not a change from baseline. The resident had chronic back pain;-The resident responded well to pain medication;-He/she did not know why there were no further assessments completed or documented in the computer for the resident after the fall;-The resident should have had fall follow up assessments per the facility protocol for falls, completed every shift for 72 hours to assess for any latent injuries. During an interview on 06/10/26, at 1:27 P.M., LPN F said the following:-The resident had an x-ray about a week after his/her fall and had a pelvic fracture;-He/she did not remember completing any fall follow up assessments for the resident around the beginning of April 2026;-The resident did not have any significant increase in pain that would have indicated at injury;-The resident's nurse should have completed fall assessments each shift for 72 hours. During interviews on 06/10/26, at 1:44 P.M. and 2:28 P.M, LPN G said the following:-On 04/07/26, the resident told him/her that he/she had fallen in the bathroom over the weekend;-He/she looked in the medical record and could not find any notes regarding a fall since 04/03/26;-He/she could not find any assessments or fall follow-up documentation. He/she did not understand why staff did not complete neurological checks or at a minimum 72-hour fall follow up assessments;-He/she texted the Director of Nursing (DON) regarding the fall and not finding follow up documentation. The DON indicated he/she did not know about the fall and asked him/her to assess the resident;-He/she did a full assessment and found only a slight bruise to the left scapula (shoulder blade);-He/she forgot to document the assessment in the medical record. He/she should have documented the assessment in a progress note. During an interview on 06/10/26, at 2:04 P.M., LPN A said the following:-He/she did not know why the resident did not have any more assessments after the initial fall assessment;-On 04/13/26, the resident said he/she was having more pain in her lower back, and he/she thought it might be due to the fall he/she had;-He/she called the physician, and they ordered an x-ray. During an interview on 06/11/26, at 10:31 A.M., the DON said the following:-A CNA was with the resident when he/she fell and helped lower him/her to the floor;-The CNA said the resident's head barely bumped the wall and did not indicate that neurological checks needed to be done;-LPN E did not initially tell him/her about the resident's fall. He/she became aware days later, but he/she was not sure exactly (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	what day;-There was a delay in contacting him/her regarding the fall;-A nurse assessed the resident the day he/she became aware, and had no new concerns or bruising;-He/she expected fall assessments be documented in the resident's chart;-He/she did not know why staff did not document fall follow-up assessments the resident's chart. During an interview on 06/11/26, at 1:12 P.M., the Administrator said the following:-The resident should have had fall assessments completed after the fall;-The resident required an x-ray about a week later and they found he/she had a fractured pelvis. 2. Review of Resident #3's face sheet showed the following:-admission date of 02/28/24;-Diagnosis included hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side (a neurological condition where a spontaneous bleed in the brain damages the left hemisphere, causing weakness and paralysis on the right (dominant) side of the body), muscle weakness, repeated falls, unsteadiness on feet, other abnormalities of gait and mobility and lack of coordination. Review of the resident's MDS, dated [DATE], showed the following:-The resident had moderate cognitive impairment;-The resident required partial/moderate staff for transfers;-The resident has had two or more falls since the last admission or reentry. Review of the resident's care plan, revised 09/26/25, showed the following:-Resident at risk for falls due to confusion, gait/balance problems, and incontinence;-Staff will assist with ADLs as needed;-Staff will anticipate the resident's needs;-Staff will assess the resident for illness;-Staff will encourage the resident to use the call light in the bathroom for assistance;-Staff will encourage the resident to use non-skin foot wear. Review of the resident's progress notes showed the following:-On 06/08/26, the certified nurse aide (CNA) called the nurse to the resident's room because he/she had to lower the resident to the floor during a transfer due to the resident not pivoting and trying to sit down during the transfer. The nurse assessed the resident for injuries. The resident did not have any injuries. Three staff assisted the resident up to the wheelchair with a gait belt. He/she educated the CNA to use two staff for transfers with the resident. The nurse notified the physician and DON;-On 06/08/26, at 2:00 P.M., the interdisciplinary team members met to discuss the residents fall on 06/08/26. Staff lowered the resident to the floor during a transfer. The nurse assessed the resident for injuries and there were none. Staff assisted the resident to the wheelchair. The staff to implement a new intervention of two staff assist with transfers. The care plan was reviewed and updated. Review of the resident's records showed staff did not document any additional fall follow-up assessments for the fall that occurred on 06/08/26. 3. Review of Resident #4's face sheet showed the following:-admission date of 09/09/25;-Diagnosis included vascular dementia with other behavioral disturbance (occurs when reduced blood flow to the brain causes cognitive decline alongside difficult neuropsychiatric symptoms), repeated falls, unsteadiness on feet, muscle weakness, and unspecified dementia (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks). Review of the resident's MDS, dated [DATE], showed the following:-The resident had significant cognitive impairment;-The resident required partial/moderate assistance from staff for transfers;-The resident has had two or more falls since the last admission or reentry. Review of the resident's care plan, updated 03/12/26, showed the following:-Resident at risk for falls;-Staff will anticipate the residents' needs;-Ensure the television is off prior to transfers;-The staff will assist the resident to bed;-The staff will complete increased observation while the resident is in bed. Review of the resident's progress notes showed the following:-On 05/27/26, at 7:08 P.M., while staff was transferring a resident from the toilet to the wheelchair the resident started to fall and staff assisted resident to the floor. Staff yelled for the nurse. The nurse did not find any injuries;-On 05/28/26, at 11:06 A.M., the interdisciplinary team members met to discuss the resident's fall on 05/27/26. Staff were assisting resident to bathroom. The resident lost their balance, and staff lowered them to the floor. The nurse assessed the resident for injuries with none found. The staff assisted the resident up. The physician and DON were notified. A new intervention was put in place. The resident will have two-person assistance with transfers. The care plan reviewed and updated. Review of the resident's records showed staff did not document any (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	additional fall follow-up assessments for the fall that occurred on 05/27/26. 4. During an interview on 06/10/26, at 10:57 A.M., LPN E said the following:-The nurse completes an initial fall assessment and makes a progress note in the resident's medical record;-Fall assessments are continued for 72 hours at least once per shift after then initial assessment. During an interview on 06/10/26, at 1:27 P.M., LPN F said the following:-The nurses respond to every fall. They complete an initial assessment for injury and then continue to assess one time per shift for 72 hours;-Staff lowering a resident to the floor is considered a fall and should be assessed per the facility protocol. The nurse checks the resident's vitals, neurological status and for any physical injuries/ pain;-The nurse completes neurological checks for 72 hours if the resident hits their head;-The nurse sets up an event under the assessment tab on the computer and can document their assessment there. They also document assessments in the progress notes. During interviews on 06/10/26, at 1:44 P.M. and 2:28 P.M, LPN G said the following:-The nurse should always complete an initial assessment and fall follow up assessments once time per shift for 72 hours;-The nurse was to enter an event note and also a progress notes regarding the assessments and any findings.During an interview on 06/10/26 at 2:04 P.M., LPN A said the following:-If a resident had a fall, the protocol was for the nurse to complete an initial assessment. The nurse assessed once per shift for 72 hours following the fall to ensure there are no latent injury;-The nurse documented the assessments in the resident's medical record;-If staff had to lower a resident to the floor it is still considered to be a fall and fall assessments should be completed every shift for 72 hours. During an interview on 06/11/26, at 12:46 A.M., the Nurse Practitioner (NP) said the following:-He/she expected staff to complete a full fall follow up, including assessing the resident every shift for 72 hours and completing neurological checks to make sure there are no latent injuries, after a fall or lowering a resident to the floor;-The nursing staff should document the assessments in the resident's chart and let him/her or the physician know if there are any unusual findings. During an interview on 06/11/26, at 10:31 A.M., the DON said the following:-He/she expected nursing staff to complete fall assessments once per shift for 72 hours following a fall for latent injuries;-Staff lowering a resident to the floor is still considered a fall and he/she expects staff to assess the resident and follow the facility fall protocol;-The nurses document the assessments in the resident's progress notes and pass on the information to the next nurse;-The staff contact the DON or on-call manager if a resident fell. During an interview on 06/11/26 at 1:12 P.M., the Administrator said the following:-He/she expected the staff to complete fall follow-up per the facility protocol;-There should be follow-up assessments completed. He/she did not know for how long but thought they should be completed each shift following a fall. Complaint #2982345

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain effective and complete an infection prevention and control program when staff failed to follow appropriate Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO - bacteria or fungi that have developed resistance to multiple classes of drugs, like antibiotics) that employs targeted gown and glove use during high contact resident care activities) for one resident (Resident #1) with an indwelling catheter (tubing placed to drain the bladder to outside the body), a nephrostomy tube (tubing placed to drain the kidney to the outside the body) and with two wounds present. The facility census was 82.Review of Centers for Disease Control and Prevention' (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of MDROs, dated 04/02/24, showed the following:-MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs;-EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities;-EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO;-Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens,changing briefs or assisting with toileting, device care or use of central line (a long, flexible tube inserted into a large vein in the chest, neck, or arm, with the tip ending close to the heart), urinary catheter (a thin, flexible, indwelling urinary tube inserted through the urethra into the bladder to drain urine continuously), feeding tube (a medical device used to deliver liquid food, fluids, and medications directly to the stomach or small intestine), tracheostomy (a surgical procedure that creates an opening, called a stoma, through the neck directly into the windpipe (trachea) /ventilator (a medical machine that helps a patient breathe or fully breathes for them)and wound care of any skin opening requiring a dressing. Review of the facility's policy titled Enhanced Barrier Precautions, dated 08/19/25, showed the following:-The facility should use EBP as an additional MDRO mitigation strategy for residents that meet the following criteria, during high-contact resident care activities;-EBP are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO;-Wounds generally include chronic wounds not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing;-Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers;-Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP.-EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. 1. Review of Resident #1 face sheet (brief information sheet about the resident) showed the following:-admitted [DATE];-Diagnoses included osteomyelitis (a localized inflammation of the bone due to an infection) of sacral (the large, triangular bone at the bottom of the lower back) and sacrococcygeal region (anatomical region at the base of the spine) vertebra (spine), stage 4 pressure ulcer (full-thickness skin and tissue loss) of sacral region, non-pressure chronic ulcer of right heel and midfoot with fat layer exposed, neuromuscular dysfunction of bladder (loss of bladder control, inability to empty bladder), and hydronephrosis (swelling of one or both kidneys caused by a buildup of urine). Review of the resident's care plan, updated 04/27/26, showed the following:-Resident had potential and actual impairment to skin integrity;-Resident has an indwelling suprapubic catheter (sterile tube inserted into the bladder to drain urine);-Resident had a stage 4 pressure ulcer of sacral region;-Staff should utilize (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265381	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwood Hills Care Center	800 N Arthur St Humansville, MO 65674

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enhanced barrier precautions. Review of the quarterly Minimum Data Set (MDS - an assessment completed by facility staff), dated 04/28/26, showed the following:-Cognitively intact;-Stage 4 pressure ulcer;-Diabetic foot ulcer;-Indwelling catheter.Review of the resident's physician orders, current as of 06/10/26, showed the following:-An order, dated 04/28/26, to check nephrostomy tube (thin, flexible catheter inserted through the directly into the kidney to drain urine) site every shift, verify if tube is draining and no kinks are present in the tube, no signs or symptoms of site infection;-An order, dated 04/28/26, for coccyx (tailbone). Staff to cleanse wound, pat dry, loosely pack with Vashe (brand name wound care solution) moistened gauze, and cover with dry dressing every day shift for wound care;-An order, dated 04/28/26, for the right heel. Staff to cleanse wound, pat dry, cover with Mepilex (brand of soft silicone foam dressing) heel border every day shift every 3 days for wound care;-An order, dated 05/01/26, for EBP for diagnoses of wound, catheter, and nephrostomy tube every shift;-An order, dated 05/19/26, for indwelling catheter to straight drainage. Review of the resident's June 2026 Medication Administration Record (MAR) showed the following:-An order dated 06/01/26, enhanced barrier precautions for diagnosis of wound, foley (catheter) and nephrostomy tube every shift;-Staff signed as completed for day, evening, and night shift on 06/01/26, 06/02/26, 06/03/26, 06/04/26, 06/05/26, 06/06/26, 06/07/26, 06/08/26, 06/09/26, and day shift on 06/10/26. Observation on 06/10/26, at 1:15 P.M., showed the following:-Licensed Practical Nurse (LPN) A prepared wound care supplies at cart in hall;-He/she requested assistance from Certified Nurse Assistant (CNA) B for positioning the resident;-An EBP sign on the resident's door with personal protective equipment (PPE) hanging in a container on the door;-The LPN entered the resident's room and placed wound care supplies on a clean barrier on the resident's bedside table;-CNA B entered the resident's room and applied gloves;-The LPN washed his/her hands at the resident's sink and applied gloves;-LPN A and CNA B did not apply gowns;-LPN A and CNA B assisted the resident to roll to their left side;-The resident had a colostomy bag (waterproof, medical-grade pouch worn over a stoma - a surgically created opening in the abdominal wall-to collect waste) on the right side of their abdomen, a catheter bag hanging on the rail of the bed frame, and a nephrostomy bag on the bed next to the resident;-The LPN removed the wound dressing on the resident's sacral area;-The LPN removed gloves, used hand sanitizer, and applied clean gloves;-The LPN completed wound care and removed his/her gloves, used hand sanitizer and applied clean gloves;-The LPN placed a clean bed pad on the bed and assisted the resident to roll to their right side as the CNA pulled the clean bed pad through and straightened the sheets;-The CNA moved the nephrostomy bag to ensure it was flat with no kinks in the tube;-The LPN moved the catheter bag to the right side of the bed for resident to be repositioned to right side;-LPN A and CNA B ensured the resident's comfort and returned the call light to the resident's reach;-LPN A and CNA B removed the trash and soiled linens, removed their gloves, and completed hand hygiene;-LPN A and CNA A exited the room;-LPN A and CNA B did not wear gowns during the wound care process. During an interview on 06/10/26, at 1:50 P.M., LPN A said the following:-EBP should be used for residents with catheters, tracheostomy, and wounds;-Depending on the situation, staff will wear gown, gloves, and sometimes masks when performing cares;-Staff should wear gowns when completing wound care for the resident. During an interview on 06/10/26, at 2:00 P.M., CNA B said the following:-If a resident had an EBP sign on the room door and staff should wear a gown and gloves with any personal cares;-Staff should wear gowns when providing wound care on the resident. During an interview on 06/10/26, at 2:25 P.M., CNA C said staff should wear a gown and gloves when working with residents that have an EBP sign on the door. Personal protective equipment (PPE) supplies are located on the resident's door. During an interview on 06/10/26, at 2:40 P.M., Registered Nurse (RN) D said the following:-Staff should follow EBP guidelines when a resident had wounds, catheters, or any inserted device;-Staff should wear a gown and gloves with any hands-on care with a resident that required EBP precautions;-The PPE supplies and an EBP precautions sign were located on the resident's door. During an interview on 06/10/26, at 3:00 P.M., the Infection Preventionist (IP) said the following:-All (continued on next page)

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	265381	A. Building B. Wing	06/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff are trained on EBP protocol;-Staff are required to wear a gown and gloves during resident cares for any residents with a tracheostomy, PICC line , wounds, G-tubes (medical device surgically inserted through the abdomen directly into the stomach), and catheters;-EBP precautions prevent staff from exposing the resident to any possible infection and to help prevent MDRO infections. During an interview on 06/10/26, at 3:10 P.M., Director of Nursing (DON) said staff must follow EBP policy. Staff should wear a gown and gloves when doing cares with residents who have catheters, wounds, and any tubes. During an interview on 06/11/26 at 1:12 P.M., the Administrator said the following:-The facility follows EBP for infection control. The nurses are familiar with the residents that require EBP be followed and should follow the infection control policy;-He/she expected staff to follow EBP when they are performing wound care, especially on an open wound. This would include wearing gloves, gowns and a mask when necessary. Complaint #3017587