STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265393	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Hills Living Center	996 State Highway 248 Branson, MO 65616

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on interview and record review, the facility failed to provide the services of a registered nurse (RN) for at least eight consecutive hours per day seven days per week when the facility did not have consistent RN coverage on the weekends. The facility census was 75.Review showed the facility did not have a specific policy pertaining to the scheduling of an RN. 1. Review of the facility's nurse schedule, timecard reports for all RNs, and facility form entitled Salaried Personnel - Direct Resident Care Logs (Salaried Time Log - logged working hours by salaried employee), dated December 2025, January 2026, and February 2026, showed the following:-On Saturday, 12/06/25, no RN was scheduled. The Minimum Data Set Coordinator/RN (MDS - a federally mandated comprehensive assessment tool completed by facility staff)) worked for 6.9 hours; -On Saturday, 12/20/25, no RN was scheduled and no RN logged time; -On Saturday, 12/27/25, no RN was scheduled. The MDS RN worked for 4.4 hours; -On Sunday, 12/28/25, no RN was scheduled. The MDS RN worked for 3.8 hours; -On Saturday, 01/03/26, no RN was scheduled. The MDS RN worked for 4.4 hours; -On Sunday, 01/04/26, no RN was scheduled and no RN logged time; -On Saturday, 01/17/26, no RN was scheduled and no RN logged time; -On Sunday, 01/18/26, no RN was scheduled and no RN logged time; -On Saturday, 01/31/26, no RN was scheduled. The MDS RN worked for 4.7 hours; -On Sunday, 02/01/26, no RN was scheduled. The MDS RN worked for 4.1 hours; -On Saturday, 02/07/26, no RN was scheduled and no RN logged time;-On Sunday, 02/08/26, no RN was scheduled and no RN logged time. During an interview on 02/12/26, at 1:15 P.M., RN K said he/she worked every other weekend. The RN was not sure how they scheduled RN coverage on the alternate weekends or when he/she had requested off. During an interview on 02/12/26, at 1:20 P.M., the Director of Nursing (DON) said the facility currently had only one floor RN, who works every other weekend. They try to fill in hours on the alternate weekends with the DON, one as-needed (prn) RN, and the MDS Coordinator, who is an RN. When the DON works on the floor, he/she records the time on the Salaried Personnel - Direct Resident Care Logs (Salaried Time Log). The prn RN and MDS RN record their weekend time by using the time clock. During an interview on 02/13/26, at 8:10 A.M., the DON said the facility did not have a policy specific to RN coverage. They should just follow the regulations. During an interview on 02/12/26, at 1:25 P.M., the facility Administrator said they had a shortage of RNs on staff. There were gaps on some weekends, and they were not always in compliance with the required RN coverage of eight consecutive hours daily.

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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility failed to implement their abuse and neglect policies when staff failed to complete criminal background checks (CBCs) for two of ten sampled employees prior to their hire/start date in a facility with a census of 75. Review of the facility's Abuse Prohibition Protocol Manual (effective 11/28/2016) showed the following:-The facility must develop and implement written policies and procedures that: -prohibit and prevent abuse, neglect, and exploitation of residents, and misappropriation of property;-It is the policy of this facility to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check;-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;-A criminal background check will be conducted on all prospective employees as provided by the facility's policy on criminal background checks. A significant finding on the background check will result in denied employment consistent with the criminal background check policy in accordance with State and Federal Regulation;-Regarding Background Checks: -The Family Care Safety Registry (FCSR) or the Employee Disqualification List (EDL) and Criminal Background Check (CBC) must be checked before the applicant/employee has any contact with residents. If you have received the EDL results and have made the CBC request, the applicant can start working at the facility. Once you receive the CBC results, you then have to evaluate the results. If the applicant/employee has a conviction on their criminal background check, Missouri facilities must check the Missouri Disqualifying Crimes list to determine if the conviction disqualifies them from employment. If the conviction is not specifically listed, the Administrator will review the file with the Quality Assurance Nurse or Director of Operations for a decision on hiring/retaining the applicant/employee. If the conviction is on the list, the applicant/employee cannot work or volunteer in the facility;-Always keep a hard copy of CBC request and the results for each employee. If you don't have these copies in the employees' files, the State will cite you. 1. Review of Dietary Aide (DA) U's employee record showed his/her hire date was 11/17/25. Staff documented a request for a CBC on 02/12/26. The facility did not document a completed CBC prior to 02/12/26 for DA U. 2. Review of Housekeeping (HK) V's employee record showed his/her hire date was 04/14/25. The facility did not document a completed CBC for HK V. 3. During an interview on 02/13/26, at 12:58 P.M., the Assistant Business Office Manager (Asst. BOM) said he/she was responsible for completing background checks on job applicants and providing education to new employees regarding abuse and neglect policies and procedures. The Asst. BOM said he/she had requested a CBC for DA U, but the results were not received. He/she said there was potentially some misinformation on the employee's request for inclusion on the FCSR that needed to be addressed by the employee or the Asst. BOM. When the state surveyor presented the list of sampled employees related to background checks, he/she had noted the uncompleted CBC and resubmitted a request on 02/12/26. HK V had requested inclusion on the FCSR, but the facility had not received a completed CBC back from them. The Asst. BOM said they had the availability of using a third-party investigation service for running background checks, but was told by a corporate manager not to enlist their services unless the facility did not get a response from FCSR. During an interview on 02/13/2026, at 1:03 P.M., the Director of Nursing (DON) and the corporate Quality Assurance Support Nurse (QA RN) said full background checks are to run, usually by the Asst. BOM, on all applicants prior to hire. The QA RN said he/she didn't think they should hire anyone until the CBC was done. Both staff said their screening policy says an employee cannot work with residents until the CBC is done to confirm there are no disqualifying indicators. The facility can use a third-party service to request a background check. During an interview on 02/13/26, at 1:22 P.M., the Administrator said the Asst. BOM had told him/her there had been some delays in response from the State's FCSR; occasionally taking up to five days to receive a clean report. The Administrator said the facility (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should use their available alternate investigative service to request a background check if there wasn't a quick response from FCSR. Staff can't work with residents until the background checks are done.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to maintain the medication storage refrigerator at the recommended temperatures, per manufactures recommendations, for multiple medications stored in the refrigerator for use. The facility census was 75.Review of the facility's policy titled Medications, Storage of, undated, showed the following:-Biologicals or medications requiring refrigeration must be kept in a separate, securely fastened refrigerator;-Drugs must be stored at appropriate temperature levels. Drugs stored in a refrigerator must be stored between 36 and 46 degrees Fahrenheit (F).Review of the Centers for Disease Control and Prevention (CDC) Guidelines for vaccines, dated 03/19/24, showed the following:-Never freeze refrigerated vaccines:-Ideal temperature of refrigerated vaccines is 40 degrees F;-Refrigerator temperature should be between 36 degrees F and 46 degrees F.Review of Lantus (insulin) package insert, dated December 2025, showed the following:-Keep unused Lantus pen or vial in refrigerator at 36 degrees F to 46 degrees F;-Do not freeze Lantus;-Store in use Lantus pen or vials in a refrigerator or at room temperature below 86 F.Review of the Novolog (rapid acting insulin) package insert, undated, showed the following:-Keep Novolog pen or vial in refrigerator at 36 degrees F to 46 degrees F;-Do not allow insulin to freeze.1. Observation on 02/11/26, at 9:31 A.M., of the medication refrigerator located in the medication room with Licensed Practical Nurse (LPN) A showed the following: -Five boxes of influenza vaccine for resident use with warning on box to store between 36 and 46 degrees;-Twenty-five pens of Lantus for resident use;-Twenty-five pens of NovoLog for resident use;-Fridge temperature measured 31 degrees.Review of the December 2025, January 2026, and February 2026 logs showed missing entries on 12/17/25, 12/18/25, 12/19/25, 12/22/25, 12/23/25, 12/24/25, 12/25/25, 12/26/25, 12/27/25, 01/02/26, 01/03/26, 01/24/26, 01/29/26, 01/30/26, 1/31/26, 02/06/26, 02/07/26, and 02/26/26.Observation on 02/12/26, at 11:26 A.M., of the medication refrigerator located in the medication room with Certified Medication Tech (CMT) B showed Keep refrigerator at 36 to 46 degrees written on refrigerator log on door of refrigerator.During an interview on 02/12/26, at 12:35 P.M., LPN C said the following:-Refrigerator temperatures are checked once a day by the night shift nurse;-He/she did not know what the temperature is supposed to be kept at but its listed on the refrigerator;-If temperatures are out of range nursing staff can adjust setting and notify the maintenance director.During an interview on 02/12/26, at 12:48 P.M., the Maintenance Director said the following:-Nursing staff will notify him/her if a refrigerator was not working correctly;-He/she can adjust setting and replace refrigerator if needed. During an interview on 02/12/26 at 2:32 P.M., LPN D said the following:-He/she is not sure what the temperature of the refrigerator should stay at but thinks it's 32 to 42 degrees F;-Night shift nurses check and maintain the temperature logs;-It is important to maintain proper temperature of the stored medication to insure it is working correctly.During an interview on 02/13/26, at 9:40 A.M., the Assistant Director of Nursing (ADON) said the following:-Refrigerator temperatures should be maintained at 36 to 46 degrees F;-Night shift nursing staff checks the temperatures and maintains an written daily log of all temperatures;-Nursing staff should notify the Maintenance Director if a refrigerator is not maintaining a proper temperature. -Nursing staff should consult with the pharmacist if a medication is stored in a temperature out of range because it may need to be replaced. During an interview on 02/13/26 ,at 11:46 A.M., the Director of Nursing (DON) said the following:-He/she expected nursing staff to notify him/her if any refrigerator is not operating correctly;-It was important to maintain proper temperature's because keeping them out of range can shorten the shelf life of the medication;-Thermostats and refrigerators can and will be replaced if needed.During an interview on 02/12/25, at 1:22 P.M., the Pharmacist said the following:-All medication stored in the refrigerator should be kept between 36 and 46 degrees F;-Staff should be checking and adjusting the temperature (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as necessary per facility policy;-He/she had made recommendations to the facility in the past to replace thermometers and to educate staff on proper storage of refrigerated medications;-It was important to maintain proper temperatures because failing to do so can destroy the medication or shorten the shelf life of the medication. During an interview on 02/13/26, at 3:20 P.M., the Administrator said the following:-He expected staff to follow facility policies in regards to storing refrigerated medication;-He expected staff to be monitoring the temperatures per policy.

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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain a complete infection control program when staff failed to use proper hand hygiene and Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs - microorganism that has developed resistance to one or more classes of antibiotics, making infections caused by it more difficult to treat) in nursing homes) during wound care for one resident (Residents #58) and medication administration for one resident (Resident #8) who had a feeding tube. Staff failed to complete proper hand hygiene during diabetic accu-checks (a point of care blood test) for one resident (Resident #1). A sample of 16 residents was reviewed. The facility census was 75.Review of the facility policy titled, Enhanced Barrier Precautions to Infection Control Guidance, undated, showed the following:-EBP is used to prevent the broader transmission of MDROs and to help protect patients with chronic wounds and indwelling devices;-EBP should be implemented for the period of their (the residents) stay or until wounds have resolved or indwelling medical devices have been removed; -EBP should be used when providing high contact resident care such as wound care, transferring, bathing, changing briefs and linens, caring for indwelling devices;-Gloves and donning and doffing of gown are required when conduction high contact resident care that are listed above. Review of the facility policy Standard and Transmission-Based Precautions, undated, showed the following: -Hand hygiene referred to hand washing with soap or using alcohol-based hand rubs that do not require water;-Hands shall be washed with soap and water whenever visibly soiled;-Wash hands after removing gloves;-Wear gloves and change as necessary during the care of a resident to prevent the cross contamination from one body site to another;-Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. Review of the facility policy Diabetic Infection Control, undated, showed the following: -Gloves are to be worn when preforming finger sticks and changed between residents;-Preform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for the use on another resident. 1.Review of Resident #58 face sheet (a form that provides resident details) showed the following: -admission date of 09/26/25;-Current diagnoses included chronic venous ulcer and inflammation of the right lower extremity (a type of chronic wound to the right lower leg), pressure ulcer of unspecified part of back (a wound to the back), and pressure ulcer to the right buttock (a wound to the right buttock). Review of the residents' quarterly Minimum Data Set (MDS-federally mandated assessment tool administered by staff), dated 01/02/26, showed the following:-Cognitively intact with no memory concerns;-Needed partial assistance with lower body care;-Foley catheter (flexible tube inserted into the body to drain fluids (like urine));-Had pressure ulcers. Review of the residents' Physician Order Report, dated 02/13/26, showed the following: -An order, dated 11/03/25, for EBP related to catheter and pressure ulcer;-An order, dated 02/11/26, to cleanse the right buttock and apply collagen powder and Maxorb-alginate dressing (a type of wound dressing), cover with border gauze, and skin prep around wound bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, revised 1/20/26, showed the following:-Risk for impaired skin integrity;-EBP due to high risk of infection. Observation of wound care on 02/10/26, at 11:02 A.M., by the Assistant Director of Nursing (ADON) and Director of Nursing (DON) showed the following:-Nursing staff washed hands, donned gloves, gathered supplies and entered the room. (The ADON and DON did not don gowns);-The DON completed wound care on resident's lower back, removed gloves, and donned new gloves;-Staff assisted resident to turn on his side removed brief and cleansed buttocks before starting wound care;-While assisting with turning the resident the ADON picked up and moved the foley catheter bag with gloved hands and then touched resident gown, covered the resident, and proceed to pick up pen and paper and moved them to the dresser before his/her changing gloves without performing hand hygiene. 2. Review of Resident #8's face sheet showed the following information:-admission date of 09/14/25;-Diagnoses included dominant /right side spastic hemiplegia and hemiparesis (weakness or paralysis) following a stroke, aphasia (difficulty with speech) following stroke, difficulty swallowing, gastrostomy status (feeding tube placed through an opening into the stomach), Type 2 diabetes, atrial fibrillation (a-fib; irregular heart rhythm), chronic obstructive pulmonary disease (COPD - breathing disorder, respiratory failure, acute bronchitis, cough, wheezing, obesity, disease of stomach (unspecified)z), cellulitis of lower limb (skin infection, occurs when bacteria enters a skin disruption such as injuries, wounds, surgical cuts, burns, etc.), pressure ulcer, kidney failure chronic pain syndrome, and high blood pressure. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderately impaired cognition;-Impaired range of motion to upper and lower extremity, one sided;-Feeding tube in place while a resident with intake via tube 51% or more;-Incontinent of bowel and bladder;-Dependent on others for bed mobility and use of manual wheelchair. Review of the resident's care plan, last updated 01/20/26, showed the following:-EBP related to PEG tube (a soft, flexible feeding tube inserted through the abdomen into the stomach to deliver nutrition, fluids, and medications directly);-Resident to be free of infection; -Ensure proper personal protective equipment is used;-Risk for infection related to PEG tube insertion site; -PEG site will remain clean, dry, and free from signs of infection; -Flush tube with prescribed amount of water before and after medications and every 4-6 hours. Review of the resident's Physician Order Sheet (POS), current as of 02/13/26, showed the following:-An order, dated 09/14/25, for NPO (nothing by mouth);-An order, dated 09/14/25, for enteral nutrition (tube feeding). The continuous feeding may be discontinued for up to one hour per day for bath and administration of medications;-An order, dated 09/14/25, flush tube with 30 milliliters (ml) of water before and after medications every shift;-An order, dated 01/06/26 for EBP related to PEG tube;-An order, dated 01/28/26, for Jevity (nutritional supplement) 1.5 calorie liquid food, 50 ml/hour (hr) per gastric tube with [NAME] water pump/bag, flush and Jevity both run at 50 ml/hr via pump. Review of the resident's electronic Medication Administration Record (eMAR), dated 01/01/26 to 02/13/26, showed staff documented administration of medications through the feeding tube per physician orders. Observation on 02/09/25, at 11:54 A.M., showed the resident's door indicated a need for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/11/26, at 11:43 A.M., showed the resident's tube feeding pump audibly indicated a need for nurse assessment. The concurrent water bag was approaching empty. Observation on 02/12/2026, at 12:40 P.M., showed Licensed Practical Nurse (LPN) A utilized hand sanitizer gel and donned gloves, but did not don a surgical gown, and entered the resident's room. After explaining the procedure to the resident and stopping the feeding pump, LPN A used a syringe to instill air into the PEG tube and placed the bell of the stethoscope against the resident's skin to verify tube placement. LPN A then replaced the syringe with a graduate (funnel) and flushed the tubing with water. The tubing was clogged; The LPN massaged the tubing until he/she was able to advance the water through the tubing. LPN A poured premeasured medications into the graduate, allowing each to instill per gravity with the graduate held above the tube insertion site. LPN A added 30 ml of water to flush the medications through the tubing. The LPN removed the graduate, reconnected the tube feeding, and restarted the pump running at 50 ml/hr. 3. During an interview on 02/12/26, at 11:08 A.M., Certified Nurse Aide (CNA) I said the following: -EBP means staff are to wear a gown and gloves when entering the room;-It was to protect the resident and us from infections. During an interview on 02/12/26, at 11:15 A.M., CNA J said EBP was for residents with catheters and means we are to wear a gown and gloves when entering that room. During an interview on 02/12/26, at 12:35 P.M., LPN C said EBP the following: -EBP was used to protect residents that have wounds and foley catheters;-Staff should use gown and gloves when taking care of EBP residents. During an interview on 02/12/26, at 2:32 P.M., LPN D said the following:-EBP was for all residents with open wounds, or foley catheters;-He/she expected all staff to wear gown and gloves for EBP residents while completing patient care. During an interview on 02/12/26, at 1:15 P.M., Registered Nurse (RN) K said staff should follow EBP for working closely to residents with wounds, indwelling catheters, or tubing of any kind, such as tube feeding. He/she said EBP should be used when administering medications through a PEG tube. During an interview on 02/13/26, at 9:40 A.M., the ADON said the following:-Any resident with open wounds, or indwelling devices will be placed on EBP precautions;-Staff should wear a gown and gloves when performing direct resident care;-He/she expects all staff to follow EBP. During an interview on 02/13/26, at 11:46 A.M., the DON said the following:-EBP was to protect residents and staff from infections;-All residents with foley cath, IV, history of MRSA (a MDRO), or indwelling devices can be placed on EBP;-Gown and gloves are required depending on task;-If there is resident contact, contact with bodily fluids, staff should be wearing gown and gloves;-He/she expected all staff to follow EBP precautions. During an interview on 02/13/26, at 3:20 P.M., the Administrator said he expected all staff to be following EBP precautions including during wound care; 4. Review of Resident #1 face sheet showed the following: -admit date [DATE];-Diagnoses included diabetes (a disease where the body fails to regulate blood sugar levels). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the residents' physician order report, dated 02/13/26, showed and order for humalog insulin (fast acting insulin to lower blood sugar levels) to give 3 units subcutaneous (under the skin) three times a day. Staff to hold if blood sugar level was less than 120 milligram/deciliter (mg/dL). Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact. Observation on 02/11/26, at 11:16 A.M., showed the following: -CMT H donned gloves without performing hand hygiene; -CMT H completed the accu-check (blood sugar check), doffed gloves, obtained insulin, and donned gloves without performing hand hygiene;-CMT H completed insulin administration, doffed gloves, and charted results without performing hand hygiene. 5. During an interview on 02/12/26 at 11:08 A.M., CNA I said staff should wash hands before and after entering a room and when changing gloves. During an interview on 02/12/26, at 11:15 A.M., CNA J said staff should wash hands before and after contact with a resident. During an interview on 02/12/26, at 12:35 P.M., LPN C said all staff should wash hands before and after contact with a resident and when changing gloves. During an interview on 02/12/26, at 2:32 P.M., LPN D said he/she expected all staff to wash hands before and after contact with a resident and when changing gloves. During an interview on 02/13/26 at 9:40 A.M., the ADON said the following:-He/she expected all staff to wash hands before and after patient contact, when going from dirty surface to clean, and when changing gloves;-He/she expects all staff to follow handwashing precautions. During an interview on 02/13/26, at 11:46 A.M., the DON said all staff should wash hands before and after resident contact and when changing gloves. During an interview on 02/13/26 at 3:20 P.M., the Administrator said he/she expected all staff to wash hands before and after resident contact and when changing gloves.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, the facility failed to complete a comprehensive and individualized care plan for one resident (Resident #10). The care plan failed to include monitoring and interventions for the following: high fall-risk; insulin (a medication that lowers the level of glucose in the blood for treatment of diabetes), for an anticoagulant (prevent or reduce the ability of the blood to clot) medication; and toileting needs. The facility census was 75.Review of the facility's (undated) policy titled, Care Plan Comprehensive, showed the following:-The purpose of an individualized comprehensive care plan includes measurable goals and time frames developed to meet the resident's highest practicable physical, mental, and psychosocial well-being.-The interdisciplinary care plan team with input from the resident, family, and/or legal representative will develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.-The comprehensive 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 instrument completed by facility staff).-Assessment of each resident is an ongoing process and the care plan will be revised as changes occur in the resident's condition.-A well-developed care plan will be oriented to: -Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence. -Managing risk factors to the extent possible or indicating the limits of such interventions. -Addressing ways to try to preserve and build upon resident strengths. -Applying current standards of practice in the care planning process. -Evaluating treatment of measurable goals, timetables and outcomes of care. -Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. -Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs. -Involving the direct care staff with the care planning process relating to the resident's expected outcomes. -Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.-The interdisciplinary care plan team is responsible for the periodic review and updating of care plans: -When a significant change in the resident's condition has occurred. -At least quarterly. -When changes occur that impact the resident's care. The facility did not provide a specific policy for the monitoring of the anticoagulant medication Eliquis (a prescription blood thinner used to treat and prevent blood clots). 1. Review of Resident #10's face sheet (brief resident profile sheet) showed the following information:-admitted to the facility on [DATE];-readmitted to the facility on [DATE];-Diagnoses included weakness; other reduced mobility; atrial fibrillation (heart rhythm disorder that causes the heart to beat fast and inefficiently, often leading to palpitations, dizziness, and fatigue. It increases the risk of blood clots and stroke); hypertension (high blood pressure); fracture of left femur (bone extends from the hip to the knee); diarrhea; constipation; insomnia (a sleep disorder that causes difficulty getting or staying asleep); depression; encephalopathy (any diffuse disease of the brain that alters brain function or structure); type 2 diabetes. Review of the current physician order report showed the following: -Order dated 08/12/25, Eliquis 2.5 milligrams (mg), 1 tablet, twice per day;-It did not show any orders for oxygen for the resident. Review of the resident's bowel/bladder assessment, dated 08/13/25 showed the following:-Always incontinent of bowel;-Constipation present;-Always incontinent of urine;-Staff did not assess the resident for a urinary toileting program;-Resident never aware of toileting needs. Review of the resident's fall risk assessment, dated 08/13/25 showed the following:-History of one or more falls within the previous 6 months;-Urgency, frequency and incontinence with elimination;-On one high fall risk drug;-Required assistance or supervision for mobility, transfer, or ambulation;-Altered awareness of immediate physical environment, impulsive, and lack of understanding of one's physical and cognitive limitations;-Staff identified resident at high risk for (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Hills Living Center	996 State Highway 248 Branson, MO 65616

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	falls. Review of the physician order report showed the following:-Order dated 09/16/25, Novolog FlexPen U-100 Insulin, 100 unit/3 milliliter (mL) per sliding scale, before meals and at bedtime: -If blood glucose is 140 to 199, give 2 units; -If blood glucose is 200 to 249, give 4 units; -If blood glucose is 250 to 299, give 6 units; -If blood glucose is 300 to 349, give 8 units; -If blood glucose is greater than 349, give 10 units. Review of the resident's quarterly MDS, dated [DATE], showed the following information:-Severe cognitive impairment;-Always incontinent of bowel and bladder;-Required extensive to total assistance from staff with bed mobility, transfers, toileting and locomotion (movement from one place to another);-Resident had two or more falls since admission/entry or reentry;-Insulin injections;-Anticoagulant use. Review of the resident's care plan revised/reviewed on 01/06/26, showed the following:-Problem start date of 01/06/26, showed impaired gas exchange related to chronic respiratory failure;-Administer two-six liters per minute of oxygen through a nasal cannula as ordered;-Supplemental oxygen can help maintain oxygen saturation at a normal level.-Avoid high concentrations of oxygen for patients with chronic obstructive pulmonary disease (COPD, a progressive lung disease that causes obstructed airflow, leading to severe breathing difficulties).-Staff did not address the resident's diagnosis of diabetes, signs and symptoms to monitor for problems related to diabetes.-Staff did not address the resident's toileting abilities, needs, or a toileting plan.-Staff did not address the resident's anticoagulant use and/or any signs and symptoms related to it's use.-Staff did not address the resident's high fall risk or any interventions to prevent falls. Review of the medication administration record (MAR) dated 02/01/26 - 02/12/26 showed the following:-Staff administered Eliquis 2.5 mg, one tablet, twice a day;-Staff administered Novolog FlexPen insulin according to the orders on the sliding scale. Staff administered the insulin at least daily. During an interview on 02/12/26, at 4:45 P.M., NA T said the following:-He/she would look for the resident's toileting plan in the care plan.-Staff should offer to toilet residents every two hours.-Resident #10 will only go to the bathroom when offered, will not ask, and does need to be prompted.-The aide did not know of any specific toileting plan for the resident.-He/she is usually incontinent, and his/her brief is usually wet.-He/she would not expect for the resident to be dry for an entire shift.-The resident's toileting information should be on the care plan.-The aide did not know if the resident was at risk for falls.-NA T would look on the care plan to find out if a resident was at-risk for falls.-NA T was not sure how to know if a resident was on a blood thinner.-NA T would look on the resident's care plan to find out if he/she was a diabetic. During an interview on 02/13/26, at 8:46 A.M., LPN C said the following:-Resident #10 was absolutely a fall risk.-The resident has had several falls but did not remember the number of falls.-LPN C would not leave the resident in his/her room because he/she would try to get up.-He/she did not know if the resident was on a blood thinner.-LPN C knew the resident was a diabetic.-He/she would expect insulin information to be on the resident's care plan.-LPN C did not know for sure if the resident had been on oxygen while at the facility. During an interview on 02/13/26, at 10:38 A.M., the Director of Nursing (DON) said the following:-She would expect residents at risk for falls and any fall interventions to be on the care plan.-Residents on an anticoagulant should have monitoring for signs/symptoms of bleeding on the care plan.-She would expect staff to monitor residents on an anticoagulant for bruising or any change of condition.-She would like to see anticoagulant monitoring on the care plan. She thought it was on the care plan if a resident was on specific anticoagulants like warfarin or Lovenox, but she did not think it was on care plans for medications that did not require regular blood laboratory tests.-She would expect staff to monitor all diabetic residents for symptoms of sweating, shaking, anything like that and to report it to the nurse.-She would expect for oxygen use not to be on a resident's care plan if the resident did not use oxygen or have oxygen ordered.-MDS coordinator X usually updates the care plans, but he/she was on vacation at this time. During an interview on 02/13/26, 11:35 A.M., MDS Coordinator W said the following:-The long-term care MDS coordinator X was on vacation. He/she is the MDS Coordinator for the rehabilitation section of the facility.-He/she would complete a resident's care plan by reviewing the physician orders, communicating with staff at the interdisciplinary team meetings (IDT - (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a group of professionals with expertise in different areas that coordinate care) every morning, at the weekly Medicare meetings, and at care plan meetings.-The long-term care MDS coordinator X; the social worker; the resident and their family, all share and collect information about each resident's needs.-He/she completes the sections of the MDS and the Care Area Assessments (CAAs - identifies the underlying causes, contributing factors, and risks related to the triggered area, helps to determine if a care plan intervention is necessary).-He/she would assess the resident as a whole and look at progress notes.-He/she would add to a care plan if a specific need was recognized and was not triggered on the CAA.-He/she expects anticoagulant medication monitoring to be on a care plan.-He/she expects residents at risk for falls and the interventions to be on the care plan.-He/she would expect for a diabetic diagnosis, insulin use, signs/symptoms of low blood glucose and high blood glucose, and the interventions to be on a care plan.-He/she would assess a resident's toileting abilities and plan by reviewing daily notes, the activities of daily living documentation by the CNAs and at the weekly Medicare meeting.-He/she would expect residents' toileting needs to be on the care plan. During an interview on 02/13/26, at 3:20 P.M., the Administrator said the following:-He would expect a toilet plan or assistance with toileting to be on a resident's care plan. It would ensure they maintain dignity, resident comfort and help prevent urinary tract infections (UTIs).-The MDS coordinator is ultimately responsible for the care plans.-Staff use IDT formatting, pull information from point of care (POC) charting completed by the CNAs, first person interviews, and nursing notes to make residents' care plans.-It would depend on the type of anticoagulant medication on whether it should be on the care plan. The care plan might need to have signs of bleeding and bruising on the care plan.-He would expect for a diabetic diagnosis, insulin use, and monitoring for signs/symptoms of high glucose and low blood glucose to be on a care plan.-All of the residents' needs and desires should be on the care plan to ensure the needs are met.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure all residents received care and treatment in accordance with professional standards of practice when facility nursing staff failed to provide assessments after falls in accordance with their change in condition policy and neurological assessment sheet (evaluation of the functioning of the nervous system, identifying any abnormalities or neurological deficits.) for two residents (Resident #12 and Resident #45) after each resident sustained a fall with potential for head injury. The facility census was 75.Review of the facility policy titled, Condition change, resident (observing, recording, and reporting) (includes falls), undated, showed the following:-After all residents fall, injuries or changes in physical or mental function, monitor the following: Observe for lacerations, swelling, discoloration, convulsions, headache, pain, personality changes, alterations in consciousness, incontinence, sensory disorder, weakness, speech disorder, gait change, stiff neck, reflexes, vital signs, bleeding, unequal pupils, flushing; -Monitor the resident's condition frequently until stable;-Complete incident, accident, risk management and report to the resident's responsible party and the physician; The facility did not provide a policy specifically covering neurological checks after fall. Review of the facility provided work sheet for neurological checks, undated, showed that neurological checks should be completed every 15 minutes times 4, every 30 minutes times 2, every hour times 2, every shift for 72 hours and that nurses' notes should reflect neurological assessments with each note. 1. Review of Resident #45's face sheet (a form that provides resident details) showed the following: -admission date of 10/21/25;-Diagnoses include chronic kidney disease, retroperitoneal hematoma (a potentially life-threatening collection of blood behind the abdominal lining caused by trauma), diabetes (a disease where the body fails to regulate blood sugar);-Resident is self-responsible. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 01/26/26, showed the following:-No cognitive impairment;-Depressed mood;-Used a walker for mobility;-Multiple falls since admission. Review of the resident's current care plan, revised on 01/19/26, showed at risk for falls due to muscle weakness and gait instability. Review of the resident's nursing progress notes, dated 11/23/25 at 3:20 P.M., showed Licensed Practical Nurse (LPN) D documented the resident fell (unwitnessed) and staff started neurological checks. Review of the resident's nursing progress notes, dated 12/04/25 at 06:06 A.M., showed LPN G documented the resident fell (unwitnessed) and staff started neurological checks. Review of the neurological assessment sheet dated 12/03/25 at 11:45 P.M., showed staff did not complete a neurological assessment on the 12/05/25, 10-6 shift, 12/06/25, 10-6 shift.Review of the resident's nursing progress notes, dated 12/11/25 at 07:49 A.M., showed Registered Nurse (RN) F documented the resident fell (unwitnessed) and staff started neurological checks. Review of the neurological assessment sheet dated 12/11/25, at 7:00 A.M., showed staff did not complete a neurological assessment on the 12/11/25, 10-6 shift, 12/12/25, 6-2 shift, 12/12/25, 10-6 shift, 12/13/25, 10-6 shift, 12/14/25, 6-2 shift. Review of the resident's nursing progress notes, dated 01/19/26 at 5:23 P.M., showed LPN E documented the resident fell (unwitnessed) and staff started neurological. Review of the neurological assessment sheet dated 01/19/26, at 5:00 P.M., showed staff did not complete a neurological assessment on the 01/21/26, 6-2 shift, 01/21/26, 2-10 shift, 01/21/25 ,10-6 shift, 01/22/25, 6-2 shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/12/26, at 12:35 P.M., LPN C said the following:-Nursing staff start neurological checks on all residents with an unwitnessed fall;-Nursing staff use neurological checks to monitor for changes in a resident with a potential head injury. During an interview on 02/12/26, at 2:32 P.M., LPN D said the following:-Nursing staff complete neurological checks on any resident with an unwitnessed fall;-Neurological checks are important to identify changes in a resident which could indicate a brain bleed. During an interview on 02/13/26 at 9:40 A.M., the Assistant Director of Nursing (ADON) said the following:-Nursing staff start neurological assessments on all residents with an unwitnessed fall;-Neurological assessments are important to help identify possible brain bleeds and changes in condition in residents with a head injury;-He/she expected nursing staff to complete all neurological checks. During an interview on 02/13/26 at 11:46 A.M., the Director of Nursing (DON) said the following:-He/she expected nursing staff to document in the nurses notes all falls and changes in condition;-Nursing staff complete neurological checks for all residents with an unwitnessed fall or a known fall with head injury. During an interview on 02/13/26 at 3:20 P.M., the Administrator said the following:-He/she expected nursing staff to start neurological assessments on residents with an unwitnessed fall or fall with head injury;-Neurological assessments are important to help staff identify possible brain injuries;-He/she expected nursing staff to complete all neurological assessments and document those assessments in the progress notes. 2. Review of Resident #12's face sheet showed the following:-admission date of 06/24/25;-Diagnoses included dementia, history of hip fracture, history of neck fracture, and head injury. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/10/26, showed the following:-Significant memory loss and severe cognitive decline;-Required touch, or partial assistance for transfers (such as moving from a chair to a bed);-Used a manual wheelchair independently;-Fell resulting in major injury in the past three months, while at the facility. Review of the resident's care plan, last updated 01/19/26, showed the following;-Unrealistic perception of abilities;-At risk for falls related to altered mental status and confusion;-At risk for falls due to a past hip fracture;-Impaired transfer ability. Review of the resident's John Hopkins Fall Risk Assessment, dated 01/21/26, showed staff assessed the resident at high fall risk (score of 18. The risk assessment for the resident had a score of 18, which is considered high fall risk. Review of the resident's progress notes, dated 12/17/25m showed staff documented the resident fell while getting out of his/her bed. The resident obtained a cut on the back of the hand. Staff did not complete neurological checks after the unwitnessed fall. Review of a fall report, dated 12/17/25, showed staff staff documented the resident fell in his/her bedroom, and the fall was unwitnessed by staff. The report directed staff to complete neurochecks on the resident for 72 hours since the fall was unwitnessed – per facility protocol, and to document appropriately. The same report showed body and pain observations. Staff left the neurological check section blank. Review of the resident's progress notes, dated 12/19/25 (two days after the fall), showed staff documented the resident's pupils equally reactive and responsive to light (PERRL). Staff did not (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document other assessments in the 72 hours (3 days) following the resident's unwitnessed fall. During an interview on 02/13/26 at 9:55 A.M., LPN C said he/she was unable to find that staff had completed ongoing assessments on the resident following the resident fall on 12/17/25. 3. During an interview on 02/12/26, at 12:35 P.M., LPN C said the following:-Nursing staff start neurological checks on all residents who have an unwitnessed fall;-Neurological checks are used to monitor for changes in a resident with a potential head injury;-It is important to complete the neurological assessments to know if the resident has had any changes. During an interview on 02/12/26, at 2:32 P.M., LPN D said the following:-Neurological checks were to be completed on any resident who has an unwitnessed fall;-Neurological checks were important to identify changes in a resident. During an interview on 02/13/26, at 9:40 A.M., the Assistant Director of Nursing (ADON) said the following:-Nursing staff were to start neurological assessments on all residents who have an unwitnessed fall;-Neurological assessments are important to help identify possible brain bleeds and changes in condition in residents with a head injury;-He/she expected nursing staff to complete all neurological checks. During an interview on 02/13/26, at 11:46 A.M., the Director of Nursing said the following:-He/she expected nursing staff to document in the nurses notes all falls and changes in condition;-Neurological checks were to be started and completed by nursing staff for all residents with an unwitnessed fall or a known fall with head injury. During an interview on 02/13/26 at 3:20 P.M., the Administrator said the following:-He/she expected nursing staff to start neurological assessments on residents with an unwitnessed fall or fall with head injury;-Neurological assessments were important to help staff identify possible brain bleed type injuries;-He/she expected nursing staff to complete all neurological assessments and documents those assessments in the progress notes.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed ensure all residents maintained acceptable standards of nutritional status when staff failed to consistently encourage fluid intake for one resident (Resident #10) whose intake was less consistently that recommended by the registered dietician (RD) The facility census was 75.Review of the facility's policy titled Hydration, undated, showed the following:-The amount is based on careful assessment. Fresh water is to be distributed each shift, with glasses within reach of the resident;-Assistance will be given by staff for residents unable to drink independently;-Between-meal hydration programs, such as juice carts and related activities promote fluid intake;-The following conditions should be considered included dehydration, confusion or disorientation, concentrated urine, total dependence and other conditions at the discretion of the nurse. 1. Review of Resident #10's face sheet (brief resident profile sheet) showed the following information:-admission date of 7/16/25;-Diagnoses included weakness, other reduced mobility, encephalopathy (any diffuse disease of the brain that alters brain function or structure), and type 2 diabetes.Review of the resident's initial nutritional assessment completed by the Registered Dietician (RD), dated 07/17/25, showed fluid intake of need of 2000 plus cubic centimeters (cc's) suggested per day and staff to continue efforts encourage the resident.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/24/25, showed severe cognitive impairment.Review of the resident's care plan, dated 01/06/26, showed the following:-At risk for inadequate oral intake;-Observe for adequate intake of food/fluids, obtain and update food/beverage preferences, and to offer snacks between meals.Review of the resident's intake and output report for the following dates showed:-On 02/01/26, a total of 1420 cc's input;-On 02/02/26, a total of 1220 cc's input;-On 02/03/26, a total of 1460 cc's input;-On 02/04/26, a total of 2400 cc's input;-On 02/05/26, a total of 1130 cc's input;-On 02/06/26, a total of 1300 cc's input;-On 02/07/26, a total of 1460 cc's input;-On 02/08/26, a total of 860 cc's input;-On 02/09/26, a total of 480 cc's input.Observation on 02/10/26 showed the following:-At 9:26 A.M., the resident sat in the wheelchair in the day room watching tv, without any drinks by the resident;-At 9:31 A.M., the resident sat in the wheelchair in the common TV room, without any drinks by the resident;-At 9:58 A.M., the resident sat in the wheelchair in the day room watching tv, without any drinks by the resident;-At 10:17 A.M., the resident sat in the wheelchair in the day room, in the same spot, with his/her eyes closed and head leaned down, without any drinks by the resident;-At 10:44 A.M., the resident sat in the wheelchair in the day room, in the same spot with his/her head down, and chin on chest, without any drinks by the resident;-At 11:09 A.M., the resident sat in the wheelchair in the day room with his/her head down and chin on chest, without any drinks nearby;-At 11:21 A.M. and 11:24 A.M., the resident sat in the wheelchair in the day room with his/her eyes open, head up, and watching tv, without any drinks nearby;-At 11:25 A.M., the resident sat in the wheelchair in the day room without any drinks nearby;-At 11:32 A.M., Licensed Practical Nurse (LPN) A checked the resident's blood glucose. The nurse did not offer the resident a drink. The resident continued to sit in his/her wheelchair in the day room;-At 11:37 A.M., the resident sat in the wheelchair in the common TV room, without any drinks nearby;-At 11:40 A.M., the resident continued to sit in the same spot in the day room, without any drinks nearby;-At 11:51 A.M., the resident sat in the same spot/position in the common TV room. No drink offered, provided or beside the resident;-At 11:54 A.M., the resident continued to sit in the wheelchair in the same spot in the day room, without any drinks nearby;-At 11:58 A.M., Certified Nursing Assistant (CNA) I wheeled the resident from the day room to the dining room table. He/she did not offer the resident a drink;-At 12:03 P.M., the resident sat in the wheelchair in the dining room. The resident had drinks in front of him/her;-At 12:07 P.M., the resident sat at the dining table, with two drinks, a Kool-Aid, coffee and a shake supplement placed in front of him/her;-At 12:11 P.M., the resident continued to sit in the wheelchair at the dining room table;-At 12:25 P.M., the resident continued to sit at one of the assist tables. The resident drank and ate a couple of bites of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	food on his/her own;-At 12:29 P.M., the resident continued to eat without assistance;-At 12:31 P.M., staff assisted the resident to eat;-At 12:39 P.M., the resident ate all of his/her dessert. Staff came over to prompt/cue the resident to eat lunch;-At 12:44 P.M., staff continued to assist the resident with eating.-At 12:57 P.M., the resident ate some bites of corn nugget without staff assist. Staff offered and cut hotdog into bites for the resident;-At 1:05 P.M., the resident continued to sit in the wheelchair in the dining room eating lunch. LPN N cued the resident to eat at times;-At 1:09 P.M., the LPN N continued to prompt/cue the resident to eat. He/she ate a few bites of the hot dog. The LPN N asked the resident about not eating much lunch and the resident said not very hungry. The resident drank all of the shake supplement, two-thirds cup of Kool-Aid drink, and all of the coffee;-At 1:15 P.M., LPN N wheeled the resident to the activity room for a church activity. The resident did not have any drinks nearby;-At 1:28 P.M., the resident sat in the wheelchair in the activity room for the church activity. The resident did not have any drinks nearby;-At 1:58 P.M., a visitor came to visit the resident and sat beside him/her. The resident did not have any drinks nearby;-At 2:08 P.M., the resident sat in the wheelchair in the activity room. The resident did not have any drinks nearby;-At 2:26 P.M., the Bible study finished. The visitor and the resident continued to sit in the activity room. The resident did not have any drinks nearby;-At 2:41 P.M., the resident continued to sit in the wheelchair in the activity room. Staff explained the rules of the game to the group. Staff did not offer a drink. The resident did not have any drinks nearby.Oservation and interview on 02/10/26, at 2:52 P.M., showed the following: -CNA O said he/she usually took the resident to the restroom about now. The CNA went to the resident in the activity room and asked to take him/her to the bathroom;-CNA O and Nurse Assistant (NA) P assisted the resident to the bathroom. The brief appeared dry. CNA O said his/her brief was clean and dry. CNA O assisted the resident off the toilet and pulled up the resident's brief and pants. The urine was dark and concentrated. The aides transferred the resident back to his/her wheelchair. CNA O asked the resident if he/she wanted to go back to the activity, the resident said no. CNA O asked if he/she wanted to go to the TV room. The resident did not answer. Staff wheeled the resident to the common TV area and did not offer the resident a drink. The resident did not have any drinks nearby.Review of the resident's intake and output report for 02/10/26 showed a total input of 1190 cc's of fluid.During an interview on 02/10/26, at 2:10 P.M., CNA Q said the following:-The resident usually gets up for meals and goes to most of the activities;-The resident usually lays down after breakfast and lunch but did not today;-The resident can say if he/she needs a drink but will not initiate.During an interview on 02/10/26, at 2:18 P.M., CNA M said the following:-The night shift staff usually get the resident up for breakfast;-The resident does not like to lay down after meals;-The resident will not initiate any activities, such as drinking. -The resident does need to be prompted.During an interview on 02/10/26, at 2:23 P.M., CNA Student R and CNA Student S said the following:-The aides said their shift started after lunch;-They are allowed to provide the following cares to resident: nail care, pass water, change briefs, help in the bathroom, and about anything else.During an interview on 02/12/26, at 4:45 P.M., NA T said the following:-Hydration needs and plan should on the care plan;-The resident needed encouragement to drink;-Staff should offer the resident fluids every two hours;-The resident can drink on his/her own but needs to be offered. He/she will not ask.During an interview on 02/13/26, at 8:46 A.M., LPN C said the following:-He/she expected every resident to be offered a drink at least every two hours;-The CNAs document fluid intake every shift in the vitals section of the electronic medical record (EMR);-He/she would not expect the resident to be dry for an entire shift. The staff should push fluids if the resident was found dry.During an interview on 02/13/26, at 10:38 A.M., the Director of Nursing (DON) said the following:-The staff should give residents drinks at least every two hours;-She would expect the CNAs and nurses to document input and output during each shift;-She would not expect for the resident to be dry if he/she had not been toileted for an entire shift;-If the resident was dry for the entire shift, the physician should be told because there should be some urine output for the resident;-The DON would assume the resident was at risk for dehydration.-She did not know the resident very well and did not know if (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265393	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Hills Living Center	996 State Highway 248 Branson, MO 65616

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident could ask for a drink on his/her own;-She would expect staff to offer fluids any time they pass him/her. During an interview on 02/13/26, at 3:20 P.M., the Administrator said the following:-He would expect the staff to check on residents every two hours;-He would expect the staff to pass ice water every shift, if not more often, which would include the residents that are in the day room or activity room.