

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Apple Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 West Thomas Avenue Waverly, MO 64096	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Apple Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 West Thomas Avenue Waverly, MO 64096	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents on the locked unit had the opportunity to make and receive phone calls without being overheard. Residents on the locked unit, who did not have their own phone, had to use the telephone in the nurses' office and could not have a private conversation without having to request staff to leave the office, which was not always practicable or possible. The practice affected three sampled residents (Residents #1, #3, and #4) who did not have their own phone, out of eight total sampled residents, five of which were on the locked unit. The census on the locked unit was 16 residents. The total facility census was 44 residents. Review of the facility's Resident Use of Telephones policy, dated February, 2021 showed: -Residents shall have easy access to telephones. -Telephones are available to residents to make and receive private telephone calls. -The telephones at the nursing stations should be reserved for staff use unless no other alternate is available. Residents should use telephones at the nursing stations for as brief a period as possible. -Telephones will be in areas that offer privacy and accommodate the hearing impaired and wheelchair-bound residents. -Resident phones are located inside the nurses' station on one unit and across from the nurses' station on the other unit. 1. Review of Resident #1's admission Record showed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with a primary diagnosis of schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems). Review of the resident's behavioral care plan showed no restrictions on his/her phone use or justification for monitoring his/her phone calls. During an interview on 12/18/25 at 1:49 P.M. the resident said: -Residents were only allowed to make phone calls from the nurses' office. Staff stay right next to residents when they talk and don't provide privacy. -He/She was doing legal stuff and needed more privacy and sometimes needed to be on the phone when staff were busy. -Residents were only allowed to talk on the phone when staff were available. In the morning there was an approximately two-hour period residents were allowed to make phone calls between around 9:30 A.M. and 11:30 A.M. In the afternoon residents were allowed to call from approximately 1:00 P.M. or 1:30 P.M. until approximately 3:00 P.M. or 3:30 P.M, but the time periods varied according to what staff was doing. There was one staff person who would cut him/her off when he/she needed to leave the office. Observation on 12/18/25 at 2:30 P.M. showed: -Licensed Practical Nurse (LPN) A yelled from the nursing station for Resident #1 to come to the nurses' office for a phone call. -The resident stood and talked on the phone while LPN A remained seated in front of the computer during the entire conversation. -The phone cord was approximately two to three foot in length when unstretched. There was a second chair in the nurses' office, but not within reach of the phone. -Every word the resident said could be heard in the hallway when standing outside the nurses' office door. During an interview on 12/18/25 at 2:39 P.M. Resident #1 said: -LPN A had asked him/her if he/she wanted privacy before he/she took the call. That was the first time any staff had ever asked if he/she wanted privacy during a phone call. -He/She told LPN A he/she could stay during the call because he/she was OK with it being overheard, but often he/she wanted privacy and had never before been offered privacy from staff during a phone call. During an interview on 12/19/25 at 9:19 A.M. the Administrator said: -Resident #1's legal representative did not want the resident to have electronic devices in his/her room. He/she did not know if that included use of a cordless phone. -The facility had not yet clarified with the resident's guardian what no electronic devices in the resident's room included or if the resident would be allowed to make private calls. During an interview on 12/19/25 at 1:43 P.M. Resident #1's legal representative said: -Resident #1 had behavioral problems in the past involving the use of electronic devices. -He/She hadn't discussed with the facility specifics about how the resident could talk privately on the phone. -The resident should be allowed to make private phone calls and there should be a way he/she could do that. 2. Review of Resident #3's admission Record showed he/she was admitted on [DATE] and readmitted on [DATE] with a primary diagnosis of attention-deficit hyperactivity disorder (ADHD, a developmental disorder typically characterized by a persistent pattern of inattention and/or hyperactivity - a physical state in which a person is abnormally and easily excitable or exuberant, as well as forgetfulness, loss of control or impulsiveness, and distractibility) During an interview on 12/18/25 at 1:58 P.M. the resident said: -He/She didn't have a personal phone. -He/She called his/her family on or around Christmas. -Residents had to use the phone in the nurses' office, but didn't know what hours residents were allowed to use the phone. -There was no private phone for residents to use on the hall or any portable phone they could use for a private conversation. He/she would</p>		