

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  12/30/2025
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)
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to prevent verbal and physical abuse for two sampled residents (Resident #2 and Resident #3) out of 7 sampled residents. On 12/26/25 Resident #2 and Resident #3 yelled and hit each other when staff left the behavioral unit unsupervised. The facility census was 43 residents. Review of the facility Abuse and Neglect Policy revised on 9/2021 showed:-The residents have the right to be free of abuse, neglect or mistreatment.-As a facility will be actively protect our resident from abuse. -To the extent possible, nurse aid assignments will be consistent so that the resident is most comfortable with the employee and the employee most knowledgeable about the needs of the resident. -Residents are most likely to strike out when they are in a situation where they feel like may not have control over. 1. Review of Resident #2's admission Face Sheet showed the resident admitted with the following diagnoses:-Paranoid Schizophrenia (is Schizophrenia with paranoid features, is a severe mental illness characterized by intense delusions (false beliefs, often persecutory) and hallucinations (especially auditory, like hearing voices), coupled with significant paranoia, distrust, anxiety, and social withdrawal).- Schizoaffective disorder (is a serious, chronic mental illness blending symptoms of schizophrenia (psychosis like hallucinations/delusions) with a mood disorder (mania or depression), causing significant impairment in thinking, perception, mood, and behavior, requiring combined treatment with medication, therapy, and support for effective management). Review of Resident #2's Brief Interview for Mental Status (BIMS) Evaluation dated 12/11/25 showed he/she was moderately cognitively impairment. Review of Resident #3's admission Record showed he/she was admitted with the following diagnoses: -Bipolar disorder (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Major depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living) Review of Resident #3's BIMS Evaluation dated 12/11/25 showed he/she was cognitively intact. Review of the resident's Facility Physical Aggression Initiated report dated 12/26/25 at 7:00 P.M. showed:-Resident #2 was involved in altercation with Resident #3 in the hallway of the behavioral health locked unit. -On 12/26/25 at approximately 7:00 P.M. Resident #3 was upset over not receiving his/her medications. Resident #2 explained to the resident that his/her medication was not going to be given yet due to the facility internet being out. Resident #3 approached Resident #2 with a raised voice and cursing. Resident #2 yelled back asking Resident #3 to get out of his/her face. Resident #2 then struck at Resident #3 in his/her upper arm. -Resident #2 said he/she told Resident #3 what Certified Medication Technician (CMT) A said to him/her about the facility internet being down and medications not being done yet. Resident #3 got in his/her face and started yelling. Resident #2 told Resident #3 to get out of his/her face and then Resident #2 hit Resident #3. -The facility internet had gone down, and the Director of Nursing (DON) was in the facility printing Medication Administration (MAR) and Treatment Administration Records (TAR) for all residents so medications could be administrated. Review of the facility investigation summary dated 12/26/25 showed:-Resident #2 said he/she told Resident #3 that CMT A had told him/her about the facility internet being down and medication administration was not being done yet. Resident #3 got in Resident #2's face and started yelling. Resident #2 told Resident #3 to get out of his/her face and Resident #2 hit Resident #3. He/she did not remember where he/she had hit Resident #3. -Resident #3 said he/she did not do anything, and Resident #2 hit him/her in upper arm.-Resident #4 said Resident #3 went to the door. Resident #2 tried telling Resident #3 the medications was late, and Resident #3 started swinging. -Resident #5 said Resident #2 hit Resident #3 in his/her arm and Resident #3 was cussing at him/her because Resident #2 told Resident #3 the medication was going to be late that night.-Upon completion of the investigation, it was determined Resident #2 had attempted to redirect Resident #3 out of his/her personal space. Resident #2 yelled get out of my face and struck Resident #3 in the right upper arm. Review of the Resident #5's BIMS Evaluation dated 12/23/25 showed he/she was moderately cognitively impaired. During an interview on 12/29/25 at 12:58 P.M. Resident #5 said: -There was just an argument and misunderstanding between Resident #2 and Resident #3.-No staff member was on the unit at the time of disagreement between Resident #2 and Resident #3. Review of Resident #4's BIMS Evaluation dated 12/15/25 showed he/she was cognitively intact. During an interview on 12/29/25 at 12:59 P.M. Resident #4 said:-He/she had witnessed the altercation in the hallway between Resident #2 and Resident #3.-Resident #2 and Resident#3 were yelling at each other, as Resident #2 punched/hit Resident #3 in his/her arm. -There were no facility staff on the locked unit at the time -He/she had to pound on the locked double door to get a</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>(continued on next page)</p>

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to ensure adequate staffing coverage to provide supervision and oversight for two sampled residents (Resident #2 and Resident #3) who reside on the secure behavioral locked unit. On 12/26/25 Certified Medication Technician (CMT) A left the secured behavioral health unit unsupervised resulting in a physical and verbal altercation between Resident #2 and Resident #3 out of 7 sampled residents. The facility census was 43 residents. The facility was not able to provide a staffing policy at the time of exit. 1. Review of Resident #2's admission Face Sheet showed the resident admitted with the following diagnoses: -Paranoid Schizophrenia (is Schizophrenia with paranoid features, is a severe mental illness characterized by intense delusions (false beliefs, often persecutory) and hallucinations (especially auditory, like hearing voices), coupled with significant paranoia, distrust, anxiety, and social withdrawal).- Schizoaffective disorder (is a serious, chronic mental illness blending symptoms of schizophrenia (psychosis like hallucinations/delusions) with a mood disorder (mania or depression), causing significant impairment in thinking, perception, mood, and behavior, requiring combined treatment with medication, therapy, and support for effective management). Review of Resident #2's Brief Interview for Mental Status (BIMS) Evaluation dated 12/11/25 showed he/she was moderately cognitively impairment. Review of Resident #3's admission Record showed he/she was admitted with the following diagnoses: -Bipolar disorder (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Major depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living) Review of Resident #3's BIMS Evaluation dated 12/11/25 showed he/she was cognitively intact. Review of the resident Facility Physical Aggression Initiated report dated 12/26/25 at 7:00 P.M. showed:-Resident #2 was involved in altercation with Resident #3 in the hallway of the behavioral health locked unit. -On 12/26/25 at approximately 7:00 P.M. Resident #3 was upset over not receiving his/her medications. Resident #2 explained that his/her medication was not going to be given yet due to the facility internet being out. Resident #3 approached Resident #2 with a raised voice and was cursing. Resident #2 yelled back at the resident telling him/her to get out of his/her face. Resident #2 then struck at Resident #3 in his/her upper arm. -Resident #2 said he/she told the resident that CMT A told him/her that the facility internet was down and medications were not done yet. Resident #3 got in his/her face and started yelling. Resident #2 told Resident #3 to get out of his/her face and then Resident #2 hit Resident #3. -The facility internet had gone down, and the Director of Nursing (DON) was in the facility printing Medication Administration (MAR) and Treatment Administration Records (TAR) for all residents in order to administer medications. Review of the facility investigation summary dated 12/26/25 showed:-Resident #2 said he/she told Resident #3 that CMT A had told him/her about the facility internet being down and medication administration was not being done yet. Resident #3 got in Resident #2's face and started yelling. Resident #2 told Resident #3 to get out of his/her face and Resident #2 hit Resident #3. Resident #2 did not remember where he/she hit Resident #3. -Resident #3 said he/she did not do anything, and Resident #2 hit him/her in upper arm.-Resident #2 tried telling Resident #3 why the medications were late, and Resident #3 started swinging. -Resident #5 said Resident #2 hit Resident #3 in the arm and Resident #3 was cursing at him/her because Resident #2 told Resident #3 the medications was going to be late that night.-Upon completion of the investigation, it was determined Resident #2 had attempted to redirect Resident #3 out of his/her personal space. Resident #2 yelled get out of my face and struck Resident #3 in the right upper arm. During an interview on 12/29/25 at 11:09 A.M. Resident #2 said:-He/she resided on the behavioral locked unit. -It was a holiday, and staffing was short that evening.-CMT A was on the behavioral unit when facility internet went down. -CMT A was not able to provide medications and left the unit to get printed copies of all resident's MAR's. -No facility staff were on the locked behavioral unit at time of the incident. Review of CMT A's undated witness statements showed: -He/she was starting to prepare for the medication pass and heard banging on the locked behavioral unit door. -He/she went to see what was going on and Resident #5 said Resident #2 and Resident #3 were fighting and throwing punches. -After talking to with each resident separately, Resident #2 admitted he/she punched Resident #3 because he/she was screaming and yelling at him/her. -Resident #3 stated he/she yelled but did not hit anyone. -Resident #5 said both Resident #2 and Resident #3 hit each other. During interview on 12/29/25 at 1:15 P.M. CMT A said:-He/she was assigned to the medication pass for both units. -He/she came into the facility to assist evening medication pass. -He/she was off the unit when</p>		