STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to ensure a resident was able to exercise their rights related to private and unrestricted communication when the facility imposed restrictions on telephone usage, including limiting the duration of calls, restricting individuals the resident could communicate with, and monitoring the resident's phone conversations without documented clinical justification, a physician's order, or appropriate care plan intervention for one sampled resident (Resident #1) out of four sampled residents. The facility census was 43 residents.Review of the facility's Resident Rights policy date February 2021 showed the resident had the right to:-Communication with and access to people and services, both inside and outside of the facility.-Exercise his/her rights as a resident of the facility and as a resident or citizen of the United States.-Be supported by the facility in exercising his/her rights.-Exercise his/her rights without interference, coercion, discrimination or reprisal from the facility.-Privacy and confidentiality.-Voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal.-Communicate with outside agencies (local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations) regarding any matter.-Communicate in person, by mail, email and telephone with privacy. Review of the facility's Telephones, Resident Use of policy revised February 2021 showed:-Residents shall have access to telephones.-Designated telephones are available to residents to make and receive private telephone calls.-Telephones will be in areas that offer privacy and accommodate the hearing impaired, and wheelchair bound residents. 1. Review of Resident #1's Face Sheet showed the following diagnoses:-Schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems).-Paranoid Schizophrenia (a form of schizophrenia [a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others] characterized by persistent preoccupation with illogical, absurd, and changeable delusions, usually of a persecutory, grandiose, or jealous nature, accompanied by related hallucinations).-Manic episode (a period when your mood, behavior and energy level become much higher or more intense than usual).-Bipolar disorder (a chronic mental health condition characterized by extreme mood swings, alternating between high-energy manic or hypomanic episodes and deep depressive episodes).-Mood disorder (mental health conditions involving persistent, severe disturbances in emotional state, such as depression or mania, that disrupt daily functioning). Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) showed the resident was cognitively intact. Review of the resident's medical record dated February 2026 showed:-A message to staff that said the advocate (a representative of a federal non-profit agency) was not allowed to call the resident and the resident was not allowed to call them per the guardian.-An email from the Public Administrator (PA) to the facility dated 02/05/26 at 3:15 P.M., that said the facility staff had reported to the PA that the resident had been making calls to several different lawyers. The resident was not able to hire or be calling different lawyers because of his/her guardianship. The resident had been advised about only being able to contact his/her lawyer or (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	writing the Judge several times in the past. The resident had abused this rule and would have the following consequence. His/her calls restricted to one call per day, that was to be supervised by staff and not to be to a random lawyer. The resident could receive calls from his lawyer that had been appointed through the court. The PA was ok with the resident calling him/her once per month unless the lawyer told staff that he/she was comfortable with the resident calling more often and it would be whatever was approved by his lawyer.-An email from the PA dated 02/11/26 at 10:44 A.M., said he/she told the resident to write down the names and numbers of family he/she wanted to add to his/her call list. He/She did not have the list when the PA went onto the unit and wanted the PA to approve whomever he/she wanted. He/she informed the resident to write down names and numbers so it could be given to the PA to review before the PA can add or increase the resident's calls.-An email from the facility to the PA dated 02/11/26 at 2:49 P.M., contained a list of contacts created by the resident.-An email from the PA to the facility dated 02/11/26 at 3:15 P.M. said the list provided was approved.-An email from the PA to the facility dated 02/11/26 at 3:28 P.M. said that the PA talked to the resident's mother and he/she mentioned he/she was supposed to get mail from the advocate. The email said please do not give the resident any mail from the resident's mother. Hold it or return it to sender.-An email from the facility to the PA dated 02/17/26 at 2:52 P.M. said the state came in and suggested that the facility get the phone restrictions in writing from the lawyer or judge. The email said was it possible for the PA to get those phone restrictions in writing and email them to the facility?-An email from the PA to the facility dated 02/19/26 at 9:05 A.M. said it was not possible to have either the lawyer or the judge do that. The resident's lawyer was told of the restrictions and that the lawyer would need to call the facility to allow more calls. I can only assume he/she did not do that based on how he/she reacted when I told him/her about the restrictions. The restrictions would need to be kept in place going forward to mainly not allow the resident to call the advocate. The restriction was to keep the resident safe from the advocate as they had been negative to several other residents at other facilities. I will say as long as there are no issues next week, we could lift things to three calls, but I want to make sure it is up to the staff availability, so the resident was not dictating when he/she made calls to the staff.-An email from the PA to the facility dated 02/23/26 at 12:43 P.M. asked if there were any other phone issues. If not, the resident could have three calls per day but still needed to be supervised because of the advocate issue. If calls were returned to three per day, let the resident know it was being supervised just because he/she was not allowed to call the advocate.-There was no physician's order, assessment, or clinical documentation supporting justification of restricting telephone access. Review of the residents' care plan revised in February 2026 showed:-Focus: Resident was at risk for behavioral disturbance related to schizophrenia disorder, bipolar disorder, paranoid schizophrenia with history of delusions and paranoia. Resident paced up and down the hall on the unit and crouched along the wall in the hallway often. Conspires with peers to fabricate stories and delusions, calls state frequently, manipulates peers/staff, refuses cares and refuses medications.-Staff interventions included:--Resident could receive calls from his/her lawyer that had been appointed through the court. --The PA was ok with the resident calling them once a month unless the attorney told staff that he/she was comfortable with the resident calling more often and it would be whatever was approved by his/her lawyer.--Resident was not allowed to talk to the advocate from an outside agency.--Per the PA, the resident was not able to hire and should not be calling different lawyers because of his/her guardianship. The resident had been advised about only being able to contact his/her lawyer or writing the Judge several times in the past.-Per the PA, the resident's calls were restricted to two calls per day that were to be supervised by staff and not placed to a random lawyer. Review of the residents progress notes dated February 2026 showed:-On 02/05/26 at 4:32 P.M., a social services note said the Social Services Director (SSD) and charge nurse went and explained to the resident that his/her guardian had changed his/her phone privileges to one call per day and that all calls must now be supervised. This change was made after it was reported that the resident had been contacting a couple of lawyers. The social worker and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	charge nurse reviewed the guardian's decision with the resident and explained that supervision was in place to ensure the appropriate use of phone privileges.-On 02/05/26 at 7:53 P.M., a behavioral nursing note said The Certified Nursing Assistant (CNA) overheard a conversation between the resident's roommate and another resident. The other resident subsequently took his/her phone down to their room. When the nurse inquired about the phone's whereabouts, the other resident stated he/she had loaned it to the resident. The nurse informed the resident that loaning his/her phone to the resident was not permissible. The resident then retrieved his/her phone. -On 02/13/26 at 11:58 A.M., a plan of care note said the resident exhibited behaviors of agitation and manipulation. The residents redirection was unsuccessful. The resident was upset with the guardian's restrictions. Care plan was updated. Continue POC.-On 02/13/26 at 2:15 P.M., a social services note said the SSD received a call from a person on 2/13/26 requesting to speak with the resident and SSD informed him/her that he/she was not allowed to call here per the guardian. He/She stated the facility was not doing the right thing, and SSD informed him/her that if he/she had any questions or concerns, he/she needed to reach out to the guardian.-On 02/19/26 at 2:14 P.M., a communication with family note said yesterday around dinner time, the resident's uncle called, seeking to speak with him/her. I apologized and clarified that the resident had already utilized his/her two permitted phone calls for the day. The uncle questioned how that policy applied to incoming calls. Staff explained the understanding was that the limit pertained to both incoming and outgoing calls. He/She then used profanity and disconnected the call. During an interview on 05/05/26 at 2:10 P.M., the resident said:-He/She was notified by the guardian and a staff nurse who no longer works at the facility, that his/her phone privileges had been restricted.-He/She was told that the restrictions were because he/she was calling lawyers.-The court appointed lawyer didn't return any of his/her calls.-He/She was allowed three calls per day for a maximum of 15 minutes.-He/She did not feel calls were private because the staff monitored all calls by listening outside of the office.-If the person he/she called didn't answer, it counted as a call made.-If someone called the facility for him/her, it counted as two calls.-The restrictions make him/her feel watched and it really made him/her upset. -It was depressing not to be able to reach out and call family whenever he/she wanted to. -It would really help him/her to stay on track if he/she could call whomever, whenever. 2. Observation on 05/05/26 at 1:41 P.M. showed Resident #4:-Was lying in bed doing a crossword puzzle. -He/She did not have a landline or cell phone in the room. During an interview on 05/05/26 at 1:41 P.M. the resident said:-He/She had used the facility's phone in the past to make calls.-If he/she needed to make a call, he/she would just ask whoever was sitting at the desk.-No one had ever put any restrictions on the number of phone calls he/she could make in a day or the time which he/she could stay on the phone.-He/She could make a phone call whenever he/she wanted to.-He/She felt like his/her calls were private and staff were not monitoring. 3. Observation on 05/05/26 at 1:46 P.M. showed Resident #3:-Was sitting in bed watching television. -He/She had a cell phone on his/her bedside table. During an interview on 05/05/26 at 1:46 P.M. the resident said:-He/She had to use the facility's phone because his/her cell phone hadn't been working properly lately.-He/She did not have any limit on the number of calls placed per day.-He/She could make calls whenever he/she wanted.-He/She felt like calls were private.-If it was crowded with other people, that would be the only time he/she could not use the phone. 4. During an interview on 05/05/26 at 2:24 P.M., Certified Medication Technician (CMT) A said:-The telephone usage policy depended on the resident. The residents could take the cordless phone with them to use unless they had restrictions.-There was a binder labeled communications that outlined the residents and their restrictions that included phone privileges. Information about restrictions could also be found in the residents care plan.-A Social Services employee informed him/her of the restrictions but they no longer worked at the facility.-The reason Resident #1 was placed on communication restrictions was they were making phone calls to and getting calls from lawyers and some unknown lady was calling him/her.-Resident #1 had not had any behaviors that he/she was aware of.-Resident #1 had restrictions of three calls per day with a 15-minute limit.-Staff were to monitor the residents' (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phone calls. During an interview on 05/05/26 at 2:43 P.M., CNA A said:-Residents could take the cordless phone with them to use unless they had restrictions.-Resident #1 was on phone restrictions for contacting a lady but not sure who or why.-Resident #1 had not displayed any behaviors toward staff or other residents.-Resident #1's calls were supposed to be monitored while in the nurse's station office. During an interview on 05/05/26 at 2:55 P.M., Licensed Practical Nurse (LPN) A said:-He/She was responsible for the residents on the locked unit while on duty.-There was a designated area in front of the nurse's station for residents to make phone calls.--NOTE: Observation of this area was less than three feet from the nurse's station, it was not partitioned off and consisted of two chairs, a table and a phone.-There was no limit to how many calls a resident could place per day unless they had restrictions.-He/She could probably find information on phone restrictions on the resident's face sheet.-He/She was not aware of anyone who currently had phone restrictions. During an interview on 05/05/26 at 3:05 P.M., the PA said:-He/She advised the facility that the resident's phone calls needed to be limited by person and time and also needed to be monitored.-Restrictions were made because the resident was calling the state, talking to non-family members and speaking with an advocate who was giving improper legal advice.-The resident wanted to get a job and live in a less restrictive environment.-There had been no physician involvement saying that this restriction was clinically necessary.-The advocate called numerous facilities and hot lined them.-There was no attempt at any less restrictive measures prior to the ones currently in place.-He/She believed the facility should continue with the current restrictions. During an interview on 05/05/26 at 4:15 P.M., the Administrator said:-There were no limits on the number of phone calls a resident could place unless the guardian directed it.-Staff had been trained on residents' communication rights through in-services and Relias (an online, accredited education platform designed for senior care and skilled nursing facilities to ensure compliance, train staff, and improve patient outcomes) training.-There was a care plan meeting in February the guardian suggested limiting the resident's access, time, and the people he/she could call and who could call him/her.-He/She advocated for the resident by talking with the guardian and having care plan meetings.-There were no less restrictive measures attempted prior to the current phone restrictions.-Residents were educated on their communication rights during the monthly resident council meetings.-The advocate had not promoted any harm that he/she knew of. -The resident had not had any behaviors.-He/She was not sure why the resident's calls had been restricted, the guardian said it was due to issues in the past at another facility.-Communicating with the advocate would cause psychological stress and false hope of emancipation.-The resident had the right to communicate with people outside of the facility.-The resident had the right to communicate with outside agencies.-The resident had the right to communicate on the telephone in private. 2807761

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure one sampled resident (Resident #2) had appropriate and timely identification and treatment of a Urinary Tract Infection (UTI - an infection of one or more structures in the urinary system) and to report a change in the resident's condition to the physician out of four sampled residents. The facility census was 43 residents.Review of the facility's Change in a Resident's Condition or Status policy revised November 2018 showed:-The facility promptly notified the resident, his/her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.-The nurse would notify the resident's attending physician or physician on call when there had been a significant change in the resident's physical/emotional/mental condition.-A significant change of condition was a major decline or improvement in the resident's status that would not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions.-Except in medical emergencies, notifications would be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.-When identifying situations that warrant immediate notification the nursing staff would consider factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results:--Whether the result should be conveyed to a physician regardless of other circumstances.--Whether the resident's clinical status was unclear or whether he/she had signs and symptoms of acute illness or condition change and was not stable or improving.-If the resident had signs and symptoms of acute illness or condition change and he/she was not stable or improving, or there were no previous results for comparison, then the nurse would notify the physician promptly to discuss the situation, including a description of relevant clinical findings as well as the test results.-A physician could be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent.-Facility staff should document information about when, how and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report. Review of the facility's undated Lab and Diagnostic Test Results-Clinical Protocol policy showed:-The physician would identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs.-The staff would process test requisitions and arrange for tests.-The laboratory, diagnostic radiology provider, or other testing source would report test results to the facility.-When test results were reported to the facility, a nurse would first review the results. If staff who first received or reviewed lab results could not follow the remainder of this procedure for reporting and documenting the results, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. 1. Review of Resident #2s Face Sheet showed the following diagnoses:-Autistic disorder (a lifelong neurodevelopmental condition related to brain development that affects how people see others and socialize with them).-Bipolar disorder (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs).-Severe intellectual disabilities. Review of the resident's health status and medication change notes dated 02/22/26 to 04/03/26 showed the resident was on monitoring for starting Risperdal (antipsychotic medication that treated mental health conditions like schizophrenia, bipolar disorder and some symptoms of autism) and Lithium (primarily used to stabilize mood, treating acute mania and reducing the frequency and severity of manic episodes in bipolar disorder) with no signs or symptoms of adverse effects. Review of the resident's health status note dated 03/08/26 showed:-The physician was contacted about the resident experiencing pain during urination and noted cloudiness. -A new order was received to obtain a urinalysis (UA- a diagnostic test that analyzes a urine sample to detect various health issues, including infections (UTIs), kidney disease, liver disease, and diabetes). Review of the resident's laboratory report dated and reported to the facility on [DATE] showed:-The UA specimen was never received in the lab due to not being collected. -The facility was advised to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	collect a sample on the next routine lab day. Review of the resident's health status note date 03/14/26 showed:-The resident complained of not feeling well and he/she had been feeling dizzy since 03/13/26 along with intermittent nausea without vomiting, sweats, chills and congestion. -The resident's skin color was noted to be pale with dark circles under the eyes. -Skin was clammy and warm. -Appetite was poor at this time. -Fluids and rest were encouraged and as needed Tylenol was given at this time. -Staff noted they would continue to monitor signs and symptoms and if they worsened, staff would re-evaluate and contact the physician. Review of the resident's health status note dated 03/15/26 showed:-The resident complained of not feeling well and reported generalized body aches and fatigue. -Skin was pale and clammy with dark circle under the eyes. -Nausea without vomiting and decrease in appetite. -The resident complained of dizziness when ambulating. -There was bronchial congestion noted upon inspiration and expiration. -Staff continued to encourage fluids and rest. Review of the residents' health status note dated 03/22/26 showed:-Staff noted no adverse reactions. -The resident refused breakfast, coffee, and snacks. -The resident reported poor sleep the previous night. -The resident continued to feel unwell. Review of the resident's health status note dated 03/23/26 showed:-The resident continued to complain of not feeling well, having nausea, and feeling lightheaded and dizzy. -The resident had a 17-pound weight loss and general malaise feeling. -A call was placed to the primary care physician.-New orders were received for a chest x-ray (a common, painless imaging test that uses electromagnetic radiation to create pictures of the inside of the body, particularly bones and dense tissues) and Zofran (a prescription medication used to prevent nausea and vomiting). Review of the resident's health status note dated 03/25/26 showed:-The resident continued to report feeling unwell, appeared pale, had clammy skin, and was shaky. -The resident reported not sleeping well and experiencing dizziness. -The resident was encouraged to stay hydrated. Review of the resident's health status note dated 03/26/26 at 2:46 P.M. showed:-The physician made rounds and new orders were placed for Ciprofloxacin (a broad-spectrum fluoroquinolone antibiotic used to treat various serious bacterial infections, including urinary tract infections (UTIs), pneumonia, and certain types of infectious diarrhea) 500 milligram (mg) twice daily and Trazadone (prescription antidepressant medication, often used off-label to treat insomnia and anxiety due to its sedative properties) 25 mg at bedtime.--NOTE: There was no culture and sensitivity received from the lab, so the physician would not have known which organism was in the urine and therefore which antibiotic it would be sensitive to. Cipro was a broad-spectrum antibiotic. Review of the resident's medical record showed:-The resident was sent to the emergency room (ER) on 03/26/26 and arrived at 5:15 P.M.-The resident's chief complaint was having nausea and diarrhea for the last two weeks and began having shortness of breath today. -The resident was diagnosed with a UTI. Review of the resident's health status note on 03/26/26 at 10:30 P.M. showed:-The resident returned to facility from the ER with a diagnosis of a UTI and started the Ciprofloxacin medication that evening. --NOTE: The hospital had not yet completed the urine culture, so it was not yet known which antibiotic would be effective. Review of the resident's laboratory results dated and reported to the facility on [DATE] showed:-The results of the UA culture.-Advised that the organism found was susceptible to penicillin (a group of antibiotic medicines derived from Penicillium fungi, used to treat various bacterial infections) as well as other alternate first-generation antibiotics but not Ciprofloxacin. Review of the resident's health status note date 03/30/26 showed:-The facility received a call from the ER where the resident was seen a few days before and notified of the results of the UA culture and noted that the current antibiotic therapy was not effective. -The physician was contacted and issued a new order for Keflex (cephalexin) a widely used oral, first-generation cephalosporin antibiotic that treated bacterial infections) 500 mg twice daily. During an interview on 05/05/26 at 2:23 P.M. the resident said:-He/She had difficulty and pain during urination a couple of months ago and reported it to the staff. -Staff obtained a urine sample about five different times but did not give him/her any medication for it.-There was a delay getting medication.-The hospital did a UA and discovered he/she had a UTI.-When he/she got back to facility, the staff started antibiotic (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication, but it was the wrong one because they had to change it a few days later.-Urination was very uncomfortable and painful for several weeks before it got better. I didn't feel well either. During an interview on 05/05/26 at 2:53 P.M., Licensed Practical Nurse (LPN) A said:-Laboratory specimens were collected on Monday and Wednesday.-The procedure for collection was after receiving a physician's order, to get a clean catch sample from a specimen collector, transfer it to a sterile urine cup, fill out the resident's info on the cup's label and place it into the refrigerator on the locked unit. The information for the resident and the specimen was put in the lab's log at the nurse's station then the lab would pick it up on the facility's designated days.-If a UA was not picked up by the lab after it was collected, it was kept in the fridge. He/She was not aware of any alternate procedure.-The nurses were responsible for ensuring the collection of UA specimens.-The UA result from the 03/08/26 collection said the specimen was never received by the lab.-The laboratory the facility was using was having staffing issues and could not pick up specimens on several occasions over several weeks that the staff and facility were aware of.-The physician was not notified until 03/23/26.-The physician and administration should have been notified at least within 24 hours after the specimen had not been collected and received by the laboratory. During an interview on 05/05/26 at 4:15 P.M., the Director of Nursing (DON) and Administrator said:-The UA collection process consisted of placing the physician's order in the resident's medical record, entering the laboratory order into the online system, and collecting and storing the specimen.-The charge nurse was responsible for this, then the DON and the Administrator.-The physician ordered specimen on 03/08/26 had not been picked up on 03/11/26 and the laboratory communicated this to the facility.-The facility had been having problems with the laboratory picking up specimens timely due to staffing issues on their end before the resident's UA order was received and after.-If the specimen had not gotten picked up by the laboratory, the physician should have been notified, then the resident should have been sent out to urgent care to have the specimen collected and tested.-The physician was not notified that the resident's UA had not been collected by the lab after being ordered.-The nurse should have notified him/her and the Administrator that the resident's specimen was not picked up by the laboratory.-The physician was not notified of the resident's reported change in condition 03/14/26 through 03/22/26 but should have been.-The physician should be notified of a change in condition depending on the severity of the issue, typically within 24 hours.-The charge nurse was responsible for notifying the physician regarding the health status of the resident.