STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265433	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln County Nursing & Rehab	1145 East Cherry Street Troy, MO 63379

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide residents with a safe, clean, and homelike environment, including providing housekeeping and maintenance services necessary to maintain an orderly and comfortable interior. The facility census was 85. Review of the undated facility policy, Cleaning Floors, showed the following:-Spills need to be mopped up immediately;-Sweep the floor, pushing all debris forward, using dustpan to remove debris;-Mop one small area at a time, beginning at the rear of the room in a figure eight motion. Use a scraper to remove stubborn stains and debris on the floor. Be sure to mop under and around equipment, along walls, and in corners. 1. Observation on 04/15/26 at 8:17 A.M., in occupied resident room [ROOM NUMBER], showed a hole in the drywall under the PTAC (packaged terminal air conditioner) unit. There was white spackle on the wall under and to the left side of the PTAC unit. 2. Observation on 04/13/26 at 11:50 A.M., in occupied resident room [ROOM NUMBER], showed dirt and debris on the resident's bed sheets. Observation on 04/14/26 at 2:58 P.M., showed the dirt and debris on the resident's bed sheets. Observation on 04/15/26 at 9:08 A.M., showed dirt and debris on the resident's bed sheets. During an interview on 04/15/26 at 9:08 A.M., the resident said he/she would like staff to change his/her sheets. Observation on 04/15/26 at 12:35 P.M. showed dirt and debris on the resident's bed sheets. 3. Observation on 04/13/26 at 11:50 A.M. showed the following:-A strong urine odor on the 500 hall;-Black scuff marks up and down the 500 hallway;-The floor on the 500 hallway was stick 4. Observation on 04/13/26 at 1:10 P.M., in occupied resident room [ROOM NUMBER], showed the following:-Piles of trash and food on the floor, including an open can of food with a dirty spoon in it, dirty napkins/Kleenex, pieces of food, wrappers from crackers and other food items all along the wall and under the bed;-Several food and personal items piled on the floor and along the wall (not in storage containers);-Food pieces and food stains on the resident's bedding and mattress. 5. Observation on 04/16/26 at 8:08 A.M. showed a strong urine and stale odor on the 500 hall. Observations on 04/13/26 at 1:25 P.M. showed a strong urine odor on the 600 hall. Observation on 04/14/26 at 8:00 AM. showed a strong urine odor on the 600 hall. Observation on 04/15/26 at 8:00 A.M. showed a strong urine odor on the 600 hall. Observation on 04/16/26 at 8:12 AM. showed a strong urine odor on the 600 hall. 6. Observation on 04/14/26 at 8:12 A.M., in occupied resident room [ROOM NUMBER], showed the following:-A puddle of yellow, dried liquid was on the fall mat and floor;-The room smelled like urine. Observation on 04/14/26 at 12:25 P.M., showed the room smelled like urine. Observation on 04/14/26 at 6:05 P.M., showed the following:-A puddle of yellow liquid under the bed;-The room smelled like urine. Observation on 04/15/26 at 8:39 A.M., showed the following:-A puddle of yellow, dried liquid under the bed;-The room smelled like urine. 7. Observations on 04/14/26 from 8:30 A.M. to 3:58 P.M. and on 04/15/26 from 10:06 A.M. to 12:35 P.M., showed the following: -In resident room [ROOM NUMBER], an 8-inch section of cove base trim by the bathroom door was missing, the floor tiles by the window were chipped, a 2-inch long hole was in the drywall behind bed A, and the handle on the wardrobe for bed A was loose and hanging;-In the soiled utility room, one of two room lights did not work and a 6-inch by 8-inch section of the floor tile was missing; (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the 200 hall shower room, a 6-inch by 12-inch section of floor tile behind the toilet was missing; -The door handle to resident room [ROOM NUMBER] was very loose; -In resident room [ROOM NUMBER], a 6-inch section of cove base trim by the bathroom door was missing; -In resident room [ROOM NUMBER], there was a 6-foot by 3-foot by 3-foot area between the bed and the wall and a 3-foot by 3-foot by 8-foot area between the two residents' beds that contained clothes, papers, stuffed animals, decorations, and totes stacked up and in piles. There was no clear walkway on either side of the bed; -The door handle to resident room [ROOM NUMBER] was very loose; -In resident room [ROOM NUMBER], one handle was missing from the wardrobe and the second handle was not securely mounted to the door and had one of two screws missing. There was a 3-inch circular hole in the wall by the bathroom that was not patched or painted; -In resident room [ROOM NUMBER], there was a 6-foot by 6-foot by 10-foot area that contained several papers, boxes, paper towel rolls, trash, food, and beverages stacked on the bedside table, floor, and refrigerator. There was no clear pathway on the floor between the bed and the wall with the window; -In resident room [ROOM NUMBER], the window was cracked; -In resident room [ROOM NUMBER], there was a 3-foot by 2-foot by 10-foot area that contained several books, clothing, and decorations stacked on the floor by the bed. There was no clear pathway on the floor between the bed and the wall with the window; -In the bathroom for resident room [ROOM NUMBER], there was no shower head on the shower fixture; -The door to resident room [ROOM NUMBER], the plastic door covering was coming loose from the door; -In the bathroom for resident room [ROOM NUMBER], there was no shower head on the shower fixture; -The floor of the guest bathroom in the lobby was discolored brown in multiple areas. There were rust stains on the sink and drain. During interviews on 04/14/26 at 3:00 P.M., 04/15/26 at 10:45 A.M. and 1:44 P.M., the Maintenance Director said the following: -Staff encouraged residents to have a clutter-free space in case of an emergency where they might need to evacuate; -Some residents cleared excess items from their rooms in the past but were starting to accumulate items again; -He was unaware of the cracked window in room [ROOM NUMBER]; -The facility had a floor tech who completed work on the floors as needed; -There was a binder at the nurses' station for staff to note maintenance issues, and he checked the binder each Monday morning. Staff informed him verbally of maintenance issues that were urgent. During an interview on 04/15/26 at 2:27 P.M., the Administrator said she expected residents to have a safe, clean, orderly, and comfortable environment at the facility.

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F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure two residents (Resident #74 and #25) were free from verbal abuse. On 03/30/26, Housekeeper A yelled at Resident #74 after the resident requested assistance with care and screamed and cursed at Resident #25 when the resident confronted him/her about how he/she talked to Resident #74. The facility census was 85. The administrator was notified of the past noncompliance on 04/09/26, which occurred on 03/30/26. On 03/30/26, the facility terminated Housekeeper W from employment at the facility for the allegation of staff to resident abuse and inserviced all staff on abuse prevention. Review of the facility's undated policy, Abuse Policy, showed the following: -Each resident will be free from abuse. Abuse can include verbal, mental, sexual or physical abuse; -Residents will be protected from abuse, neglect, and harm while they are residing at the facility; -No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection; -The facility will strive to educate staff and other applicable individuals in techniques to protect all parties. 1. Review of Resident #74's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/18/26, showed the following: -He/She had a diagnosis of Alzheimer's disease;-He/She required substantial/maximal assistance with dressing; -He/She required partial/moderate assistance with sitting on the side of the bed to lying flat on the bed, rolling from lying on his/her back to his/her left and right side and returning to lying on his/her back on the bed, and from lying to sitting on the side of the bed;-He/She was dependent on staff to transfer to and from a bed to a chair or wheelchair. Review of the resident's care plan, updated 03/13/26, showed the resident required assistance with activities of daily living and mobility due to weakness and cognitive impairment. During an interview on 04/08/26 at 11:55 A.M., the resident said the following: -Housekeeper W told him/her to 'shut up' and said the words fuck, damn, and shit; -It wasn't right what Housekeeper W said to him/her and it made him/her feel bad inside. 2. Review of Resident #25's Level II Preadmission Screening and Resident Review (PASRR, a federally mandated screening process for individuals with serious mental illness, intellectual disability/developmental disability, and/or related condition who apply for or reside in a nursing facility to evaluate the most appropriate setting and identify service needs based on the mental health condition), dated 10/06/25, showed the following:-He/She had a serious mental illness;-He/She had dependency needs for emotional and physical care;-He/She had a history of domestic violence in his/her two prior marriages;-He/She had a history of mood disorder including depression and anxiety symptoms;-He/She had a diagnosis of major depressive disorder (moderate-severe) with a prior history of suicide attempt;-He/She had poor coping skills and a history of trauma. Review of the resident's quarterly MDS, dated [DATE], showed he/she had moderate cognitive impairment. During an interview on 04/08/26 at 11:53 A.M., the resident said the following: -Housekeeper W was in his/her and Resident #74's room cleaning;-Housekeeper W started yelling at Resident #74 because Resident #74 was yelling for help; -Housekeeper W said Resident #74 had been yelling at Housekeeper W for four hours but Housekeeper W hadn't been in their room for that long; -Resident #25 told Housekeeper W not to talk to Resident #74 that way;-Housekeeper W started cursing at him/her (Resident #25) and called him/her a 'bitch' and said 'damn you'; -It upset him/her (Resident #25) that Housekeeper W picked on him/her because he/she couldn't defend himself/herself. 3. Review of the facility investigation, Initial Reporting Form, completed by the administrator, dated 03/30/26, showed the following:-Allegation type: abuse, mental/verbal;-The Assistant Director of Nursing (ADON) heard two people shouting and cursing at each other;-The ADON walked down the hall and observed Housekeeper W shouting obscenities at Resident #74;-The ADON escorted Housekeeper W from the building and suspended him/her pending investigation;-On the evening of 03/30/26, Housekeeper W was terminated. Review of Housekeeper (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	W's written statement, dated 03/30/26, showed the following: -Housekeeper W was cleaning a resident room;-Resident #74 kept yelling and hollering at Housekeeper W while he/she was cleaning the room; -Resident #74 needed help getting tucked into bed and that was not Housekeeper W's job; -Resident #25 told Resident #74 an aide would be there to help him/her; -The more Resident #74 shouted, the shorter Housekeeper W's temper got and eventually Housekeeper W snapped; -Housekeeper W screamed and cursed at Resident #74. During an interview on 04/14/26 at 2:04 P.M., Certified Nurse Assistant (CNA) CC said the following: -He/She heard Housekeeper W's voice from down the hall and went to Resident #74 and Resident #25's room; -Housekeeper W was nose to nose with Resident #74, and told the resident, Shut the fuck up bitch. I'm trying to do my job; -The ADON responded to the situation and removed Housekeeper W from the area. During an interview on 04/09/26 at 1:43 P.M., CNA AA said when he/she arrived to the residents' room, Housekeeper W was facing Resident #74 about two feet away and told the resident, Shut the fuck up. During an interview on 04/08/26 at 3:33 P.M., the Assistant Director of Nursing (ADON) said the following: -On 03/30/26, he/she heard shouting in a residents' room; -When he/she arrived to the residents' room, Resident #74 sat in his/her wheelchair in the walkway near the sink and was crying and shouting; -Housekeeper W stood slightly behind Resident #74's and to the resident's right side; -Housekeeper W shouted and cursed at Resident #74 and said, I can't do my fucking job; -He/She told Housekeeper W to leave the resident's room and walked Housekeeper W out of the building. During an interview on 04/09/26 at 8:48 A.M., CNA BB said the following: -He/She got to the residents' room just as Housekeeper W was leaving, and Housekeeper W to Resident #74 to, Shut the fuck up;-The ADON told Housekeeper W to leave the building and escorted him/her outside. During an interview on 04/08/26 at 2:13 P.M., the Housekeeping Supervisor said the following: -On the evening of 03/30/26, she called Housekeeper W; -Housekeeper W told him/her he/she had a bad day. Resident #74 asked Housekeeper W to lay Resident #74 down and Housekeeper W said he/she couldn't do that, and an aide would have to lay Resident #74 down; -Housekeeper W said he/she got in Resident #74's face and yelled and cursed at Resident #74. During an interview on 04/08/26 at 5:39 P.M., the Administrator said the following:-She was in her office when the ADON escorted Housekeeper W from the building;-Staff in-servicing on the facility's abuse policy started that day (03/30/26) and was ongoing with staff as they reported to work;-She expected staff to talk respectfully to residents and not to curse at them.