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 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 a registered nurse (RN) eight consecutive hours a day, seven days a week. The facility census was 85. During an interview on 04/16/26 at 8:45 A.M., the Administrator said the facility did not have a policy directly addressing RN coverage. Review of the facility assessment, updated 01/09/26, showed the facility resources needed to provide competent support and care for the resident population every day and during emergencies included RN coverage eight hours per day. Review of the Centers for Medicare and Medicaid Services (CMS) [NAME] report for Quarter 1, 2026 (reporting period 10/1/25 - 12/31/25) showed the facility did not meet the eight-hour per day RN requirement on 10/19/25, 10/26/25, 10/31/25, 11/01/25, 11/15/25, 11/16/25, 11/22/25, 11/28/25, 11/29/25, 12/12/25, 12/13/25, 12/14/25, 12/21/25, 01/24/26 and 01/29/26. Review of RN time sheet punches and schedules from 10/19/25 through 4/14/26, showed the following: -No RN coverage on 10/19/25, 10/26/25, 10/31/25, 11/01/25, 11/15/25, 11/16/25, 11/22/25, 11/28/25, 11/29/25, 12/12/25, 12/13/25, 12/14/25, 12/21/25 and 01/24/26;-On 01/29/26, RN coverage for 5.28 hours; -On 02/8/26, no RN coverage; -On 03/8/26, RN coverage for one hour; -On 04/02/26, RN coverage for 7.18 hours. During an interview on 04/16/26 at 3:00 P.M., the Staffing Coordinator said the following: -She had been the staffing coordinator since November 2025;-The facility was required to have an RN in the building eight hours each day;-If there was not an RN on the schedule, she let the Director of Nursing (DON) and Administrator know, so they could reach out to corporate to fill the shifts. During an interview on 04/16/26 at 10:45 A.M., the DON said the following: -There should be an RN in the building eight hours of each day;-In the last six to eight months, there had not been an RN in the building eight hours each day;-In the past three months, she felt there had been an RN present in the building eight hours each day. During an interview on 04/16/26 at 10:07 A.M., the Administrator said the following: -She was aware an RN was required in the building eight hours of each day;-The facility had an issue that was identified on the Payroll Based Journal (PBJ, a method to collect auditable and verifiable staffing data from nursing facilities) report with no RN coverage for multiple days in October, November and December 2025;-Since December, she was only aware of one day in January when the facility did not have RN coverage for eight hours.

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
	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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, staff failed to store, prepare, and serve food in accordance with professional standards for food service safety. Staff did not securely seal food items, store food per manufacturer's instructions, or store food items off the floor. Staff did not practice proper hand and glove hygiene, sanitary dish handling, and consumption of personal food and beverage items. Staff did not maintain surfaces and equipment free from a buildup of grease and debris. Staff failed to ensure an air gap was present at the facility's ice machine drains to prevent possible backflow from the drain back into the ice machines. The facility census was 85. 1. Review of the facility policy, Storage of Dry Food and Supplies, dated May 2015, showed the following:-The dietary department will store food and supplies according to facility guidelines and state regulations;-Food is to be stored a minimum of six inches above the floor;-Food should be protected from splash or other contamination. Review of the facility policy, Safe Food Handling, dated May 2015, showed the following:-Dietary employees will follow safe food handling guidelines to prevent the spread of foodborne illness;-All food should be tightly sealed. Observation on 04/13/26 at 11:03 A.M., during the initial tour of the dietary department, showed the following: -In the reach-in freezers, an open bag of tater tots and an open bag of breaded fish were unsealed and were open to the air; -In the dry storage room, a half-full gallon bottle of soy sauce, with a label that read 'Refrigerate after opening for quality', sat unrefrigerated on the shelf. Two boxes containing 35-pound bottles of frying shortening sat on the floor. During an interview on 04/15/26 at 12:49 P.M., the Dietary Manager said the following: -Food items should be securely sealed and not stored on the floor; -He was unaware the soy sauce should be refrigerated. During an interview on 04/15/26 at 2:27 P.M., the Administrator said she expected staff to store food in a safe and sanitary manner. 2. Review of the facility policy, Handwashing, dated May 2015, showed the following:-Wet hands and forearms with warm water;-Lather hands with antiseptic soap;-Wash hands, giving particular attention to the areas between fingers, around cuticles, and under fingernails. Wash forearms as well;-Rinse thoroughly with warm water beginning at the top of the forearm;-Wipe hands dry with clean paper towel;-Turn off water with paper towel and dispose of paper towel;-Eating and drinking in the dietary department is to occur in designated areas only. Review of the facility policy, Glove Use, dated May 2015, showed the following:-Food items should not be handled with bare hands;-Hand washing per guidelines should occur between each task;-Gloves should be worn if handling food is necessary. Extra caution should be taken when multiple tasks are being completed;-Gloves should be removed when changing or walking away from specific tasks and hands should then be washed per guidelines;-Hands should be washed after disposing of trash or food, after handling dirty dishes, after picking up anything from the floor, when changing tasks, and any other time deemed necessary. Observation on 04/13/26 from 12:08 P.M. to 1:27 P.M., in the kitchen during the lunch meal serviced, showed the following: -Cook HH served food onto residents' plates at the steam table; -Cook HH used his/her bare hands to touch the eating surface of bowls and plates, serving utensil handles, meal tickets, reach-in cooler door handles, and his/her personal cell phone, shirt, and face; -He/She opened and drank from a personal beverage container in the food preparation area; -Cook HH did not wash his/her hands and used his/her bare hands to grasp and place pieces of bread onto residents' plates. Observation on 04/14/26 from 12:07 P.M. to 1:41 P.M., in the kitchen during the lunch meal serviced, showed the following: -Cook KK served food onto residents' plates at the steam table. Dietary Aide II placed items onto residents' meal trays; -Cook KK used his/her gloved hands to touch reach-in cooler door handles, grasp a slice of cheese for a cheeseburger, and touch the microwave door handle to heat soup for residents. He/She removed his/her gloves and put on new gloves without washing his/her hands. [NAME] KK used his/her gloved hands to remove cooked chicken from the bone, tear it into bite-sized pieces, and placed the pieces of chicken onto residents' plates; -Dietary Aide II picked up a (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	meal ticket that dropped onto the floor and placed it back onto the food serving counter. He/She washed his/her hands at the handwashing sink, turned off the faucet handles with his/her clean hands, and continued assisting with the meal service. Dietary Aide II touched and discarded trash items from the counter, did not wash his/her hands, and carried stacks of clean glasses to the serving area; -Cook KK used his/her gloved hands to pick a hamburger bun from the floor. He/She removed his/her gloves, used his/her bare hands to adjust the stove knob, and opened the reach-in freezer door. He/She washed his/her hands at the two-compartment food preparation sink, turned off the faucet with his/her clean hands, and carried his/her used paper towels to the steam table area and sat the used paper towels on the plate warmer. During an interview on 04/15/26 at 1:23 P.M., [NAME] JJ said the following: -Staff should wash their hands anytime they touch items that contaminate their hands, after changing their gloves, and before conducting clean tasks; -After washing their hands, staff should turn off faucet handles with a paper towel and not with their clean hands; -Staff should consume beverages and handle personal items, such as cell phones, away from the food serving and preparation areas; -Staff should not touch food items with their bare hands or with soiled gloves; -Staff should handle plates and cups by the non-eating surfaces of those items. During an interview on 04/15/26 at 12:49 P.M., the Dietary Manager said the following: -Staff should not handle ready-to-eat food items, such as pieces of bread, with their bare hands; -Staff should not handle or consume personal items in the food preparation area; -Staff should wash their hands between tasks, after glove changes, and after anything that contaminates their hands; -Staff shouldn't pick meal tickets off the floor and put them back on the serving line. During an interview on 04/15/26 at 2:27 P.M., the Administrator said she expected staff to prepare and serve food in a safe and sanitary manner. 3. Review of the facility policy, Ice Machine Maintenance, dated May 2015, showed the following:-Empty the ice machine completely;-Clean the chest;-Place a sanitizing solution in the machine for two hours and circulate the solution according to manufacturer recommendations;-Remove the sanitizing solution, rinse with water and allow to air dry. Observation on 04/13/26 at 11:15 A.M., during the initial tour of the dietary department, showed multiple dried, white drips across the exterior and interior surface of the ice machine. There was a moderate accumulation of moist light-brown and pink-colored residue on the plastic above the ice storage area. During an interview on 04/15/26 at 12:49 P.M., the Dietary Manager said the following:-The maintenance supervisor used to clean the ice machine;-Two months ago, he/she found out it was the dietary department's responsibility to clean the ice machine but the Maintenance Supervisor hadn't had the chance to show him/her how to disassemble and clean the machine. During an interview on 04/15/26 at 1:38 P.M., the Maintenance Supervisor said the following: -He cleaned the ice machine twice a year in January and July;-He last cleaned the ice machine in January 2026;-The last time a company came to deep clean and descale the ice machine was last Spring; -He planned to train the dietary staff how to clean the ice machine soon since the ice machine cleaning responsibilities were transferred to the dietary department. 4. Review of the facility policy, Cleaning Floors, dated May 2015, showed the following:-Kitchen floor maintenance will be done after each meal;-Spills need to be mopped up immediately;-Sweep the floor;-Prepare detergent solution according to manufacturer instructions;-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 floor. Be sure to mop under and around equipment, along walls and in corners;-Rinse the area with clean warm water using a clean mop head. Observation on 04/13/26 at 12:48 P.M., in the kitchen, showed the following: -A heavy accumulation of dark gray residue and food debris on the floor under the six-burner stove, griddle, fryer, and toaster table; -A moderate accumulation of brown residue on the floor throughout the kitchen, especially in the high traffic areas. During an interview on 04/13/26 at 12:40 P.M., the Dietary Manager said a floor technician was supposed to clean and strip the floors in the kitchen soon. Last Saturday and Sunday, [NAME] HH cleaned under the fryer and used a scrub brush to clean under the stove. 5. Review of the facility policy, Ice Machine Maintenance, dated May 2015, showed the following:-Make sure there is (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	an air gap at all inlets for water;-Check for possible leakage or dripping into the machine. Observation on 04/13/26 at 11:15 A.M., of the facility's ice machine located in the alcove next to the kitchen, showed the following: -At the bottom of the ice machine, a 3-foot long section of 1-inch diameter PVC pipe connected the ice machine drain to a 4-inch floor drain. The PVC pipe was propped up by a 0.5-inch diameter rusty metal rod inserted inside the end of the PVC pipe above the floor drain. A large white towel was on the floor by the floor drain and partially blocked the PVC pipe. There was not a sufficient air gap at the drain; -At the back of the ice machine, a 2-foot long clear hose and a 2-foot long white hose connected the upper ice machine drain and were inserted inside a 4-inch flanged PVC drain pipe. The flanged drain pipe connected to a 2-inch diameter 3-foot long PVC pipe that connected directly to the drain of a nearby utility sink. There was not an air gap at the drain. During an interview on 04/15/26 at 1:38 P.M., the Maintenance Supervisor said he was unaware the ice machine drains did not contain air gaps to prevent the potential backflow of liquids back into the machine.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to ensure residents received mail on regular mail delivery days, as identified by the United States Postal Service (USPS), including Saturdays. The facility census was 85.Review of the facility's undated policy, Resident Rights, showed the following:-It is the purpose of this facility to meet the Federal and State Mandate in respect to resident rights;-The residents have a right to a dignified existence, self-determination and communication with and access to people and services inside and outside the facility;-The residents have a right to communicate freely; During a group interview on 04/15/26 at 2:00 P.M., Resident #15 and Resident #68 said residents did not receive mail on Saturdays. Resident # 68 said the Business Office Manager (BOM) went to the post office to get the mail Monday through Friday. During an interview on 04/16/26 at 10:07 A.M., the Administrator said the facility staff did not deliver mail to the residents on Saturdays when the BOM was not the manager on duty. The BOM was only at the facility as a manager on duty on the weekends about every six weeks.

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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; -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 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer medications as ordered for five residents (Resident #68, #37, #44, #75, and #73), in a review of 18 sampled residents, and for one additional resident (Resident #7). The facility census was 85.Review of the facility policy, Medication Administration, revised 02/07/2013, showed the following:-Purpose:-Medications are given to benefit a resident's health as ordered by the physician;-Guidelines:-Administer medication;-Important: If the resident refuses medication, indicate failure to administer medication on the medication record by circling initials and making a notation on the back of the medication record (include date, time, what occurred, initials, and title);-Record the medication given on the medication sheet. Review of the undated facility policy, Physician Orders, showed the following: -The following information is provided to assist you in recording physicians' orders:-Current lists of orders must be maintained in the clinical record of each resident to avoid confusion and errors;-Physician orders must be reviewed and renewed. 1. Review of Resident #7's physician's orders, dated February 2026, showed the following:-Diagnoses of cellulitis (deep inflammation of the tissues just under the skin, caused by infection), diabetes, chronic pain and lymphedema (swelling that with accumulation of large amounts of lymph fluid in the affected region); -Doxycyline (an antibiotic) 100 mg twice daily for ten days (start date 02/25/26);-Lidocaine pain relief adhesive patch, 4 percent (%), apply one patch to left shoulder and one patch to right knee daily;-Torsemide (a diuretic) 20 mg daily;-Trulicity (a once-weekly injection used to improve blood sugar control) 0.75 mg/0.5 mL subcutaneously (SQ, beneath the skin) once a week on Mondays. Review of the resident's medication administration record (MAR), dated February 2026, showed the following:-On 02/02/26, staff documented Trulicity 0.75 mg/0.5 mL was unavailable;-On 02/25/26, staff documented the morning dose of doxycycline 100 mg by mouth was unavailable;-On 02/25/26, staff documented lidocaine pain relief adhesive patch was unavailable; -On 02/25/26, staff documented torsemide 20 mg was unavailable;-On 02/26/26, staff documented lidocaine pain relief adhesive patch was unavailable; -On 02/26/26, staff documented torsemide 20 mg was unavailable;-On 02/28/26, staff documented lidocaine pain relief adhesive patch was unavailable. Review of the facility's E-Kit medications showed the following medications were available:-Doxycycline (antibiotic) 100 mg tablet;-Torsemide (diuretic) 20 mg tablet.(Review showed no documentation staff administered the medications from the E-kit when the resident's medications were not available.) Review of the resident's medical record showed no documentation staff notified the pharmacy when the medications were not available. Review of the resident's physician's orders, dated March 2026, showed an order for lidocaine pain relief adhesive patch, apply one patch to left shoulder and one patch to right knee daily. Review of the resident's MAR, dated March 2026, showed on 03/16/26, staff documented lidocaine pain relief adhesive patch was unavailable. Review of the resident's medical record showed no documentation staff notified the pharmacy when the medication was not available. Review of the resident's physician's orders, dated April 2026, showed the following:-Lidocaine pain relief adhesive patch, apply one patch to left shoulder and one patch to right knee daily;-Potassium chloride 10 mEq, two capsules by mouth daily. Review of the resident's MAR, dated April 2026, showed the following:-On 04/05/26, 04/06/26, 04/07/26 and 04/08/26, staff documented lidocaine pain relief adhesive patch was unavailable; -On 04/08/26 and 04/09/26, staff documented potassium chloride 10 mEq two capsules was unavailable. Review of the facility's E-Kit medications showed potassium chloride (supplement) 10 milliequivalent (mEq) tablet was available. (Review showed no documentation staff administered the medications from the E-kit when the resident's medication was not available.) Review of the resident's medical record showed no documentation staff notified the pharmacy when the medication was not available. During an interview on 04/14/26 at 6:10 P.M., the resident said the facility frequently ran out of his/her medications. 2. Review of Resident #68's physician's orders, dated February 2026, showed the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following:-Bupropion (an antidepressant) 150 mg by mouth daily;-Protonix (a medication to reduce stomach acid) 40 mg daily;-Spironolactone (a diuretic) 50 mg daily. Review of the resident's MAR, dated February 2026, showed the following:-On 02/10/26, staff documented bupropion 150 mg daily was unavailable;-On 02/15/26, staff documented Protonix 40 mg was unavailable;-On 02/16/26 and 02/17/26, staff documented spironolactone 50 mg was unavailable. Review of the facility's E-Kit medications showed the following medications were available:-Bupropion (antidepressant) 75 mg tablet;-Pantoprazole (also known as Protonix) 40 mg tablet;-Spironolactone (used to treat high blood pressure, heart failure, or hypokalemia (low potassium levels in the blood) 25 mg tablet. (Review showed no documentation staff administered the medications from the E-kit when the resident's medications were not available.) Review of the resident's medical record showed no documentation staff notified the pharmacy when the medications were not available. Review of the resident's physician's orders, dated March 2026, showed the following:-Celebrex (pain medication) 200 mg by mouth daily;-Spironolactone 50 mg by mouth daily. Review of the resident's MAR, dated March 2026, showed the following:-On 03/21/26, staff documented spironolactone 50 mg was unavailable;-On 03/29/26, staff documented Celebrex 200 mg was unavailable. Review showed no documentation staff administered the spironolactone from the E-kit when the resident's medication was not available. Review of the resident's medical record showed no documentation staff notified the pharmacy when the medication was not available. Review of the resident's physician's orders, dated April 2026, showed an order for duloxetine (a medication used to treat depression and anxiety) 30 mg daily. Review of the resident's MAR, dated April 2026, showed on 04/11/26, 04/12/26, and 04/13/26, staff documented duloxetine 30 mg was unavailable. Review of the facility's E-Kit medications showed duloxetine 30 mg tablet was available.(Review showed no documentation staff administered the medications from the E-kit when the resident's medication was not available.) Review of the resident's medical record showed no documentation staff notified the pharmacy when the medication was not available. During an interview on 04/14/26 at 6:34 P.M., the resident said the facility often ran out of his/her scheduled medications. 3. Review of Resident #37's physician's orders, dated March 2026, showed the following:-admitted to the facility on [DATE];-Diagnoses of atrial fibrillation (irregular heart rhythm), peripheral vascular disease (poor circulation), arthritis, hypothyroidism (the thyroid is not making enough thyroid hormone), hypertension, pain, and GERD;-Amlodipine 5 mg daily;-Eliquis (blood thinning medication) 2.5 mg twice daily;-Gabapentin (used to treat seizures and nerve pain) 100 mg three times daily;-Levothyroxine (thyroid medication) 88 micrograms (mcg) daily;-Lidocaine adhesive medicated patch 4%, apply to right knee daily;-Metoprolol succinate (blood pressure medication) 50 mg daily;-Pantoprazole 40 mg twice daily;-Pravastatin (used to lower cholesterol and triglycerides (fat)) 10 mg at bedtime. Review of the resident's MAR, dated 03/08/26, showed the following:-Staff documented the morning dose of pantoprazole 40 mg was unavailable;-Staff documented pravastatin 10 mg was unavailable, check E-kit, admission after medications delivered; -Staff documented levothyroxine 88 mcg was unavailable;-Staff documented lidocaine adhesive medicated patch was unavailable;-Staff documented metoprolol succinate 50 mg was unavailable;-Staff documented the morning and noon doses of gabapentin 100 mg were unavailable;-Staff documented amlodipine 5 mg was unavailable;-Staff documented the morning dose of Eliquis 2.5 mg was unavailable. Review of the resident's MAR, dated 03/09/26, showed staff documentation the levothyroxine 88 mcg daily was unavailable. Review of the facility's E-Kit medications showed the following medications were available:-Amlodipine (blood pressure medication) 5 milligram (mg) tablet;-Eliquis (blood thinner) 2.5 mg tablet;-Gabapentin (used to treat seizures and nerve pain) 100 mg tablet;-Levothyroxine (thyroid medication) 88 micrograms (mcg) tablet;-Metoprolol succinate (blood pressure medication) 25 mg tablet;-Pantoprazole (also known as Protonix - used to treat gastroesophageal reflux disease (GERD) (stomach contents leak backwards into the esophagus) 40 mg tablet. (Review showed no documentation staff administered the medications from the E-kit when the resident's medications were not available.) Review of the (continued on next page)

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	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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's medical record showed no documentation staff notified the pharmacy when the medications were not available. Review of the resident's physician's orders dated April 2026, showed an order for lidocaine adhesive medicated patch 4% apply to right knee daily. Review of the resident's MAR, dated April 2026, showed on 04/06/26 and 04/07/26, staff documented the lidocaine adhesive medicated patch 4% was unavailable. Review of the resident's medical record showed no documentation staff notified the pharmacy when the medication was not available. 4. Review of Resident #44's physician's orders, dated 03/16/26 - 04/16/26 showed the following:-admitted to the facility on [DATE];-Atorvastatin (a cholesterol medication) 20 mg daily;-Lisinopril (a medication used to treat high blood pressure and heart failure) 10 mg daily;-Pantoprazole (a medication used to treat too much acid in the stomach) 40 mg twice daily;-Carbidopa-levodopa (a medication used to treat Parkinson's disease) 10-100 mg three times a day. Review of the resident's MAR, dated 03/21/26, showed the following:-Staff documented the morning dose of pantoprazole 40 mg was unavailable;-Staff documented the morning dose of atorvastatin 20 mg was unavailable;-Staff documented the morning dose of lisinopril 10 mg was unavailable. Review of the facility's E-Kit medications showed the following medications were available:-Atorvastatin 20 mg tablet;-Lisinopril 5 mg tablet;-Pantoprazole 40 mg tablet.(Review showed no documentation staff administered the medications from the E-kit when the resident's medications were not available.) Review of the resident's medical record showed no documentation staff notified the pharmacy when the medications were not available. Review of the resident's MAR, dated April 2026, showed on 04/12/26 staff documented carbidopa-levodopa 10-100 mg (bedtime dose) was unavailable and the medication was not in the E-kit. Review of the resident's medical record showed no documentation staff notified the pharmacy when the medication was not available. 5. Review of Resident #75's undated continuity of care document (CCD) showed his/her diagnoses included Type 2 diabetes mellitus (metabolic disease) with diabetic chronic kidney disease (CKD, impaired kidney function), and long-term use of injectable non-insulin antidiabetic drugs. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/06/26, showed the following:-Moderately impaired cognition;-He/She received an insulin injection in the last seven days. Review of the resident's physician orders, dated March 2026, showed an order for semaglutide (a weekly injection for managing type 2 diabetes) inject 1 mg subcutaneously (beneath the skin) once a week on Wednesday. Review of the resident's MAR, dated March 2026, showed on 03/11/26 at 12:30 P.M., Licensed Practical Nurse (LPN) FF documented semaglutide was not administered due to the medication was not available. (Review showed no documentation staff administered the medication on any other date during the week of 03/08/26-03/14/26.) Review of the resident's medical record showed no documentation staff notified the pharmacy when the medication was not available. Review of the resident's physician orders, dated April 2026, showed an order for semaglutide, inject 1 mg subcutaneously once a week on Wednesday. Review of the resident's MAR, dated April 2026, showed on 04/08/26 at 12:30 P.M., LPN G documented semaglutide was not administered due to the medication was not available. (Review on 04/14/26 showed no documentation staff administered the medication on any date between 04/08/26 and 04/14/26.) During an interview on 04/16/26 at 11:25 A.M., LPN G said the following:-If medication was unavailable during the medication pass, staff should check the overflow medications in the medication room and the E-kit;-Staff should let the charge nurse know if the medication was unavailable in the facility, so the charge nurse could notify the pharmacy. Review of the resident's medical record showed no documentation staff notified the pharmacy when the medication was not available. During an interview on 04/13/26 at 1:42 P.M., the resident said the following:-He/She was to receive weekly injectable medication for his/her diabetes;-He/She didn't receive his/her injection last week because the facility was out of his/her medication and he/she had not yet received it for this week;-The facility ran out of medications frequently. 6. Review of Resident #73's undated CCD showed his/her diagnoses included severe sepsis with septic shock (infection of the blood), urinary tract infection (UTI) (a common infection (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	caused by bacteria entering and spreading within the urinary system, including the bladder, urethra or kidneys). Review of the resident's quarterly MDS, dated [DATE], showed the resident's cognition was intact. Review of the resident's progress notes, dated 03/23/26 at 2:33 P.M. showed the following:-The resident had been admitted to the hospital for septic shock (infection of the blood) due to urinary infection;-He/She will be coming back to the facility with a right midline intravenous (IV) and has already had a course of antibiotic for today, however, he/she will need it for two more days then can go to oral antibiotics on 03/25/26. Review of the resident's physician orders, dated April 2026, showed an order for cefpodoxime (antibiotic) 200 milligram (mg) twice a day for 10 days (administration times of 6:30 A.M. - 2:30 P.M., 2:30 P.M. - 10:30 P.M) for UTI (order start date 04/08/26 and end date 04/18/26). Review of the resident's MAR, dated April 2026, showed Certified Medication Technician (CMT) Y documented cefpodoxime was not administered during the 6:30 A.M.-2:30 P.M. medication pass on 04/13/26 due to the medication was not available. During an interview on 04/13/26 at 1:42 P.M., the resident said the following:-He/She didn't get his/her antibiotic today;-Staff told him/her they were out of his/her antibiotic, and it would hopefully be in by tomorrow; -He/She was worried about missing his/her medication because he/she just returned from the hospital with sepsis and a UTI;-The facility ran out of medications all the time. 7. During an interview on 04/15/26 at 8:30 A.M., CMT Y said the following:-The facility frequently ran out of scheduled medications;-There were a lot of new CMTs who were not restocking the medication carts and ordering medications timely. During an interview on 04/15/26 at 2:01 P.M., CMT U said the following:-If a medication was unavailable in the cart or medication room, staff could usually pull the medication from the facility's E-kit;-If the medication was not in the E-kit, hopefully the facility would receive the medication from the pharmacy later that day; -Staff should let the charge nurse know if a medication was unavailable so the charge nurse could call the pharmacy;-He/She documented the medication was unavailable when the medication was not available to administer. During an interview on 04/16/26 at 11:25 A.M., LPN G said the following:-If medication was unavailable during the medication pass, staff should check the overflow medications in the medication room and the E-kit;-Staff should let the charge nurse know if the medication was unavailable in the facility, so the charge nurse could notify the pharmacy. During an interview on 04/15/26 at 8:12 A.M., the Assistant Director of Nursing (ADON) said the following:-If a medication was not available during the medication pass, staff administering medications should check in the E-kit. If the medication was not in the E-kit, the charge nurse should contact the pharmacy;-It may take the pharmacy two to three days to deliver the medications; -He/She was aware there were issues with medications not being available but thought it was getting better. During an interview on 04/16/26 at 3:49 P.M., the Director of Nursing (DON) said the following:-She were to follow physicians orders and administer medications as ordered;-She was not aware of any issues with residents not receiving their medications;-Everyone knew how to reorder medications. She expected staff to reorder medications as needed; -She expected staff to check the E-kit for medications and to administer medications from the E-kit if the medication was available.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two residents (Residents #60 and #62), in a review of 18 sampled residents, and two additional residents (Residents #31 and #45), who required assistance with activities of daily living (ADLs), received the necessary care and services to maintain good grooming and personal hygiene. The facility census was 85. Review of the facility's undated policy, Activities of Daily Living, showed the following:-The purpose was to assist resident in achieving maximum function;-The policy did not address bathing/showering, dressing or clothing changes. Upon request, the facility provided no other policy related to bathing/showering, dressing or clothing changes. 1. Review of Resident #45's Progress Notes, dated 11/28/25 at 12:52 P.M., showed the resident's family member said the resident had a stroke a few years ago. Since his/her stroke, the resident has been unable to maintain proper hygiene and perform ADLs. Review of the resident's Shower Sheets, dated 03/01/26 - 03/10/26, showed the following:-On 03/04/26, the resident received a shower;-On 03/07/26, the resident refused a shower;-No documentation the resident received a shower 03/05/26 - 03/10/26 (six days). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment tool to be completed by the facility, dated 03/10/26, showed the following:-Cognitively intact;-Did not reject care;-Independent for shower/bath, upper and lower body dressing and personal hygiene;-Occasionally incontinent of bladder. Review of the resident's care plan, dated 03/13/26, showed the following:-The resident was continent of bowel and bladder most of the time;-The resident was able to maintain personal hygiene on his/her own;-No documentation regarding bathing. Review of the resident's Shower Sheets, dated 03/10/26 - 04/13/26, showed the following:-On 03/11/26, the resident refused a shower. The resident requested a shower tomorrow, 03/12/26;-On 03/12/26, no documentation staff offered or the resident received or refused a shower;-On 03/14/26, the resident received a shower (10 days since his/her last shower on 03/04/26);-On 03/18/26, the resident refused a shower. The resident requested a shower tomorrow, 03/19/26;-On 03/19/26, no documentation staff offered or the resident received or refused a shower;-On 03/22/26, the resident received a shower (eight days since last shower on 03/14/26);-On 03/25/26, the resident refused a shower;-On 04/01/26, the resident refused a shower;-On 04/04/26, the resident refused a shower. The resident requested a shower tomorrow, 04/05/26;-On 04/05/26, no documentation staff offered or the resident received or refused a shower;-On 04/08/26, the resident refused a shower;-On 04/11/26, the resident refused a shower. Staff documented the resident was encouraged to shower but refused.(Review of the resident's shower sheets showed no documentation staff offered the resident a partial bath and/or assistance with personal hygiene when he/she refused to take a shower.) Observation on 04/13/26 at 11:50 A.M., showed the following:-The resident sat on the side of his/her bed;-There was a strong smell of body odor in the room;-The resident's hair was disheveled and greasy;-The resident had white flakes in his/her hair and a dime-sized amount of tan debris in his/her hair by his/her left ear;-The resident had white flaky skin on his/her shirt and dried food debris on the front of his/her pants. During an interview on 04/13/26 at 11:50 A.M., the resident said he/she needed staff assistance to get in and out of the shower. He/She was supposed to receive a shower today. Observation on 04/14/26 at 2:52 P.M., showed the following:-The resident walked down the hallway with his/her walker;-He/She wore the same shirt and pants he/she wore on 4/13/26;-The resident's hair was disheveled and greasy;-There were white flakes in the resident's hair and a dime sized amount of tan debris in the resident's hair by his/her left ear;-There was white flaky skin on the resident's shirt and dried food debris on the front of the resident's pants. During an interview on 04/14/26 at 2:52 P.M., the resident said he/she did not get his/her shower yesterday, maybe he/she would get a shower today. Observation on 04/14/26 at 2:58 P.M., in the resident's room, showed the following:-The resident was not in his/her room;-There was a strong smell of body odor in the room. Observation on 04/15/26 at (continued on next page)

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	265433	A. Building B. Wing	04/16/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:08 A.M., showed the following:-The resident sat on the side of his/her bed;-He/She wore the same pants he/she wore on 4/13/26 and 04/14/26;-The resident wore the same shirt as 04/14/26;-The resident's hair was disheveled and greasy;-There were white flakes in the resident's hair and a dime-sized amount of tan debris in the resident's hair by his/her left ear;-There was white flaky skin on the resident's shirt and dried food debris on the front of his/her pants. During an interview on 04/15/26 at 9:08 A.M., the resident said the following:-He/She needed staff's help to change his/her clothes;-He/She would like to change his/her clothes daily;-He/She told staff he/she needed assistance. Observation on 04/15/26 at 12:35 P.M., showed the following:-A strong smell of body odor was in the resident's room;-The resident lay on his/her left side in bed;-The soles of the resident's feet were black/brown with debris and dirt;-He/She wore the same pants he/she wore on 4/13/26 and 04/14/26;-The resident wore the same shirt he/she wore on 04/14/26;-The resident's hair was disheveled and greasy;-There were white flakes in the resident's hair and a dime sized amount of tan debris in the resident's hair by his/her left ear;-There was white flaky skin on the resident's shirt and dried food debris on the front of the resident's pants. During an interview on 04/15/26 at 12:57 P.M., Nurse Aide (NA) I said the following:-The resident was independent with changing his/her clothes and personal hygiene;-The resident did not like to take showers;-The resident needed encouragement to change his/her clothes daily. Observation on 04/16/26 at 11:16 A.M., showed the following:-The resident sat on his/her rollator walker at the nurses station;-The resident had body odor;-He/She wore the same pants he/she wore on 4/13/26, 04/14/26 and 04/15/26;-The resident wore the same shirt he/she wore on 04/14/26 and 04/15/26;-The resident's hair was disheveled and greasy;-There were white flakes in the resident's hair and a dime-sized amount of tan debris in the resident's hair by his/her left ear;-There was white flaky skin on the resident's shirt and dried food debris on the front of his/her pants. During an interview on 04/16/26 at 11:16 A.M., the resident said he/she had not received a shower this week. Review of the resident's Shower Sheets, dated 03/23/26 - 04/16/26, showed no documentation the resident received a shower or partial bath for 25 days. During an interview on 04/16/26 at 11:25 A.M., Licensed Practical Nurse (LPN) G said the following:-If a resident refused showers, staff should offer a partial bath or provide assistance with personal hygiene and changing clothes;-A resident should not wear the same pants for four days. 2. Review of Resident #31's quarterly MDS, dated [DATE], showed the following:-Dependent on staff for toileting hygiene and personal hygiene;-Required substantial/maximal assistance with roll left and right;-Always incontinent bladder and bowel. Review of the resident's care plan, dated 04/14/26, showed the following:-The resident was incontinent of bowel and bladder;-Provide incontinence care after each incontinent episode;-Assist of one to two staff with toileting and hygiene. Observation on 04/14/26 at 6:42 P.M., showed the following:-The resident lay awake in bed;-Certified Nurse Assistant (CNA) P and LPN GG entered the resident's room;-The resident was incontinent of urine and a moderate amount soft feces;-There was a very strong urine smell in the resident's room;-The front of the resident's gown was wet with urine;-CNA P performed frontal pericare;-CNA P and LPN GG rolled the resident to his/her left side;-The disposable incontinence pad under the resident was saturated with urine;-CNA P used disposable wipes to perform rectal pericare;-CNA P did not clean the resident's buttocks and thighs (areas in contact with the urine saturated incontinence pad);-CNA P tucked the soiled incontinence pad under the resident's hips and placed a clean incontinence pad under the resident's hips;-CNA P assisted the resident to roll to his/her back in bed;-CNA P removed the resident's soiled gown and placed a clean gown on the resident. 3. Review of Resident #62's care plan, dated 03/17/26, showed the following:-The resident needed assistance with ADLs (e.g. transfers, dressing, toileting, and maintaining personal hygiene);-Assist daily and as needed with hygiene needs;-Provide incontinence care after each incontinent episode. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Dependent on staff for toileting hygiene;-Required substantial/maximal assistance for personal hygiene;-Required partial/moderate assistance for roll left and right;-Always incontinent of bowel and bladder. Observation on 04/14/26 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 7:12 P.M., showed the following:-The resident lay awake in bed;-The resident was incontinent of urine and a large amount of liquid feces;-The resident's incontinence brief was saturated with urine and feces;-There was a strong smell of urine in the room;- CNA P performed frontal pericare and assisted the resident to roll to his/her left side;-CNA P performed rectal pericare;-CNA P did not clean the resident's hips or upper buttocks (areas in contact with the soiled incontinence brief); -CNA P tucked the resident's soiled incontinence brief under the resident's hips and placed a clean incontinence brief under the resident's hips;-CNA P assisted the resident to roll to his/her back and fastened the incontinence brief. During an interview on 04/14/26 at 8:12 P.M., CNA P said the following:-The resident's hips were not visibly wet when he/she rolled the resident so he/she did not clean the resident's hips and thighs;-He/She should clean all wet/soiled areas of the resident's skin when providing pericare. 4. Review of Resident #60's comprehensive MDS, dated [DATE], showed the following:-Severely impaired cognition;-Did not reject care;-Dependent on staff for showering/bathing;-Required substantial/maximal assistance from staff for personal hygiene;-Always incontinent of bowel and bladder. Review of the resident's care plan, last revised 03/13/26, showed the following:-He/She required staff assistance with ADL's: e.g maintain personal hygiene;-He/She is incontinent of bowel and bladder; provide incontinence care after each incontinence episode;-The care plan did not address bathing or document the resident refused care. Review of the resident's shower sheets and the facility shower binder for March 2026, showed the following:-The resident's bathing days were Mondays and Thursdays (day shift);-No documentation the resident received or refused a shower on 03/02/26 through 03/04/26;-On 03/05/26, the resident refused bathing; -No documentation the resident received or refused a shower on 03/06/26 through 03/09/26;-On 03/09/26, the resident refused bathing; -No documentation the resident received or refused a shower on 03/10/26 and 03/11/26;-On 03/12/26, the resident received a shower (first documented shower since the resident returned to the facility from the hospital on [DATE]); -No documentation the resident received or refused a shower on 03/13/26 through 3/15/26;-On 03/16/26, the resident received a shower;-No documentation the resident received or refused a shower on 03/17/26 and 03/18/26;-On 03/19/26, the resident refused bathing; -No documentation the resident received or refused a shower on 03/20/26 through 03/22/26;-On 03/23/26, the resident refused bathing; -No documentation the resident received or refused a shower on 03/24/26 and 03/25/26;-On 03/26/26, the resident received a shower (ten days since his/her last shower on 03/16/26); -On 03/30/26, the resident received a shower. Review of the resident's shower sheets for April 2026, showed the following:-On 04/02/26, the resident received a bed bath; -On 04/06/26, the resident refused bathing. Staff attempted to convince the resident to take a shower and he/she did not comply with the request; forwarded to the director of nursing (DON); -On 04/09/26, the resident refused bathing. Observation on 04/13/26 at 1:05 P.M. showed the following:-The resident lay in his/her bed;-His/Her hair was disheveled;-There was a strong body odor and urine odor in his/her room. Review of the resident's shower sheets for April 2026, showed the resident received a shower on 04/13/26. During interviews on 04/13/26 at 1:10 P.M. and on 04/17/26 at 9:05 A.M., the resident's roommate said the following:-He/She was very concerned about his/her roommate not receiving his/her showers;-The resident was always incontinent of bowel and bladder;-He/She could smell urine and feces all the time;-He/She wore three disposable masks (personal protective equipment) when he/she slept because of the resident's odors. During an interview on 04/16/26 at 8:40 A.M. and 9:07 A.M., CNA Q said the following:-If Resident #60 refused his/her shower, he/she would get the nurse to see if he/she can convince the resident to shower; -Other staff have mentioned the resident refuse a lot. During an interview on 04/16/26 at 9:15 A.M., LPN G said the following:-The resident refused cares a lot; -If the resident refused, he/she would check back later. 5. During an interview on 04/16/26 at 3:49 P.M., the Director of Nursing (DON), said the following:-Staff should clean all soiled areas of a resident's skin when performing peri-care;-She should offer partial baths and continue to encourage residents who refuse to take showers and to change clothes to take one throughout the day.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on observation, interview, and record review, the facility failed to ensure three nurse aides (NA J, NA I and NA K), in a review of seven staff reviewed, completed a certified nurse aide (CNA) training program within four months of their employment in the facility. The facility census was 85. During an interview on 04/16/26 at 8:45 A.M., the Administrator said the facility did not have a policy directly addressing the use of NAs and the timeframe to become certified. 1. Review of the current employee list, provided by the facility, showed NA J's date of hire was 08/20/25. Review of NA J's employee file showed no documentation he/she completed a CNA training program within four months of his/her hire date. Review of the facility schedule for April 2026 showed NA J was scheduled to work as an NA from 6:00 A.M.to 6:00 P.M. on 04/03/26, 04/04/26, 04/05/26, 04/08/26, 04/09/26, 04/13/26 and 04/14/26. Review of the facility provided daily staffing sheets for 04/13/26 through 04/16/26 showed the following: -NA J was assigned to resident hall E from 6:00 A.M. to 6:00 P.M. on 04/13/26;-NA J was assigned to resident hall D from 6:00 A.M. to 6:00 P.M. on 04/14/26. Observation on 04/13/26 at 4:03 P.M. showed NA J assisted another staff to transfer Resident #62 from his/her bed to his/her wheelchair. 2. Review of the current employee list, provided by the facility, showed NA I's date of hire was 09/25/25. Review of NA I's employee file showed no documentation he/she completed a CNA training program within four months of his/her hire date. Review of the facility schedule for April 2026 showed NA I was scheduled to work as an NA from 6:00 A.M. to 6:00 P.M on 04/01/26, 04/02/26, 04/06/26, 04/07/26, 04/10/26, 04/11/26, 04/12/26, 04/15/26 and 04/16/26. Review of the facility provided daily staffing sheets for 04/13/26 through 04/16/26 showed the following: -NA I was assigned to resident hall A from 6:00 A.M. to 6:00 P.M. on 04/15/26;-NA I was assigned to resident hall E from 6:00 A.M. to 6:00 P.M. on 04/16/26. Observation on 04/15/26 at 11:05 A.M. showed NA I provided incontinence care for Resident #7 and transferred the resident with a mechanical lift. During an interview on 04/15/26 at 8:20 A.M., NA I said the following:-He/She worked as an NA in the facility for eight months;-He/She just completed CNA class and was waiting to take his/her certification test;-He/She was working on the A hall by himself/herself today. 3. Review of the current employee list, provided by the facility, showed NA K's date of hire was 10/02/25. Review of the facility nursing scheduled for January 2026 through April 2026 showed NA K was scheduled to work as an NA from 10/02/25 through 01/18/26, took leave from 01/19/26 through 02/28/26, and returned to work as an NA on 03/03/26. Review of NA K's employee file showed no documentation he/she completed a CNA training program within four months of his/her hire date. Review of the facility provided schedule for April 2026 showed NA K was scheduled to work as an NA from 6:00 A.M. to 6:00 P.M. on 04/04/26, 04/05/26, 04/07/26, and 04/14/26. He/She was scheduled to work as an NA from 2:00 P.M. to 10:00 P.M. on 04/10/26, 04/11/26, and 04/12/26. Review of the facility provided daily staffing sheets for 04/13/26 through 04/16/26 showed NA K was assigned to resident hall F from 2:00 P.M. to 6:00 P.M on 04/14/26. 4. During an interview on 04/16/25 at 10:45 A.M., the Director of Nursing (DON) said the following: -An NA had four months to complete the CNA training program;-The facility had three NAs (NA K, NA I and NA J) who had worked as an NA for longer than four months; -The NAs started the program as a web-based program and were not successful and transitioned to an in-seat program;-Two of the three NAs were waiting to test, and one NA went on extended leave and wasn't finished with his/her training. During an interview on 04/16/26 at 3:00 P.M., the Administrator said the following: -NAs were required to complete the CNA training within four months of hire;-She was aware there were three NAs who have not completed their CNA training within four months of hire;-All three NAs started the program on a web-based format and were unsuccessful, so they transitioned to an in-seat program;-NA I completed classes and needed to take his/her test, but hadn't scheduled the test yet;-NA J was supposed to take his/her test on the 04/10/26 and while taking his/her test, the test shut off and he/she was not able to get back into the test;-NA K was off on extended leave and had not been added back to the class.

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	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

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review at least every 12 months for three certified nurse assistants (CNAs) and failed develop a process to identify weaknesses and to provide regular in-service education based on the outcome of these reviews. The facility census was 85. Review of the facility policy, Employee Evaluations, dated July 2006, showed the following: -Employee evaluations are primarily viewed as an important management tool, helping to evaluate and increase the quality of an employees' performance and make decisions about work assignments;-Evaluations give guidance to employees on areas of performance where they can improve;-Using the Employee Evaluation form in conjunction with a current job description, the supervisor should review all employees upon the following time schedule: -90 days after the initial date of hire; -Annually, on or near the anniversary of the individual's hire date. 1. Review of the facility assessment, updated 01/09/26, showed services and care offered based on residents' needs:-General care: activities of daily living, mobility and fall/fall with injury prevention, bowel/bladder, skin integrity, mental health and behavior, medications, pain management, infection prevention and control, management of medical conditions, therapy, other special care needs, nutrition and person centered/directed care: psycho/social/spiritual support;-Competencies for general care: facility conducts monthly in-service meetings with staff;-Competency assessments, performance reviews and observed abilities are also completed;-Training is conducted based from assessments and observation results. 2. Review of the facility staff list, provided by the facility, showed Certified Nurse Assistant (CNA) D was hired on 10/29/14. Review of CNA D's employee file showed no documentation staff completed an annual performance evaluation. 3. Review of the facility staff list, provided by the facility, showed CNA E was hired on 10/09/23. Review of CNA E's employee file showed no documentation staff completed an annual performance evaluation. 4. Review of the facility staff list, provided by the facility, showed CNA F was hired on 10/11/23. Review of CNA F's employee file showed no documentation staff completed an annual performance evaluation. 5. During an interview on 04/16/26 at 10:07 A.M., the Administrator said the following: -She believed the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) completed the annual CNA performance reviews -She believed staff conducted in-services related to required elements and any identified areas to review as needed. During an interview on 04/16/26 at 10:45 A.M., the Director of Nursing (DON) said the following:-She did not complete a formal performance evaluation or review for CNAs who were employed for 90 days;-She did not complete a formal performance evaluation or review for CNAs who were employed for 12 months or longer;-She had not formally identified any weaknesses to determine what education pieces should be completed. During an interview on 04/29/26 at 12:29 P.M., the Assistant Director of Nursing (ADON) said the following: -She had been the ADON for about a year;-She did not complete any of the CNA performance evaluations or tracking of staff education;-She had not been told she was responsible for any aspect of the CNA performance evaluations.

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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 ensure all medications available for administration on the Certified Medication Technician (CMT) cart for halls B/E/F, CMT medication room, and stock medication room were not expired. The facility census was 85. Review of the facility's undated policy, Storage of Medications, showed the following: -No discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. All such drugs must be returned to the issuing pharmacy or destroyed in accordance with established guidelines;-Drugs must be stored in an orderly manner in cabinets, drawers, or carts. 1. Observation on 04/14/26, at 6:07 P.M., of the CMT medication cart for halls B/E/F showed the following: -A sticky residue was in the bottom two drawers which contained stock bottles of medications;-A sticky residue was in the top drawer which contained inhalers and eye drops. Staff's personal items, including keys, were stored with the eye drops;-An opened stock bottle of Vitamin E (a dietary supplement) 180 milligram (mg) soft gel capsules contained eight capsules and had an expiration date of 8/25; -An opened bottle of diphenhydramine/lidocaine/aluminum hydroxide/magnesium hydroxide/simethicone (a liquid medication used to treat mouth sores), approximately 3/4 full, labeled for Resident #24, had an expiration date of 02/20/26. 2. Observation on 04/14/26 at 6:07 P.M. of the CMT medication room and over-the-counter stock/wound care supplies storage room, showed the following: -An opened bottle of Omega-3 (a dietary supplement) 2000 mg had an expiration date of 03/2026; -Two opened 13-ounce containers of stock Reguloid daily fiber (a laxative) had an expiration date of 02/2026;-Five unopened 13-ounce containers of stock Reguloid daily fiber had an expiration date of 02/2026;-An opened 16-ounce bottle of Lactulose (a solution used to treat constipation), labeled for Resident #51, had an expiration date of 08/31/25;-An unopened 16-ounce bottle of Lactulose, labeled for Resident #51, had an expiration date of 08/31/25;-An opened bottle of glucosamine and chondroitin (a dietary supplement) 500 mg/400 mg had an expiration date of 03/2025;-Six unopened bottles of oyster shell calcium and vitamin D (a dietary supplement) had an expiration date of 07/2025. 3. Observation 04/14/26 at 6:40 P.M. of the nurse medication/treatment cart for hall B/D/E showed the following: -An opened bottle of nitroglycerin (a medication to treat chest pain) tablets 0.4 mg, labeled for Resident #91, had an expiration date of 12/2025; -An opened vial of heparin (an injectable medication used as blood thinner to prevent blood clots) 5000 units/ml, approximately 1/2 full, labeled for Resident #84, had an expiration date of 03/31/26;-An unopened vial of heparin, labeled for Resident #84, had an expiration date of 03/31/26;-An opened and in-use pen of Lantus (long-acting insulin used to treat diabetes), containing approximately 10 units, labeled for Resident #46, was not dated to show when staff opened the pen;-An opened stock bottle of arthritis pain relief acetaminophen (a medication used to treat pain) 650 mg had an expiration date of 06/2025; -An opened stock bottle of melatonin (a dietary supplement used to aid in sleep) had an expiration date of 12/2025. One white pill that was a different color and size was intermixed with the melatonin tablets.-An opened stock bottle of naproxen sodium (a medication used to treat inflammation and pain) 220 mg had an expiration date of 03/2025;-The expiration date on an opened stock bottle of acetaminophen 500 mg, containing seven tablets, was not clear to identify when the medication expired;-An opened stock bottle of acetaminophen 325 mg did not have an expiration date. 4. During an interview on 04/14/26 at 7:23 P.M., CMT B said the following:-He/She was unsure if anyone was specifically responsible for checking the medication carts and storage room for expired medications, but felt like everyone who used the medication carts and passed the medications should check for expired medications;-If a resident's medication was expired, staff were to remove the medication from the medication cart and put it in the nurses medication room to be sent back to pharmacy; -If an over-the-counter (stock) medication was expired, he/she felt staff should pull it from the medication cart or storage room and (continued on next page)

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	265433	A. Building B. Wing	04/16/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	put it on the counter in the CMT medication room for the Director of Nursing (DON) or charge nurse;-Anyone who used the cart was responsible for keeping the carts clean;-Staff's personal items should not be stored in the medication cart. During an interview on 04/14/16 at 7:20 P.M., Licensed Practical Nurse (LPN) L said the following:-All nurses who used the medication/treatment cart were responsible for checking for expired medications;-He/She was not sure what the process was for expired medications, but he/she would give them to the DON or Assistant Director of Nursing (ADON);-Everyone who used the medication carts were responsible for ensuring they were clean;-Staff should not store their personal items in the medication carts. During an interview on 04/16/26 at 10:45 A.M., the DON said the following: -The DON, ADON, all nursing staff who pass medications, and the pharmacists were responsible for checking the medication carts and storage rooms for expired medications; -The staff who used the medication carts were responsible to keep the carts clean and orderly;-Staff should not store their personal items in the medication carts. During an interview on 04/16/26 at 11:51 A.M., the consultant pharmacist said the following:-She was at the facility monthly and conducted spot checks of the medication rooms and medication carts;-She did not check every medication in the medication rooms and on the medication carts;-She did not check the stock medication room for expired medications;-It was ultimately the facility's responsibility to ensure there were no expired medications in the medication room, medication carts or in the stock medication room.

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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 follow current infection control standards for three residents (Resident #8, # 9 and #62) in a review of 18 sampled and three additional residents (Residents #7, #31, and #34). Staff failed to follow enhanced barrier precautions (EBP) by not wearing appropriate personal protective equipment (PPE) while providing personal care for Residents #34 and #7. Staff failed to perform hand hygiene and change gloves as indicated by facility policy while providing personal care for Residents #8, #9, #31 and #62. The facility census was 85.Review of the facility's policy Enhanced Barrier Precautions to Infection Control Guidance, last revised March 2024, showed the following:-The purpose is to prevent broader transmission of MDRO (multidrug-resistance organisms) and to help protect residents with chronic wounds;-Enhanced Barrier Precautions (EBP) should be implemented for the period of their stay or until wounds have been resolved;-The following residents require EBP, 3.Residents with a wound, regardless of their MDRO status;-Use EBP when providing high-contact resident care activities such as the following: 2.Transferring residents from one position to another; 3.Providing hygiene; 4.Changing bed linens; 5.Changing briefs or assisting with toileting;-Equipment needed- gown and gloves;-Conduct proper hand hygiene before starting care;-Gloves and donning and doffing of gown are required when conducting high-contact resident care activities that are listed above;- Residents with a wound or indwelling medical device AND excretions or secretions that are unable to be covered or contained and are NOT known to be infected or colonized with any MDRO should be placed on contact precautions unless or until a specific organism is identified;-Secretions or excretions include wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and pose an increase potential for environmental contamination and risk of transmission of a pathogen. Review of the facility's policy, Gloves, last revised March 2024, showed the following:-Wear gloves when it can be reasonably anticipated that hands will be in contact with mucous membranes, non-intact skin, any moist body substances (blood, urine, feces, wound drainage, oral secretions, sputum, vomitus, or items/surfaces soiled with these substances) and/or persons with a rash;-Gloves must be changed between residents and between contacts with different body sites of the same resident;-They should reduce the likelihood of contaminating the hands, but gloves cannot prevent penetrating injuries due to needles or sharp objects;-Dirty gloves are worse than dirty hands because microorganisms adhere to the surface of a glove easier than to the skin on your hands;-Handling medical equipment and devices with contaminated gloves is not acceptable. 1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/07/26, showed the following:-Dependent on staff for toileting hygiene and personal hygiene;-Always incontinent of bowel and bladder. -Always incontinent of bowel. Review of the resident's care plan, last revised 04/15/26, showed the following:-He/She required extensive assistance from staff with activities of daily living (ADL) care: dressing, toileting, and maintaining personal hygiene;-Provide incontinence care after each incontinence episode. Observation on 04/14/26 at 7:05 P.M. showed the following:-Certified Nurse Assistant (CNA) R and Nurse Assistant (NA) S entered the resident's room and put on gloves (no observation of hand hygiene prior to donning gloves);-CNA R removed the resident's urine- and feces-saturated Hoyer pad (mechanical lift pad used to transfer residents from one position to another), pants and incontinence brief and placed them in the clear trash and dirty linen bags placed at the foot of the bed;-NA S assisted the resident to turn to his/her left side;-The resident had a large, soft bowel movement that was dried to his/her skin;-CNA R cleaned the resident's bottom with disposable wipes;-CNA R removed his/her gloves, did not perform hand hygiene, and held the resident's hands as NA S removed the resident's shirt;-CNA R touched the doorknob of the resident's room and touched the clean linen cart in the hallway to obtain a clean gown for the resident;-CNA R and NA S attempted to place the (continued on next page)

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	265433	A. Building B. Wing	04/16/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown on the resident in which the resident refused, so NA S covered the resident with his/her blanket and then removed his/her gloves;-CNA R and NA S washed their hands;-CNA R carried the bags of dirty linens and trash to the soiled utility room, did not perform hand hygiene, then walked into the dining room and pushed another resident down the hall in a wheelchair to his/her room. During an interview on 04/14/26 at 8:20 P.M., NA S said he/she should change his/her gloves before and after care. He/She should wash his/her hands before and after care, before and after every task, and between dirty and clean tasks when providing care. During an interview on 04/14/26 at 8:30 P.M., CNA R said the following:-He/She should perform hand hygiene before going into a resident's room and when coming out of a resident's room;-He/She should have washed his/her hands after going from dirty to clean task and before and after glove change when providing care to the resident 2. Review of Resident #31's quarterly MDS, dated [DATE], showed the following:-Dependent on staff for toileting hygiene, upper body dressing and personal hygiene;-Required substantial/maximal assistance with roll left and right;-Always incontinent bladder and bowel. Review of the resident's care plan, dated 04/14/26, showed the following:-The resident was incontinent of bowel and bladder;-Provide incontinence care after each incontinent episode. Observation on 04/14/26 at 6:42 P.M. showed the following:-The resident lay in bed;-CNA P and Licensed Practical Nurse (LPN) GG entered the resident's room;-The resident was incontinent of urine and a moderate amount soft feces;-The front of the resident's gown was wet with urine;-CNA P wore gloves and performed frontal pericare;-CNA P and LPN GG rolled the resident to his/her left side;-The disposable incontinence pad under the resident was saturated with urine;-CNA P performed rectal pericare;-CNA P tucked the soiled incontinence pad under the resident's hips, and without changing gloves or washing his/her hands, placed a clean incontinence pad under the resident's hips and touched the resident's left knee to roll to his/her back in bed;-CNA P removed the resident's soiled gown;-Without changing gloves or washing his/her hands, CNA P placed a clean gown on the resident, placed a clean sheet on the resident, and handed the resident the bed remote;-CNA P removed his/her gloves, and without performing hand hygiene, covered the resident with a blanket and handed the resident pillows and stuffed animals. 3. Review of Resident #62's care plan, dated 03/17/26, showed the following:-The resident needed assistance with ADLs (e.g. toileting and maintaining personal hygiene);-Assist daily and as needed with hygiene needs;-Provide incontinence care after each incontinent episode. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Dependent on staff for toileting hygiene;-Required partial/moderate assistance for roll left and right;-Always incontinent of bowel and bladder. Observation on 04/14/26 at 7:12 P.M., showed the following:-The resident lay in bed and was soiled with urine and a liquid feces; -Without performing hand hygiene, CNA P put on gloves;-CNA P performed frontal pericare and assisted the resident to roll to his/her left side;-CNA P performed rectal pericare;-CNA P tucked the resident's soiled incontinence brief under his/her hips, and without changing gloves or washing his/her hands, CNA P put a clean incontinence brief under the resident's hips, assisted the resident to roll to his/her back, touched the resident's right hip and shirt and repositioned the clean incontinence brief under the resident's hips. CNA P fastened the incontinence brief, placed a pillow under the resident's head, covered the resident with a sheet and lowered the resident's bed. During an interview on 04/14/26 at 8:12 P.M., CNA P said the following:-He/She usually used alcohol-based hand rub (ABHR) prior to applying gloves and washed his/her hands after he/she removed his/her gloves;-He/She should change his/her gloves and perform hand hygiene after performing pericare and prior to touching clean items. 4. Review of Resident #8's quarterly MDS, dated [DATE], showed the following:-Dependent on staff for toileting hygiene and personal hygiene;-Always incontinent of bladder. Review of the resident's care plan, last revised 03/25/26, showed the following:-He/She received antibiotic therapy for urinary tract infection (UTI);-He/She required staff assistance for ADL care: dressing, toileting and maintaining personal hygiene;-He/She was incontinent of bowel and bladder. Observation on 04/14/26 at 8:03 P.M. showed the following:-Nurse Aide (NA) N and Certified Nurse Assistant (CAN) R put on gloves and entered the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's room (no observation of hand hygiene prior to donning gloves); -NA removed the resident's shirt and cleaned under the resident's breasts;-NA N removed the resident's urine-saturated incontinence brief and provided frontal perineal care for the resident;-NA N did not remove his/her gloves and assisted CNA R to turn the resident to his/her left side;-NA N cleaned the resident's bottom; -NA N tied the soiled linen bag and removed his/her gloves;-NA N carried the soiled linen and trash bags to the soiled utility room down the hall and then used the hand sanitizer in the hallway to perform hand hygiene. During an interview on 04/14/26 at 8:25 P.M., NA N said he/she should perform hand hygiene before and after providing care and between dirty and clean tasks when providing care. 5. Review of Resident #34's physician's orders, dated March 2026, showed the following;-Diagnosis of an open wound to his/her left lower leg;-Wound treatment: cleanse area with cleanser of choice, apply skin prep (protective barrier wipes) to peri wound (skin immediately surrounding a wound), apply collagen powder (a bioactive topical wound dressing that promotes healing) to wound bed, cover wound bed with maxorb AG (a highly absorbent, antimicrobial/alginate dressing), cover with self-adhesive foam dressing once daily. Review of the resident's care plan, last revised 03/10/26, showed the following:-The resident had an ulcer on his/her left ankle;-The resident had a wound which required EBP signage to be placed on the door to inform staff that EBP was required;-Staff to utilize EBP while providing care to the resident. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment tool to be completed by the facility, dated 03/20/26, showed the resident had a stage III pressure ulcer (Full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) present on admission. Observation on 04/13/26 at 4:15 P.M. of the residents' door showed the following:-EBP signage was posted on the resident's door that directed staff to apply a gown and gloves with high-contact resident care activities;-No disposable gowns and gloves were on the door or outside the resident's room. Observation on 04/14/26 at 1:45 P.M., showed the following:-Registered Nurse (RN) A wore gloves, did not wear a gown, and provided incontinence care for the resident and changed the resident's urine-soiled bed sheet;-The resident had a dry dressing on his/her left ankle. During an interview on 04/20/26 at 3:30 P.M., RN A said the following:-He/She did not wear a gown when he/she provided incontinence care and changed the resident's sheet;-He/She only wears a gown and gloves when performing wound care to the resident. Observation on 04/14/26 at 6:27 P.M., showed the following:-The Assistant Director of Nursing (ADON) entered the resident's room and put on gloves;-The ADON did not wear a gown;-He/She assisted the resident to dress in a gown, removed his/her gloves, left the room, returned to the room with two clear bags, put on gloves, picked up the resident's shirt from under the bed and put it in a clear bag; -He/She removed his/her gloves and put them in the trash, removed the bag from the trash can, tied the bag, put a new bag in the trash can and left the room. During an interview on 04/22/26 at 6:30 A.M., the ADON said the following:-Staff should wear a gown and gloves when providing direct patient care/contact for any resident with a wound;-She was not sure if she should wear a gown when putting a gown on the resident; she did not consider that enough direct contact. 6. Review of Resident #7's significant change MDS, dated [DATE], showed the following:-Cognitively intact;-Dependent on staff for toileting hygiene;-Required partial to moderate assistance for roll left and right;-One unhealed pressure ulcer (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction). Review of the resident's care plan, revised 04/13/26, showed the following:-The resident has an open area to his/her right lower extremity;-Use EBP precautions;-Currently, on antibiotics for treatment of cellulitis (deep inflammation of the tissues just under the skin, caused by infection) of the right lower extremity. Observation on 04/15/26 at 11:05 A.M., showed the following:-An EBP sign directing staff to apply gown and gloves with high-contact care activities hung on the resident's room door;-The resident lay awake in bed and was incontinent of urine;-The resident had a wound dressing on his/her right lower leg; -NA I and CNA BB entered the resident's room, put on gloves, and did not put on a (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown; -NA I performed peri-care for the resident;-NA I and CNA BB dressed the resident and transferred the resident from the bed to the wheelchair with the mechanical lift. During an interview on 04/15/26 at 11:30 A.M., NA I and CNA BB said the following:-The EBP sign on the resident's door was for another resident;-The resident didn't have any open wounds. During an interview on 04/15/26 at 11:30 A.M., the resident Licensed Practical Nurse (LPN) G was the only staff who wore a gown when providing his/her care. 7. During an interview on 04/16/26 at 3:49 P.M., the Director of Nursing (DON) said the following:-Staff should perform hand hygiene after providing perineal cares and before touching a clean surface;-Staff should perform hand hygiene between glove changes.-Staff should wear a gown when providing personal care or any high contact resident care for a resident requiring EBP and who had a wound.

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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 interview and record review, the facility failed to treat one resident (Resident #8), in a review of 18 sampled residents, with dignity and respect when staff told the resident to urinate and defecate in his/her incontinence brief. The facility census was 85.Review of the facility's undated policy, Resident Rights, showed the following:-It is the purpose of this facility to meet the Federal and State Mandate in respect to resident rights;- The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility;-A facility must protect and promote the rights of each resident;-Resident Rights are to be fully respected and adhered to. 1. Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment tool to be completed by facility staff, dated 03/17/26, showed the following:-Moderately impaired cognition;-Dependent on staff for toileting hygiene;-Always incontinent of bowel and bladder. Review of the resident's care plan, last revised 03/25/26, showed the following:-He/She required staff assistance for activities of daily living (ADL) care: for example (e.g.), transfers and toileting;-He/She was incontinent of bowel and bladder. During an interview on 04/13/26 at 12:15 P.M., the resident said the following:-Staff used to take him/her to the bathroom in the hall to have a bowel movement, and now staff want him/her to go on a bed pan or in his/her incontinence brief;-When staff ask him/her to go in his/her incontinence brief, they leave him/her wet/dirty for long periods of time and do not come to check or change him/her frequently;-He/She preferred to go to the bathroom on the to the toilet rather than going in his/her incontinence brief;-He/She had a hard time having a bowel movement lying down; it was much easier when he/she sat on the toilet;-When staff tell him/her to go to the bathroom in his/her incontinence brief, it made him/her feel like nobody cared. During an interview on 04/15/26 at 1:07 P.M., Certified Nurse Assistant (CNA) X said the following:-The resident required a hoyer lift (mechanical lift) for transfers, so it was difficult to get him/her up to the toilet; -It helped the resident have a bowel movement if he/she sat on the toilet, because he/she had constipation; -Staff sometimes used the hoyer lift to put the resident in the shower chair/commode because it was easier for the resident to use the bathroom when he/she sat upright; -The resident asks staff to get him/her up to use the toilet, and we remind him/her to go in his/her incontinence brief, because he/she cannot walk and he/she will usually get distracted and start talking about his/her family member. During an interview on 04/15/26 at 1:10 P.M., Licensed Practical Nurse (LPN) M said the following:-The resident preferred to sit to have a bowel movement;-When Hospice was at the facility, Hospice staff put the resident in a shower chair, and the resident used the commode to go to the bathroom;-He/She tells the resident, You can go to the bathroom in your brief. You have a brief on.-No one had ever instructed him/her not to get the resident up to go to the bathroom. During an interview on 04/15/26 at 10:25 A.M., the Hospice nurse said when Hospice staff got the resident up in the shower chair, the resident used the bathroom on the commode. During interviews on 04/16/26 at 12:20 P.M. and 3:49 P.M., the Director of Nursing (DON) said the following:-She expected staff to treat the residents with dignity and respect;-She should not tell Resident #8 to have a bowel movement in his/her incontinence brief or on a bed pan if the resident preferred to use the toilet and was capable of doing so.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to follow facility policy for notifying the physician and resident representative when one resident (Resident #88) had a change in condition. The facility census was 85.Review of the undated facility policy, Condition Change, Resident, showed the following: -Purpose: To observe, record and report any condition change to the attending physician so that proper treatment can be implemented;-Guidelines:1. After all resident changes in physical or mental function, monitor the following: -Observe and inquire if resident has pain. -Observe for personality changes. -Observe for alterations in consciousness. -Observe for generalized weakness. -Observe for gait, posture or balance disorder. -Take vital signs and include temp. -Observe for abdominal pain. -Observe for dyspnea (shortness of breath) or variations in respiration (irregular).2. Have someone stay with the resident while the nurse is calling the attending physician, if necessary. If you are unable to reach the attending physician or the physician on call, call the facility medical director for emergency situations.3. Notify resident's responsible party.4. Monitor resident's condition frequently until stable.5. Notify physician of condition change, need for treatment orders and/or medication order changes. 1. Review of Resident #88's undated face sheet showed the following:-His/Her family member was his/her representative;-Diagnoses included hypotension (abnormally low blood pressure (BP). Review of the resident's care plan, last revised 01/18/26, showed the following:-He/She was able to perform activities of daily living (ADL) care most of the time without assistance;-Monitor for presence of pain/intolerance during self-care;-Report any further deterioration in status to physician. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment tool to be completed by facility staff, dated 02/03/26, showed the following:-Moderately impaired cognition;-Did not use oxygen and did not have shortness of breath;-Occasional pain in past five days;-Independent with walking and transfers. Review of the resident's physician order sheet (POS), dated February 2026, showed the following:-Blood pressure weekly per physician; once a day on Monday;-Midodrine tablet, 10 milligram (mg) for hypotension. Hold for systolic (the top number reading) blood pressure (BP) greater than 140 (normal range is 90 - 120); three times a day: 6:00 A.M.-10:00 A.M., 11:00 A.M.- 2:00 P.M., 7:00 P.M.-10:00 P.M. Review of the resident's medication administration record (MAR), dated February 2026, showed the following:-On 02/23/26 (6:00 A.M. - 10:00 A.M.), CMT Y documented the resident's BP as 96/50 (LOW); -On 02/24/26 (6:00 A.M. - 10:00 A.M.), CMT Y documented the resident's BP as 96/49 (LOW).-On 02/24/26 (11:00 A.M. - 2:00 P.M.), CMT Y documented the resident's BP as 86/43 (LOW); -On 02/24/26 (7:00 P.M. - 10:00 P.M.), CMT Z documented the resident's BP as 88/66 (LOW); (Staff administered the resident's midodrine as ordered on 2/23/25 and 2/24/25.) Review of the resident's progress note, dated 02/25/26 at 1:05 A.M., showed on 02/24/26 at 7:30 P.M., Licensed Practical Nurse (LPN) T stepped inside the resident's room and asked the resident what he/she needed. The resident's friend said, I'm concerned about his/her condition. I have been here since 11:00 A.M. and have watched his/her decline since I've been here. He/She is complaining of shortness of breath, increase in pain, not being able to swallow, and I know he/she had a temperature, but I had nothing to check it. LPN T explained the day shift nurse called the physician and left a message, and the physician had not returned their call. LPN T checked the resident's vital signs and BP was 128/94, pulse 102 (normal range is 60-100), respirations 24 (normal range is 12-19) and oxygen saturation (02 sat) was 84 percent (%) on room air (normal range is 95-100%). Staff took an oxygen concentrator to the resident's room and started the resident on 2 liters (L) of oxygen. Review of the resident's electronic medical record showed no documentation the day shift nurse attempted to contact the resident's physician as LPN T indicated in his/her note on 02/25/26 at 1:05 A.M. Review showed no documentation LPN T contacted the resident's representative or physician regarding the resident's change in condition on 02/24/26 at 7:30 P.M. Review of the resident's progress note, dated 02/25/26 (continued on next page)

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	265433	A. Building B. Wing	04/16/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1:38 A.M., showed LPN T documented on 02/24/26 at 8:15 P.M., LPN T checked the resident's oxygen level which was 90% until the resident started talking, and it dropped to 87%. LPN T explained to the resident he/she still needed the oxygen. LPN T documented he/she would check on the resident later. Review of the resident's progress note, dated 02/25/26 at 4:29 A.M. showed LPN T documented on 02/25/26 at 12:00 A.M., the resident's family representative called stating the resident needed to go to the bathroom but could not get up. Staff went to help the resident. The resident had been up walking, able to get himself/herself out of bed and go to the bathroom on his/her own. The resident was now unable to stand by himself/herself. It took two to three staff to walk with him/her, telling him/her to pick up his/her feet and he/she was totally bent at the waist with his/her head pointed towards the floor. Staff had to get a wheelchair to take the resident to the bathroom and put him/her on the toilet. The resident was leaning over to the left with his/her hand almost on the floor to hold himself/herself up. The resident's color remained pale, 02 sat 81% and he/she was asking for his/her parent. Medical group notified (the note was not clear to show who staff notified). Review of the resident's medical record showed no documentation staff notified the resident's representative of the resident's change in condition. Review of the resident's MAR, dated February 2026, dated 02/25/26 (6:00 A.M. - 10:00 A.M.), showed CMT U documented the resident's BP as 53/32 (LOW). Review of the resident's medical record showed no documentation staff notified the charge nurse or the resident's physician when the resident's blood pressure was low. During an interview on 04/16/26 at 1:20 P.M., CMT U said the following:-He/She was sure he/she reported the resident's low blood pressure reading of 53/32 to the charge nurse (LPN G);-If he/she gets a reading that is low, he/she took the blood pressure a few times to verify accuracy and would have reported it to the nurse. Review of the resident's progress note, dated 02/25/26 at 2:24 P.M., showed LPN G documented staff assessed the resident multiple times throughout the shift. The resident maintained alertness within normal limits (WNL) of baseline. At approximately 12:00 P.M., he/she was made aware CMT U was unable to get the resident's blood pressure. LPN G assessed the resident and was able to get a faint blood pressure of 108/58. When going to document the blood pressure, he/she saw CMT U charted a lower blood pressure earlier in the shift and had not made his/her aware of the blood pressure. CMT U at approximately 1:00 P.M. administered midodrine. The resident's oxygen saturation was at 88% on 2L at that time. Increased the resident's oxygen to 4L and resident's oxygen saturation increased to 94%. Temperature was 97.9 degrees Fahrenheit (normal range is 97.9-99.1 degrees Fahrenheit), pulse was 72, and respirations were 18. The resident remained cognitively at baseline, reported feeling weak and tired. Lung sounds clear (normal is clear) to auscultation (a diagnostic method to listen to internal body sounds - primarily heart, lungs, and intestines - using a stethoscope), no cough, and no outward shortness of breath (SOB). The resident had +1-2 bilateral lower extremity (BLE) edema (excessive accumulation of fluid in the tissue that causes swelling) noted. Call placed to the nurse practitioner (NP) and new order received for labs and STAT (immediate) chest x-ray (CXR). The NP came to the facility at approximately 1:20 P.M. to assess the resident. NP was unable to accurately hear the resident's blood pressure at that time. New order to send the resident to the hospital. Phone call placed to the resident's family representative to make aware. Emergency medical technician (EMT) arrived and transferred the resident to the hospital. During an interview on 04/16/26 at 1:15 P.M., LPN G said the following:-He/She was the charge nurse on 02/25/26;-CMT U did not notify him/her of the resident's low blood pressure reading from that morning;-He/She expected CMT U to have told him/her about the low blood pressure reading because he/she would have notified the physician/nurse practitioner sooner. During an interview on 04/16/26 at 1:30 P.M., the resident's family representative said the following:-Staff did not notify him/her of the resident's decline;-The resident called him/her at 12:00 A.M. (on 02/25/26) stating he/she was unable to get up; -He/She had a close friend who was at the facility visiting the resident, and he/she was the one who told him/her everything that was going on; the facility did not notify him/her of anything. During an interview on 04/16/26 at 3:49 P.M., the Director of Nursing (DON) said the following:-Staff should (continued on next page)

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	265433	A. Building B. Wing	04/16/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify the physician immediately as soon as they are made aware of a change in condition; -She expected staff to notify the resident's representative if the resident had a change in condition. During an interview on 04/16/26 at 1:23 P.M., the resident's Nurse Practitioner (NP) said the following:-Staff notified her by phone (on 2/25/26) regarding the resident's low blood pressure and the inability to obtain a blood pressure reading. She ordered labs and a STAT chest x-ray, then immediately went to the facility to assess the resident and was unable to obtain a blood pressure reading. She sent the resident to the hospital immediately for evaluation;-She would have expected staff to notified him/her sooner with the previous low blood pressure reading (obtained on 02/25/26 during the 6:00 A.M. to 10:00 medication pass).

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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 to implement a hydration program, including offering fluids to one resident (Resident #37), who required extensive assistance with drinking, in a review of 18 sampled residents, to ensure adequate hydration and failed to develop a plan of care to address the resident's need for assistance to drink. Resident #37 had dry lips and frequently requested water/fluids to drink. The facility census was 85.Review of the facility's undated policy, Hydration, showed the following:-Each resident is supplied with sufficient fluid intake to maintain proper hydration;-Fresh water is distributed each shift, pitchers and glasses are within reach of the resident and residents who are unable to pour and drink independently will be given assistance by the staff.;-Guidelines--Assess the resident's need to be on hydration program. The following conditions should be considered: -Recurrent urinary tract infections or other infections -Dehydration -Total dependence -Other conditions at discretion of the nurse;-Consider offering fluids according to the examples below: -On arising - 120 cc water -Breakfast - 400 cc fluid -Mid-morning - 240 cc fluid -Lunch - 400 cc fluid -Mid Afternoon - 120 cc fluid -After nap - 240 cc fluid -Supper - 400 cc fluid -Bedtime- 240 cc fluid -During night offer 120cc every two hours, if awake 1. Review of Resident #37's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 03/13/26, showed the following:-Cognitively intact;-Moderately impaired vision;-Independent with eating. Review of the resident's care plan, revised 04/07/26, showed the following:-The resident had an order for a regular diet with thin liquids;-The resident liked to eat most meals in his/her rooms;-Obtain dietary consult and follow recommendations;(The resident's care plan did not include the type of assistance the resident required for fluid intake.) Observation on 04/13/26 at 1:35 P.M., showed the following:-An unknown staff member sat the resident's lunch tray on his/her bedside table; -The resident's lips and oral mucosa appeared dry;-The resident said, my mouth is dry; -The resident's water pitcher was out of his/her reach; -The unknown staff member left the resident's room and did not offer the resident any fluids. Observation on 04/13/26 at 3:55 P.M., showed the following:-The resident lay in bed;-The resident's lips appeared dry;-The resident's water pitcher sat on his/her bedside table, not within the resident's reach. Review of the resident's Comprehensive Nutrition Assessment, completed by the Registered Dietitian, dated 04/14/26, showed the following:-The resident's ability to eat/drink: extensive assistance;-Total fluids required: 1540 milliters (mL) fluid;-Staff to anticipate needs. Observation on 04/14/26 at 8:35 A.M., showed the following:-The resident lay awake in bed;-The resident's lips were dry with dried purple-brown debris on them;-The resident's water pitcher sat on his/her bedside table, not within the resident's reach. Observation on 04/14/26 at 12:58 P.M., showed the following:-The resident lay awake in bed;-His/Her mouth appeared dry;-A water pitcher sat on the resident's bedside table, not within the resident's reach. Observation on 04/14/26 at 6:11 P.M., showed the following:-The resident lay awake in bed;-The resident's lips and oral mucosa were dry;-A water pitcher sat on the resident's bedside table, not within the resident's reach. Observation on 04/15/26 at 10:41 A.M., showed the following:-The resident's roommate's call light was on;-The resident lay awake in bed;-The resident yelled, Can I have some water?, I want some water;-The resident's lips and oral mucosa appeared dry;-A water pitcher sat on the resident's bedside table, not within the resident's reach;-The resident said, I want some water. My mouth is dry. Observation on 04/15/26 at 11:05 A.M., showed the following:-The resident lay in bed awake;-The resident's lips and oral mucosa appeared dry;-NA I and Certified Nurse Assistant (CNA) BB provided care for the resident's roommate (Resident #7);-Neither NA I nor CNA BB offered the resident fluid;-A water pitcher sat on the resident's bedside table, not within the resident's reach. During an interview on 04/14/26 at 8:57 A.M., the resident's family member said the following:-The resident liked to drink a great deal of water;-The resident couldn't take drinks without assistance;-He/She expected staff to offer the resident fluids frequently. 2. During an interview on 04/15/26 at 8:20 A.M., NA I said the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following:-The resident was unable to use his/her call light and staff must anticipate his/her needs;-The resident hollered out or moaned when he/she wanted a drink. During an interview on 04/14/26 at 12:58 P.M., CNA CC said the following:-The resident required staff to give him/her fluids;-Staff should offer water every time they were in the resident's room. During an interview on 04/16/26 at 11:25 A.M., Licensed Practical Nurse (LPN) G said the following:-The resident was at risk for dehydration and needed staff assistance with fluid intake;-Staff should anticipate the resident's needs as the resident was unable to use his/her call light to ask for staff assistance;-Staff should offer the resident fluids frequently. During an interview on 04/16/26 at 3:49 P.M., the Director of Nursing (DON) said the following:-She expected staff to offer water to residents frequently; -She should offer fluids every time they entered a room or more frequently if a resident, like Resident #37, was yelling out that he/she needed water.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a system to identify and communicate trauma-informed services for one resident (Resident #6), who had a diagnosis of post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events), in a review of 18 sampled residents, to mitigate or eliminate triggers that may cause re-traumatization. The facility census was 85. The facility did not provide a policy related to trauma-informed care. 1. Review of Resident #6's Preadmission Screening and Resident Review (PASRR, a federally mandated process requiring all applicants to Medicaid-certified nursing facilities be screened for serious mental illness and/or intellectual disability/developmental disability before admission)/Mental Illness (MI) Level II Evaluation, dated 04/29/24, showed the following:-admitted to the facility on [DATE];-Diagnoses of major depressive disorder, anxiety, and PTSD;-The resident reported he/she was molested as a child;-The resident reported he/she had bad anxiety and depression that started 10 years ago;-The resident reported feelings of hopelessness, sadness, and anxiety that began at the time;-The resident had suicidal thoughts in the past two years with thoughts of wanting to drive off a cliff after his/her family member passed away;-The resident reported loss of energy/motivation, avoids uncertainty/making decisions, and has diminished pleasure from daily activity;-The resident needs or continues to need the following supports and services: monitoring of behavioral symptoms, trauma-informed services and tools of choice or other positive behavioral support services. Review of the resident's Mental Status Exam (completed by the psychiatrist), dated 04/25/25, showed the following:-The resident reports he/she was feeling depressed and anxious and did not want to be in the facility but stated he/she was homeless, had medical issues including hip pain, and he/she was not sleeping very good;-The resident stated sometimes he/she feels suicidal but has no plan and stated he/she feels worthless. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/13/26, showed the following:-Cognitively intact;-Diagnoses of anxiety, depression and PTSD. Review of the resident's care plan, revised 03/31/26, showed the following:-The resident was at risk for adverse consequences related to receiving antipsychotic medication for treatment of PTSD;-Monitor behavior and response to medication;-Assess/record effectiveness of medication treatment;-Attempt non-pharmacological measures as outlined: reduce noise/stimulation, use validation therapy, encourage light exercise;-Pharmacy consultant review per facility policy and procedure and as needed if deemed appropriate;(Review of the resident's care plan showed no documentation regarding the resident's PTSD triggers or interventions to prevent the resident from experiencing further re-traumatization related to his/her diagnosis of PTSD.) During an interview on 04/15/26 at 3:37 P.M., the resident said the following:-He/She was abused and molested by his/her family member as a child;-He/She was very depressed and lonely;-He/She ate in his/her room and stayed in his/her room except when going outside to smoke; -None of the medications helped his/her depression or anxiety; During an interview on 04/16/26 at 11:25 A.M., Licensed Practical Nurse (LPN) G said the following:-He/She was unsure if the resident had a history of PTSD;-He/She was not aware of an assessment nurses were to complete for residents with PTSD or past trauma;-If a resident had a history of PTSD or past trauma, it should be included in the resident's care plan. During an interview on 04/16/26 at 2:01 P.M., the MDS/Care Plan Coordinator said the following:-She was new to completing MDS and care plans;-PTSD history and PASSR information should be included in the resident's care plan. During an interview on 04/16/26 at 8:40 A.M., the Social Service Designee said the following:-The resident had a history of PTSD on admission to the facility, so he/she arranged for the resident see a psychiatrist;-She did not complete an assessment for residents with a history of PTSD or past trauma; she just set up for the psychiatrist to see the residents; -She didn't realize the resident was abused in the past. During an interview on 04/16/26 at 3:49 P.M., the Director of Nursing (continued on next page)

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

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the following:-The admission nurse was responsible for assessing the resident for trauma on admission, and the MDS Coordinator and Social Services should follow up;-PASSR information and a diagnosis of PTSD should be addressed on the resident's care plan;