STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265481	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pin Oaks Living Center	1525 West Monroe Mexico, MO 65265

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of practice when staff failed to complete an assessment and documentation or obtain physician orders for treatment related to a fall with injury for one additional sampled resident, (Resident #10) in a review of 11 sampled residents. The facility census was 88. Review of the undated facility policy, Resident Condition Change, showed the following:-Purpose: To observe, record and report any change to the attending physician so that proper treatment can be implemented;-After a resident falls, injuries or changes in physical or mental function, monitor the following: -a. Observe for lacerations. If present, clean and apply dry, sterile dressing or dressing of physician's choice. Note size, depth and amount of bleeding or drainage;-b. Observe for swelling and discoloration, if present, chart size, site, amount and color;-d. Observe and inquire if resident has headache or pain;-k. Observe for gait, posture or balance disorder;-n. Take vital signs and include temperature;-3. Complete an incident, accident or risk management report per facility guidelines;-4. Notify resident's responsible party;-6. Notify physician of condition change, need for treatment orders and/or medication order changes. 1. Review of Resident #10's undated Continuity of Care Document showed the following: -admission on [DATE];-Diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness or paralysis of one side following a stroke). Review of the resident's baseline care plan, dated 09/17/25, showed the following: -Cognition - confused; -Communication - verbal;-Interventions - monitor condition and report changes to Director of Nursing (DON)/physician as applicable;-Safety concerns - unsteady/unsafe independent transfers;-Bowel and bladder - always incontinent. Review of the resident's electronic health record showed the following:-A neurological assessment flow sheet documented by LPN J on 09/18/25 at 6:15 P.M.;-No documentation of a fall event for 09/18/25;-No documentation in the resident's nursing progress notes of a fall or treatment of any injuries related to a fall on 09/18/25;-No physician orders for treatment of an injury related to a fall on 09/18/25;-No evidence of notification of physician or responsible party related to a fall on 09/18/25. Review of the resident's undated Continuity of Care Document showed the resident discharged from the facility on 09/22/25. During an interview on 09/24/25 at 1:50 P.M., the resident's responsible party said the following: -The resident told him/her and the resident's sibling he/she fell while at the facility when taking himself/herself to the bathroom and had to get himself/herself up off the floor; -When the resident discharged to home, the resident had a bruise on his/her wrist and skin tears on his/her elbows and knee from the fall that had been treated with butterfly (an adhesive bandage to close a wound or flap) bandages; -The facility did not notify him/her of the fall or injuries requiring treatment. Review of the resident's electronic health record, safety event for fall report, dated 10/02/25 (11 days after discharge), documented by the Registered Nurse (RN) Educator, showed the following: -Description: fall in room;-Was fall witnessed? No, must begin 72-hour neurological checks per protocol and document appropriately;-Body observation - location of injury was left blank;-Notifications: attending faxed - no, physician notified - no, resident representative notified - no, care plan reviewed - no. During an interview on 11/18/25, at 1:03 P.M., Licensed Practical Nurse (LPN) D said the following: -He/She was not working when the resident fell but noticed neurological checks were started on the resident and had heard the resident had fallen;-With any resident fall, there should be documentation as well as a progress note, and any orders written if necessary;-With any condition change, the physician and responsible parties should be notified. During an interview on 11/22/25 at 8:31 P.M., LPN J said the following: -He/She was assigned to the resident's unit for a short period of time until another staff member (Registered Nurse F) took over;-He/She did not specifically recall the resident falling;-If he/she started the neurological checks, it would have been for an unwitnessed fall or for a fall with a head injury;-He/She did not specifically recall treating the resident for a skin tear;-If a resident has a fall, the normal procedure was to complete an assessment and nursing note, complete a fall event, notify the physician, notify the responsible party and notify the DON;-He/She only covered the unit for a short period of time and would have passed on to the oncoming nurse the event details; he/she did not complete any of the steps of facility procedure following the resident's fall; -The oncoming nurse should have made a nursing note at the minimum due to completing the neurological checks;-He/She would have passed on in report the need for the neurological checks and would have assumed the nurse taking over would have completed the nursing note, fall event form, notified the physician, notified the responsible party and DON. During an interview on 11/18/25 at 4:30 P.M., RN E said the following: -He/She did not specifically recall