STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265618	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hampton Place	4700 Brandon Woods Columbia, MO 65203

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to prevent a fall with major injury by not ensuring staff provided protective oversight for one resident (Resident #1) out of one sampled resident during a shower and failed to use a gait belt (a canvas belt placed around the resident's waist to assist with ambulation and transfers) during a transfer for one resident (Resident #4) out of one sampled resident. The facility census was 69.The administrator was notified on 09/22/25 of past Non-Compliance which occurred on 09/20/25 when the administrator implemented a new intervention to monitor the resident while showering. Staff were in-serviced on 09/20/25 and 09/21/25 regarding the new intervention.1. Review of the facility's Skilled Fall Policy, dated 05/2005, showed the purpose of the Fall Program is to develop, implement, observe and evaluate an interdisciplinary approach and mange strategies and interventions that foster resident independent and quality of life. The community shall ensure that the Fall Program is maintained to reduce the occurrence of falls, reduce risk of injury, and promote independence and safety. Each resident residing at this facility will be provided services and care that ensures that the resident's environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. [NAME] resident will be assessed for the casual risk factors for falling at the time of admission/readmission, change of condition, quarterly and after every fall in the community.2. Review of Resident #1's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool, dated 07/19/25, showed staff assessed the resident as moderate cognitive impairment, lower extremity impairment on one side, required supervision or touching assistance from staff for showers and ambulating with a wheeled walker, and did not contain documentation of a fall since admission.Review of the resident's diagnoses record, undated, showed the resident had a diagnosis of Parkinson's Disease, history of falling, requires assistance with personal care, and other abnormalities of gait and mobility.Review of the resident's care plan, revised 09/20/25, showed staff documented the resident had a self-care deficiency with Activities of Daily (ADL)'s, resident chooses not to have assistance with showers which increases his/her risk for falls, ambulated with a wheeled walker with staff supervision, required staff participation to reposition and turn in bed, and required staff participation with personal hygiene and oral care.Review of the resident's progress notes, dated 09/20/25, showed staff documented the resident on the shower room floor. Staff documented resident was unable to move his/her arm and complained of pain, so staff sent him/her to the emergency room.Review of the resident's hospital paperwork, dated 09/20/25, showed the resident diagnosed with a fracture of his/her left pelvis and a fracture of his/her left shoulder.During an interview on 09/22/25 at 12:06 P. M., the resident said staff allowed him/her to shower by himself/herself. He/She said staff told him/her staff will now be in the shower room with him/her. He/She said he/she did not have a preference on whether a female or male staff member was in the shower room with him/her when he/she showered. He/She said he/she did not recall if he/she cared if a staff member was in the shower room with him/her prior to the fall in the shower room.During an interview on 09/22/25 at 12:08 P.M., Certified Nurse Aide (CNA) G said the resident refused to allow anyone in the shower with him/her, so staff did not stay in the shower room or monitor the resident while the resident showered. He/She said he/she was in-serviced after the resident fell to remain in the shower room while the resident showered. During an interview on 09/22/25 at 12:20 PM, Registered Nurse (RN) D said the resident was not independent with showers and should have been supervised during showers. He/She said he/she did not know staff left the resident unattended during showers. During an interview on 09/22/25 at 1:08 P.M., the administrator said the resident was a private and independent person, so there was not a staff member constantly present in the shower room with him/her. He/She said staff were following his/her request to have privacy while in the shower room. He/She said staff did periodically check on the resident while he/she was in the shower room. He/She said staff thought standing outside the door was protective oversight. The administrator said the resident will now be supervised while in the shower.During an interview on 09/22/25 at 1:09 P.M., the Director of Nursing (DON) said the resident preferred to have privacy while in the shower, so staff left him/her unattended while in the shower room. The DON said the resident told him/her, he/she did not want staff in the shower room with him/her. He/She said staff did check on the resident while in the shower room and they stood outside the closed door while he/she showered, so he/she believed staff were providing protective oversight. He/She said the resident will now be supervised during showers. 3. Review of Resident #4's admission Sheet, dated

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, facility staff failed to ensure two Nurse Aides (NA)'s (NA B and NA C) out of three sampled NAs completed the required nurse aide training program within four months of employment in the facility. The facility census was 69.1. Review showed the facility did not provide a policy in regard to requirements for NA's training program completion within four months of employment. 2. Review of NA B's personnel file showed a hire date of 04/08/25. The file did not contain documentation the NA completed the required nurse aide training program. 3. Review of NA B's personnel file showed a hire date of 04/14/25. The file did not contain documentation the NA completed the required nurse aide training program. During an interview on 09/22/25 at 10:56 A.M., Registered Nurse A said he/she was responsible to conduct the nurse aide training courses. He/She said nurse aides are required to be certified within three months. He/She said there was a period when the facility was not permitted to provide nurse aide training classes, since the facility lost their license from April until August. RN A said he/she did not know if the administration reached out to find other available classes. He/She said he/she met with the Director of Nursing (DON) weekly to discuss the status of each nurse aide in the program, but did not meet during the timeframe when the facility did not offer classes. He/She said the DON was responsible to ensure nurse aides were certified within the three months.During an interview on 09/22/25 at 12:20 P.M., RN D said NA's are required to be certified within three months of working at the facility. He/She the NA's are not allowed to work the floor after the three months if he/she was not certified.During an interview on 09/22/25 at 1:08 P.M. the administrator said NA's are required to be certified within one hundred and twenty days from the first date of employment. He/She said RN A conducts the classes and training and then discuss the status of the NA's with the DON. He/She said the facility did not provide classes from April to June, but he/she did not know what the facility was doing for the NA's during that time since he/she did not work at the facility. He/She said NA B and NA C were not certified, but still providing direct care after the one-hundred-and-twenty-day period. He/She said he/she did not know the staff were not certified but should not have been providing care until they were certified.During an interview on 09/22/25 at 1:09 P.M. the DON said NA's are required to be certified within one hundred and twenty days from the first day of employment. The DON said he/she met with RN A to go over the start dates and classes. The DON said he/she and RN A are responsible to ensure staff are certified, but there have been issues with classes. He/She said the facility was not able to conduct classes for about three weeks. He/She said the corporate office was supposed to get the NA's signed into courses at a different location. He/She said NA B and NA C were not certified but were providing direct care after the one hundred and twenty days of employment. He/She said he/she should not have been providing care for the residents when they were not certified after one hundred and twenty days. He/She said he/she was looking at terminating the NA's for not attending classes.Complaint #2615926