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	03/03/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, interview, and record review, facility staff failed to prevent the misappropriation of money from one resident's (Resident #1's) credit card when Nurse Aide (NA) A used the resident's credit card without permission for his/her personal use. The facility census was 82.1.Review of the facility's, Abuse, Prevention and Prohibition Policy, dated 03/2025, showed the owner, licensee, administrator, employee, or agent of the facility prohibit the misappropriation of resident property. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/25/26, showed staff assessed the resident as cognitively intact with an admission date of 09/15/22. Review of the resident's online bank statement, dated 02/21/26, showed an unauthorized transaction of $145.76 at a Computer Repair store. Review of a photo from the computer shop, undated at 10:44 A.M., showed Nurse Aide (NA)A at the store. Review of the computer repair shop receipt, dated 02/21/26 at 10:51 A.M., showed a charge of $145.76 paid with the resident's credit card. During an interview on 02/23/26 at 2:34 P.M., the resident said he/she kept his/her credit card in the top drawer of the dresser and found it odd it was on the floor. He/She said he/she decided to check his/her wallet and found another credit card missing. He/She said he/she checked his/her bank statements and noticed unauthorized charges on the credit card. During an interview on 02/23/26 at 3:12 P.M., the repair shop owner said NA A entered the shop around 10:50 A.M. on 02/21/26 and used the resident's credit card to purchase a laptop. During an interview on 02/23/26 3:49 P.M., Nurse Aide (NA) A said he/she did know the resident's credit card was stolen and there were fraudulent charges on his/her credit card. He/She said he/she was in the repair shop and confirmed the picture from the repair shop was him/her but he/she denied he/she used the resident's credit card. During an interview on 02/24/26 at 3:47 P.M., the administrator said staff should not take resident belongings. He/She said NA A was immediately terminated. Complaint #2785828

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, facility staff failed to report an allegation of misappropriation of one resident (Resident #1's) credit card to the State Survey Agency (SSA) within the 24-hour time frame. The facility census was 82.1. Review of the facility's, Abuse, Prevention and Prohibition Policy, dated 03/2025, showed staff are directed that all alleged violations involving misappropriation of resident property will be reported immediately to the administrator or his/her designee. The person made aware of allegations will report the allegations to the mandated state agency and law enforcement. Review of the facility's investigation, dated 02/23/26, showed the resident reported his/her debit card was missing to an agency nurse sometime between 02/20/26 through 02/21/26. The resident reported there were fraudulent charges on the account. The administrator was informed of the allegation on 02/23/26. The administrator was shown a picture of Nurse Aide (NA) A at the computer repair store where the resident's debit card was used and terminated NA A. The investigation did not contain documentation staff notified SSA with the 24-hour time frame. Review of the Department of Health and Senior Services (DHSS) complaint/facility self-report database did not contain documentation the facility reported the allegation of misappropriation of property. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/25/26, showed staff assessed the resident as cognitively intact with an admission date of 09/15/22. Review of the resident's progress note, dated 2/21/2026, showed staff documented the resident reported his/her credit card stolen out of his/her wallet. Review showed staff documented the resident did find unauthorized transactions from his/her bank account. staff left a message for the administrator to call. During an interview on 02/23/26 at 2:34 P.M., the resident said he/she reported to staff his/her credit card missing and unauthorized charges on 02/21/26. During an interview on 02/24/26 at 3:47 P.M., the Administrator said if staff was aware of misappropriation of a resident's property, the incident should be immediately reported up the chain of command. He/She said he/she was responsible to report to the state agency, but did not know about the allegation until 02/23/26. He/She said he/she received a message from a nurse on 02/21/26, he/she tried to call her back and the nurse did not answer. He/She said the nurse did not leave a message to why he/she was calling and he/she forgot to call the nurse again. During an interview on 02/24/26 at 3:48 P.M., the Director of Nursing (DON) said staff are directed to immediately report allegations of misappropriation of a resident's property to the administrator or charge nurse, so DHSS can be called to file a report. Complaint #2785828

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide necessary treatment and services consistent with professional standards of practice, to promote the healing of existing pressure ulcers for two residents (Resident #2 and #3) out of two sampled residents who admitted to the facility with pressure ulcers, when staff failed to document a full wound assessment, complete weekly skin assessments, and follow up on the Registered Dietician's recommendations for Resident #2, and failed to document the administration of wound treatments as ordered by the physician for Resident #2 and #3. The facility census was 74.1. Review of the facility's Wound Care policy, dated 01/2025, showed the following documentation should be recorded in the resident's medical record: -Type of wound and location: stage the wound in pressure, use anatomical location in description;-Partial thickness or full thickness;-Wound measurements: Head to toe (Length), Left to right (width), depth;-Undermining, tunneling, or sinus tract: using the clock method;-Exudate/drainage: type, color, amount, odor (absence or presence and describe smell);-Wound bed: types of tissue visualized, amount of visible tissue;-Describe wound edges and surrounding tissue;-Pain: factors, duration, intensity, interventions for pain relief and effectiveness;-Interventions for healing. Review of the facility's policy on Charting and Documentation, dated 2018, showed the purpose is to have a complete account of the resident's care, treatment and response to the care, documentation should be completed chronologically as issues occur. Review of the facility's policies showed it did not contain a policy to address recommendations from the Registered Dietician (RD), or the frequency for which staff should complete a skin assessment. 2. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment, dated 02/10/26, showed staff assessed the resident as: -Moderate cognitive impairment;-At risk of developing pressure ulcers;-One stage two pressure ulcer (partial-thickness skin injury with exposed dermis) present on admission; -Used pressure reducing device for bed and chair; -Received pressure ulcer care; -Received application of nonsurgical dressings (with or without topical medications) other than to feet; -Received application of ointments/medications other than to feet. Review of the resident's hospital progress note dated 02/03/26, showed one skin care team dressing recommendation dated 02/02/26, for Sure Prep no-sting skin barrier, hydrophilic wound dressing paste (used to absorb moderate levels of wound drainage and softens/loosen necrotic tissue), every 24 hours to bilateral sacrum, gluteal buttocks, and ischium (sitting bones). The note did not contain measurements or description of the wounds to be treated. Review of the resident's admission skin assessment, dated 02/04/26, showed staff documented left inner thigh scrape, and one stage two pressure injury to the sacrum with partial thickness skin loss, measurements of 2 centimeters (cm) length x 1.5 cm width x 0 cm depth, no pain, and interventions to perform treatment of skin issues, and turn resident every two hours. The record did not contain documentation of a full assessment of the wound to the resident's sacrum to include drainage, tissue type, wound edges or surrounding tissue. Review of the resident's care plan, dated 02/04/26, showed the resident admitted with a sacral stage 2pressure ulcer and abrasion to left thigh. Staff were directed to evaluate skin integrity, provide and document wound care as ordered, RD to evaluate and make diet change recommendations as needed. Review of the resident's Electronic Medical Record (EMR), dated 02/04/26 through 02/24/26, showed the record did not contain documentation staff completed a skin assessment from 02/05/26 to 02/24/26. Review of the resident's progress note, dated 02/10/26, showed the RD documented he/she recommended to offer Juven (a nutritional supplement used to support wound healing), Arginaid (nutritional wound support), or similar wound healing protein supplement twice daily to support healing. Review of the resident's Physician's Order Sheet (POS), dated 02/04/26 through 02/24/26, showed: -02/04/26: Sacral area: Cleanse daily with wound cleanser, apply Triad (a hydrophilic wound dressing), cover with bordered gauze dressing every shift for wound care, discontinued 02/12/26;-02/05/26: Left Upper Inner Thigh: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cleanse abrasion with cleanser, apply Triad and cover with bordered gauze dressing every dayshift for wound care, discontinued 02/12/26;-02/05/26: Indwelling catheter care, three times a day for wound on sacrum;-02/12/26: Sacral area: Cleanse daily with wound cleanser, apply calcium alginate (to absorb moisture and minimize infection) and cover with border gauze every shift for wound care, discontinued 02/19/26.-02/20/26: Right buttock: Cleanse area and apply duoderm (waterproof hydrocolloid dressing to promote wound healing) every shift for wound care;-02/20/26: Sacral area: Vashe (wound cleanser used to clean, irrigate and debride wounds) wet to dry with Kerlix (sterile gauze), cover with border gauze every shift for Wound Care.-The POS did not contain an order for a nutritional supplement as recommended by the RD. Review of the resident's Treatment Administration Record (TAR), dated 02/04/26 through 02/24/26, showed the record did not contain documentation staff provided wound treatments as directed to the resident's sacral area on 02/05/26, 02/08/26, 02/10/26 and 02/13/26, or to the resident's left inner thigh on 02/05/26, 02/08/26 and 02/10/26. Review of the resident's progress notes, dated 02/04/26 through 02/24/26, showed the record did not contain documentation regarding the missed treatments or that the resident refused the treatments. During an interview on 03/03/26 at 2:17 P.M., the Director of Nursing (DON) said the resident's wounds were assessed by the wound physician weekly on 02/12/26 and 02/19/26, but the nurses are still expected to complete a weekly skin assessment as triggered in the EMR, document wound treatments on the TAR, and wound assessments should include a description of the wound, drainage, tissue type, wound edges or surrounding tissue. The DON said he/she receives the RD's report with recommendations and was in the process of ensuring someone was responsible to follow-up on the RD recommendations. During an interview on 03/03/26 at 3:30 P.M., the administrator said the nurses are expected to complete a skin assessment on each resident on admission and at least weekly as prompted by the facility's EMR system and document a full assessment of any skin concern/wound per the facility's wound care policy. The Administrator said the DON is responsible to review the RD's recommendations and ensure the orders are obtained and implemented by the nursing staff. During an interview on 03/12/26 at 10:25 A.M., the wound physician said he/she would consider the resident's buttock/sacral wounds to be mostly unavoidable due to reported refusals and reluctance from the resident to reposition/off-load pressure from the wounds, and positional challenges during the two wound assessments and evaluation he/she conducted. 2. Review of Resident #3's admission MDS, dated [DATE], showed staff assessed the resident as: -re-admitted to facility on 02/02/26;-Severe cognitive impairment;-Incontinent of bowel and bladder;-At risk of developing pressure ulcers;-One stage three pressure ulcer (full-thickness skin injury with visible fat in the ulcer) present on admission; -Used pressure reducing device for bed and chair; -Received pressure ulcer care; -Received nutrition or hydration intervention to manage skin problems;-Received application of ointments/medications other than to feet. Review of the resident's care plan, dated 01/12/26, showed staff were directed to administer treatments as ordered and monitor for effectiveness. Review of the resident's POS, dated 02/02/26 through 02/12/26, showed orders to apply border gauze to left heel every dayshift, start 01/05/26, and Triad Hydrophilic Wound Dressing External Paste, apply to buttocks/right sacral area topically every shift for skin integrity, start 1/12/26. Review of the resident's TAR, dated 02/02/26 through 02/12/26, showed the record did not contain documentation staff provided wound treatments as directed to the resident's left heel on 02/07/26 and 02/08/26, or to the resident's buttock/right sacral area on 02/03/26, 02/07/26 and 02/08/26. Review of the resident's progress notes, dated 02/02/26 through 02/12/26, showed the record did not contain documentation regarding the missed treatments or that the resident refused the treatments. During an interview on 03/03/26 at 2:17 P.M., the DON said the nurses are responsible to complete wound treatments as ordered and document on the TAR once completed. The DON said he/she did not know why the nurses did not document the treatments were completed as ordered. Complaint# 2789181 and 2789901