STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265632	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Manor	209 Hickory Street Licking, MO 65542

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) to the resident and/or the resident's representative in writing at least two calendar days before discharge from skilled services. This notice informs the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting the financial liability for those services. This practice affected one resident (Resident #31) out of two sampled residents. The facility census was 39.Review of the facility's policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, undated, showed:- A resident (who is a Medicare beneficiary) is informed in advance and in writing when Medicare payment denial or change in coverage is likely;- Written notices of the likelihood of Medicare payment denial are provided to the resident/beneficiary:- As soon as the facility makes the assessment that Medicare payment certainly or probably will not be made and before the item or service is furnished;- Far enough in advance of an event (e/g/, receiving a medical service) so that the beneficiary can make a rational, informed decision without undue pressure;- The SNF ABN is only issued if the resident/beneficiary intends to continue services, and the facility believes the services may not be covered under Medicare;- If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) is issued to the resident at least two calendar days before Medicare covered services end (or the second to last day of service if care is not provided daily). 1. Review of Resident #31's medical record showed:- The resident was discharged from skilled services on 01/05/26, but remained in the facility;- The resident's skilled services ended on 01/03/26;- The NOMNC letter was not issued and signed;- The SNF ABN letter was not issued and signed;- The facility did not provide at least a two-calendar day notice of the skilled services end date. During an interview on 04/30/26 at 10:35 A.M., the Director of Therapy said Resident #31's discharge was discussed during an interdisciplinary team (IDT) meeting. During the meeting, the Social Services Designee (SSD) and Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) Coordinator were made aware of the resident's upcoming discharge from skilled therapy services. At that time, the SSD was to be out on medical leave and the MDS Coordinator was to be the back up for the SSD. The SNF ABN and NOMNC were not given to the resident or the resident representative to be signed. The SNF ABN and NOMNC should have been given to the resident or resident representative at least two days before the resident was discharged from skilled therapy services.During an interview on 04/30/26 at 11:58 A.M., the SSD said a SNF ABN and NOMNC should be given to the resident or the resident representative 48-72 hours prior to the resident being discharged from therapy services.During an interview on 04/30/26 at 1:18 P.M., the Administrator said the SNF ABN and NOMNC should be provided to the resident or the resident representative two - three days before the resident was discharged from skilled therapy services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 39. Review of the facility's policy titled, Homelike Environment, revised February 2021, showed:- Residents are provided with a safe, clean, comfortable and homelike environment;- The facility maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting;- These characteristics include a clean, sanitary and orderly environment. 1. Observations on 04/27/26 at 8:20 A.M., 04/28/26 at 3:39 P.M., and 03/29/26 at 9:11 A.M., of the dining room showed:- Three windows, approximately eight feet (ft.) by three ft., with a foggy condensation build up inside the panes of the glass obstructing and/or preventing visibility. 2. Observation on 04/27/26 at 9:57 A.M., of room [ROOM NUMBER] showed:- A toilet seat lid unattached and not secured to the toilet inside the bathroom. 3. Observation on 04/28/26 at 10:47 A.M., of the 100 Hall showed:- Several deep horizontal scratches and scuffed marks across the entire width of the door in Rooms 101, 104, 105, 112, and the beauty salon;- A toilet seat with multiple discolored areas and peeled paint inside the bathroom in room [ROOM NUMBER]. During an interview on 04/27/26 at 11:44 P.M., the resident in room [ROOM NUMBER] said he/she told staff the toilet lid was broken and needed fixed over a month ago. The toilet lid moved and slid when he/she sat down to use the bathroom. 4. Observation on 04/29/26 at 11:23 A.M., of room [ROOM NUMBER] Hall showed:- A baseball-size hole approximately mid-door, filled with a discolored putty-like substance, unsanded with an uneven surface on the bathroom door;- A baseball-size hole covered and patched with a drywall-like tape and an unfinished appearance on the ceiling;- A ventilation register (an adjustable covering for a supply air duct that delivers heat or cooled air into a room) with moisture damage and discoloration on the bathroom ceiling. Review of the Maintenance Log binder, dated 02/01/26 - 04/30/26, showed:- A repair request for the toilet seat in room [ROOM NUMBER], dated 04/08/26, and not completed;- No documentation of the other areas of concern was addressed. During an interview on 04/29/26 at 9:12 A.M., Housekeeper J said he/she reported any concerns or repairs needed to the maintenance supervisor directly or added it on the maintenance log at the nurse's station. He/She had not written down anything recently that needed addressed. Houskeeper J would also tell the Administrator if there were any environmental issues.During an interview on 04/30/26 at 11:48 A.M., the Maintenance Supervisor (MS) said he checked the maintenance log every morning when he got to work and tried to get to things in order of importance. He had been away from the facility recently and was unsure of some of the areas of concern that needed to be addressed.During an interview on 04/30/26 at 1:36 P.M., the Administrator said she would expect staff to write down needed repairs or environmental concerns on the maintenance log to be addressed and followed up on in a timely manner. She walked throughout the facility every couple of weeks with the MS while doing rounds.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to properly assess the use of a bed and chair alarm (devices that contain sensors that trigger an alarm when they detect a change in pressure) to determine if utilized as restraints (a device that limits a person's movement), failed to identify a medical symptom that supported the use of the alarms, and failed to document the least restrictive use for the alarms for one resident (Resident #5) out of one sampled resident. The facility census was 39.Review of facility policy titled, Use of Restraints, revision date April 2017, showed:- Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully;- Restraints shall only be used to treat the resident's medical symptoms(s) and never for staff convenience, or for the prevention of falls;- When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need of restraints will be documented. 1. Review of Resident #5's medical record showed:- admission date of 04/05/26;- Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), weakness, repeated falls, disorientation (temporary or chronic confusion), orthostatic hypotension (a sudden drop in blood pressure), cellulitis (an infection affecting the skin, causing tenderness) of the lower limb, and difficulty walking;- No documentation of the bed and chair alarms assessed as a restraint or consent for use;- No documentation of a medical symptom to support the use of the bed and chair alarms;- No documentation of the least restrictive use of the bed and chair alarms; Review of the resident's physician order sheet (POS), dated 04/16/25, showed:- An order for a bed/chair alarm related to impaired cognition, high risk for falls, and family request, dated 03/16/26;- The order did not address the medical symptom for the use of the bed and chair alarms. Review of the resident's Assessment for Assistive Device, dated 03/16/26, showed:- Section 1: completed by nursing staff: Reason for physical assisted device: Family provided alarm due to falls, completed and signed by facility Administrator;- Section 2: completed by physical therapy staff: resident is a fall risk due to a medical condition, and the device will help prevent injury, initialed and dated 03/16/26 by physical therapy assistant (PTA). Please describe the physical condition that is identified during assessment that limits completion of activities of daily living (ADL's), and indicate what benefit the device will be for resident: Family personal request and provided the alarm for resident, written and signed by PTA;- Did not assess to determine if the chair and bed alarms were utilized as restraints;- Failed to provide a medical symptom for the use of the alarms;- Failed to address the least restrictive use for the alarms. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/19/26, showed:- Severely impaired cognition;- Wandered one to three days out of the seven day look back period;- Partial to moderate assistance with toileting, - Substantial/maximal assistance with sit to stand and transfers;- Used a wheelchair for mobility;- Bed and chair alarms not used. Review of the resident's care plan, revised 04/14/26, showed:- The resident at risk for falls related to gait and balance problems;- An intervention of a chair and bed alarm, dated 04/14/2026;- Did not address interventions related to falls;- Did not address if the chair and bed alarms were utilized as restraints;- Did not address a medical symptom for the use of the alarms;- Did not address the least restrictive use for the alarms. Observations on 04/27/26 at 9:48 A.M., 04/28/26 at 10:43 A.M., and 04/29/26 at 11:57 A.M., of the resident showed:-The resident sat in a wheelchair with a chair alarm sensor under his/her buttocks and he/she was unable to remove the sensor. Observation on 04/28/26 at 10:20 A.M., showed:-The resident sat in his/her recliner in his/her room with a chair alarm sensor under his/her buttocks and the resident was unable to remove the sensor. During an interview on 04/30/26 at 11:28 A.M., Resident #5 said his/her chair made a loud noise sometimes and it scared him/her. He/She would rather the chair not do that. During an interview on 04/30/26 at 1:31 P.M., the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator said the resident's family purchased and provided the bed and chair alarms for the resident for fall prevention. She would expect the alarms be properly assessed.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to ensure pre-employment screenings were completed for abuse, neglect or misappropriation of property by verifying employees through the Nurse Aide Registry and Employee Disqualification List (EDL) for six employees (Employees #2, #3, #5, #6 , #7, and #9) of 10 sampled employees, placing all of the residents at risk for potential abuse or neglect. The facility's census was 39.Review of the facility's policy titled, Fiscal Services Manual, dated February 2022, showed:- Check Nurse Aide (CNA) Registry for all new hires. Complete this because some employees may have a federal indicator (a permanent ban from employment in nursing homes) on the Nurse Aide Registry that does not show up when they apply for other positions. Review of the facility's policy titled, Abuse Prohibition, not dated, showed:- It is the policy of this facility to not tolerate abuse of residents by any individual;- It is the facility policy that all employees be checked against the state CNA registry to ensure no one is employed who is excluded on this list;- All employees before starting work will have a State Police Background Check completed;- This will be completed by the designated office person with compliance monitored by the administrator and/or designee. 1. Review of Employee #2's personnel file showed:- No documented verification of the Nurse Aide Registry prior to the employee's hire date of 03/17/25. 2. Review of Employee #3's personnel file showed:- No documented verification of the Nurse Aide Registry prior to the employee's hire date of 04/01/25. 3. Review of Employee #5's personnel file showed:- No documented verification of EDL prior to the employee's hire date of 10/21/25. 4. Review of Employee #6's personnel file showed:- No documented verification of EDL prior to the employee's hire date of 10/23/25. 5. Review of Employee #7's personnel file showed:- No documented verification of EDL prior to the employee's hire date of 04/09/26. 6. Review of Employee #9's personnel file showed:- No documented verification of EDL prior to the employee's hire date of 10/22/25. During an interview on 04/30/26 at 10:20 A.M., the Business Office Manager (BOM) said he/she had only been working at the facility for about three months and thought the EDL should be completed quarterly. The BOM was not aware the Nurse Aide Registry was required to be checked on every employee. During an interview on 04/30/26 at 11:10 A.M., the Administrator said she was aware there was some concern with the background checks and had informed the BOM from this day forward the facility would be completing the employee verification packet as was required. During an interview on 04/30/26 at 12:30 P.M., the Regional Nurse Consultant (RNC) said she would expect the facility staff to complete everything on pre-hire, before staff would be able to work, and to check the EDL quarterly.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) assessment within 14 days of admission to hospice services for one resident (Resident #27) out of one sampled resident. The facility census was 39.Review of the facility's policy titled, Resident Assessments, dated October 2023, showed:- Omnibus Budget Reconciliation Act of 1987 (OBRA - a federal legislation reforming nursing home care) required assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessments include: a. admission assessment; b. Quarterly assessment; c. Annual assessment; d. Significant change in status assessment;- The Resident Assessment Instrument (RAI) user's manual provides detailed information on timing and submission of assessments;- The resident assessment coordinator is responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments. 1. Review of Resident #27's medical record showed:- admitted to hospice services on 04/15/26;- No significant change MDS dated on or after 04/15/26;- The facility failed to complete a significant change MDS within 14 days of the resident's admission to hospice. During an interview on 04/29/26 at 10:30 A.M., the Administrator said the resident had spent some days in the hospital, had a decline, and the family had requested hospice services. During an interview on 04/30/26 at 12:52 P.M., the MDS Coordinator said if a resident went on hospice services, a significant change MDS would need to be submitted. The timeframe for completing the significant change was maybe 30 days, but he/she was unsure and would consult the corporate MDS Coordinator.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) for one resident (Resident #7) out of 12 sampled residents. The facility census was 39. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, showed:- A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet residents' physical, psychosocial, and functional needs is developed and implemented for each resident;- The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission;- The interdisciplinary team (IDT - a group of healthcare professionals from diverse fields who work in a coordinated effort toward a common goal for a resident) reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay and; d. at least quarterly, in conjunction with required quarterly MDS assessment. Review of the facility's policy titled, Falls and Fall Risk, Managing, revised March 2022, showed:- Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try and prevent the resident from falling and try to minimize complications from falling;- According to the MDS, a fall is defined as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he/she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, a fall is considered to have occurred. 1. Review of Resident #7's medical record showed:- admitted on [DATE];- Diagnoses of respiratory failure (lungs cannot get enough oxygen), chronic obstructive pulmonary disease (COPD - a lung disease), anxiety (persistent worry and fear about everyday situations), bipolar (a mental disorder that causes unusual shifts in mood), depression (a serious medical illness that negatively affects how you feel, the way you think and how you act), psychoactive substance abuse (drug abuse), tobacco use, post-traumatic stress disorder (PTSD - psychological distress following a traumatic event), opioid dependence (a chronic medical condition where the brain and body become accustomed to pain medication and need it to function normally) and falls;- A fall on 12/28/25;- discharged to the hospital for evaluation on 12/28/25;- Returned to the facility with a diagnosis of a closed, non-displaced fracture of the fifth metacarpal (a broken hand bone) on 12/29/25. Review of the resident's care plan, revised 12/29/25, showed:- At risk for fall/injury due to a fall related to ambulating with oxygen. Review of the resident's significant change MDS assessment, dated 01/23/25, showed:- No fall with a major injury. During an interview on 04/27/26 at 11: 31 A.M., Resident #7 said he/she had fallen a couple of times in the past because he/she had tripped over his/her oxygen tubing and oxygen tank which resulted in a fractured hand. During an interview on 04/29/26 at 1:34 P.M., the MDS Coordinator said he/she just started in the MDS role, but a resident who had a fall with a major injury should be documented on the MDS assessment. During an interview on 04/29/26 at 1:38 P.M., the Corporate MDS Coordinator said a resident's MDS should have reflected a fall with a major injury. During an interview on 04/29/26 at 1:43 P.M., the Regional Nurse Consultant (RNC) said if a resident had a fall with a major injury, it should be documented on the MDS. During an interview on 04/30/26 at 1:33 P.M., the Administrator said if a resident had a fall with a major injury, it should have been documented on the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement care plans with specific interventions to meet individual needs for two residents (Residents #2 and #3) out of 12 sampled residents. The facility census was 39.Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, showed:- The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident;- The comprehensive, person-centered care plan: includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his/her rights, including the right to refuse treatment, any specialized services to be provided as a result of Preadmission Screening and Resident Review (PASRR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities) recommendations and which professional services are responsible for each element of care, includes the resident's stated goals upon admission and desired outcomes, builds on the resident's strengths, reflects currently recognized standards of practice for problem areas and conditions;- Care plan interventions are chosen after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making;- When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 1. Review of Resident #2's medical record showed:- admitted on [DATE];- Diagnoses of stroke affecting the right side, major depressive disorder (persistent sadness, loss of interest, and low energy lasting at least two weeks), generalized anxiety (feelings of fear, dread, unease, or worry about future events), neuropathic bladder (a dysfunction caused by nerve damage, leading to inability to control the bladder, resulting in incontinence or urine retention), spinal stenosis (the narrowing of spaces within the spine, putting pressure on the nerves and spinal cord), and Stage 3 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), and paroxysmal atrial fibrillation (irregular heart rhythm);- An order for brexpiprazole (an antipsychotic (medications used to manage psychosis, including hallucinations, delusions, paranoia, and severe agitation) medication) 2 milligrams (mg) by mouth daily, dated 03/07/26;- An order for diazepam (an antianxiety medication) 2 mg by mouth at bedtime, dated 03/06/26;- An order for hydroxyzine (an antihistamine medication) 25 mg by mouth every 6 hours as needed for anxiety, dated 03/06/26;- An order for Eliquis (a blood-thinner medication) 5 mg by mouth two times daily, dated 03/70/26;- An order for hydrocodone-acetaminophen (a narcotic pain medication used to treat moderate to severe pain) 5-325 mg by mouth every 4 hours as needed for pain scale 6 - 10, dated 03/06/26;- An order for tramadol (a narcotic pain medication used to treat moderate to severe pain) 100 mg by mouth every 6 hours as needed for pain - moderate, dated 03/16/26;- An order for trazodone (an antidepressant medication) 50 mg by mouth at bedtime, dated 03/06/26;- An order for zolpidem (a hypnotic medication used for a sleep aid) 10 mg by mouth at bedtime, dated 03/06/26. Review of the resident's care plan, revised 03/30/26, showed:- Did not address brexpiprazole, diazepam, hydroxyzine, Eliquis, hydrocodone-acetaminophen, tramadol, trazodone, and zolpidem with person-centered interventions. 2. Review of Resident #3's medical record showed:- admitted on [DATE];- Diagnosis of Stage 2 pressure ulcer (partial-thickness skin loss with exposed dermis, presenting as a shallow open ulcer) to the coccyx (tailbone) and the left buttock; - An order for a urinary catheter (a sterile tube inserted into the bladder to drain urine), dated 01/29/26;- An order to cleanse the left buttock pressure ulcer (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with wound cleanser, pat dry, apply collagen (a protein wound healing agent) powder with barrier (a skin barrier) cream to the wound bed, and cover with border foam (sterile wound dressing) dressing. Change dressing as needed, dated 03/27/26;- An order to cleanse the coccyx ulcer with wound cleanser, pat dry, apply collagen particles and cover with abdominal pad (ABD - a thick highly absorbent dressing). Change daily and as needed for dislodgement or soiling one time a day, dated 04/28/26. Review of the resident's care plan, dated 03/20/26, showed:- Did not address the resident's coccyx and left buttock pressure ulcers and the urinary catheter with person-centered interventions. During an interview on 04/30/26 at 1:27 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) Coordinator said she would expect blood thinner medications, antipsychotics, antianxiety, antidepressants, urinary catheters, and wounds to be addressed on a resident's care plan. She would expect person-centered interventions to be on the care plan as well. During an interview on 04/30/26 at 2:02 P.M., the Administrator said she would expect wounds, urinary catheter use, blood thinners, and psychotropic medication use to be addressed on a resident's care plan. She also would expect the care plan to include individualized interventions for each area of concern.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Manor	209 Hickory Street Licking, MO 65542

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update and revise care plans with specific interventions tailored to meet individual needs for one resident (Resident #7) out of 12 sampled residents. The facility census was 39. Review of the facility's policy titled, Revising Care Plans, undated, showed:- It is the policy of this facility to ensure that all comprehensive care plans are reviewed and revised promptly to reflect changes in the resident's condition, treatment, or goals of care;- Care plan revisions are essential to ensure individualized, person-centered, and safe care and to promote accurate, updated interventions that reflect the resident's needs and preferences;- Care plans must be reviewed and revised quarterly, upon a significant change, new physician's orders that impact resident care, after hospitalizations or acute medical events, and upon resident/family request or concerns;- Nurses and other direct care staff must promptly notify the Interdisciplinary Team (IDT - a group of healthcare professionals from diverse fields who work in a coordinated effort toward a common goal for a resident) new pressure injuries, falls, behaviors, infections, or weight changes;- Revised care plans must identify the reason for revision, include updated goals, interventions, and timetables. 1. Review of Resident #7's medical record showed:- admitted on [DATE];- Diagnoses included respiratory failure (lungs cannot get enough), chronic obstructive pulmonary disease (COPD - a lung disease), anxiety (persistent worry and fear about everyday situations), bipolar (a mental disorder that causes unusual shifts in mood), depression (a serious medical illness that negatively affects how you feel, the way you think and how you act), psychoactive substance abuse (drug abuse), tobacco use, opioid dependence (a chronic medical condition where the brain and body become accustomed to pain medication and need it to function normally) and falls;- A new diagnosis of post-traumatic stress disorder (PTSD - psychological distress following a traumatic event) dated 12/05/25. Review of the resident's April 2026 physician order sheet (POS) showed: - An order for Prazosin (a blood pressure medication also used for PTSD) 2 milligram (mg) 2 capsules by mouth one time a day related to chronic PTSD, dated 12/05/25. Review of the resident's care plan, revised 12/29/25, showed:- PTSD not addressed with no triggers identified and/or interventions in place. Review of the resident's Trauma Informed Consent Assessment, dated 04/15/26, showed:- No PTSD triggers indicated.During an interview on 04/27/26 at 9:42 A.M., Resident #7 said closed-in spaces and loud sudden noises triggered his/her PTSD. He/She didn't like to have his/her door to be completely shut and placed a door hanger on the door handle, so it didn't close all the way.Observations on 04/27/26 at 9:48 A.M., 04/28/26 at 9:55 A.M., and 04/29/26 at 4:26 P.M., showed:- A plastic hanger hung on the doorknob preventing the door from closing. During an interview on 04/29/26 at 2:37 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) Coordinator said a resident's diagnosis of PTSD should be reflected on the resident's individualized care plan with triggers identified and interventions in place. During an interview on 04/30/26 at 1:46 P.M., the Administrator said a resident's diagnosis of PTSD should be reflected on the resident's individualized care plan with triggers identified and interventions in place. During an interview on 04/30/26 at 1:49 P.M., the Regional Nurse Consultant (RNC) said a resident's diagnosis of PTSD should be reflected on the resident's individualized care plan with triggers identified and interventions in place.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nursing staff followed professional standards of practice for medication administration for one resident (Resident #11) out of 12 sampled residents reviewed for medication administration. The facility failed to follow facility policy and accepted standards of nursing practice during transdermal pain patch (medicated adhesive patch applied to the skin to deliver a specific dose of medication) administration. The facility census was 39.Review of the facility policy titled, Transdermal Drug Delivery System Patch Application, revised July 2024, showed:- Remove the old patch from the body;- Wear gloves when handling patches;- Rotate patch application sites to prevent irritation;- Dispose of patches appropriately. 1. Review of Resident #11's medical record showed:- admitted on [DATE];- Diagnosis of chronic pain. Observation on 04/30/26 at 12:09 P.M., of the resident's transdermal pain patch administration showed:- Licensed Practical Nurse (LPN) G put on gloves, opened the new patch package, and labeled the patch with the date, time, and his/her initials;- LPN G found the old patch attached to the resident's lower back with tape, removed the old patch, and placed the medicated adhesive side of the old patch directly on the bedside table;- LPN G applied the new patch to the resident's lower back in the same location where the old patch was located;- LPN G removed gloves, picked up the old patch with his/her bare hands, pushed the resident into the hallway in a wheelchair while carrying the old patch in his/her bare hand, and disposed of the old patch in a sharps container on the medication cart in the hallway. During an interview on 04/30/26 at 12:45 P.M., the Regional Nurse Consultant (RNC) said she would expect nurses to remove the old patch while wearing gloves and dispose of the old patch appropriately without placing it on a bedside table. The RNC said staff should not handle an old pain patch with bare hands. During an interview on 04/30/26 at 1:16 P.M., the Administrator said nursing staff should rotate the patch application sites rather than applying a patch to the same location. She said staff should not carry used pain patches with bare hands while transporting residents in the hallway. During an interview on 05/06/26 at 10:42 A.M., LPN G said he/she carried the used pain patch without gloves into the hallway before disposal.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe environment during smoking by not providing adequate supervision while smoking and failed to complete smoking assessments at least quarterly for one resident (Resident #7) out of four residents. The facility census was 39. Review of the facility's policy titled, Facility Smoking Policy and Procedure, undated, showed:- Purpose: To set guidelines and safety standards for residents who smoke;- Policy: A smoking assessment will be completed on admission for each resident who smokes to determine if they are capable of safely smoking unsupervised. The facility will also perform the same assessment, quarterly or as needed for change of condition to ensure those residents who smoke unsupervised are able to do so safely;- The facility will provide a staff member to supervise during scheduled smoking times. Staff will oversee the entire smoke time, ensuring that residents are dressed appropriately and all safety measures are followed. Staff will monitor temperatures and weather conditions and residents will not go out and smoke if the temperature is less than 32 degrees Fahrenheit;- The designated smoking area is on the back patio/break area;- There will be absolutely no smoking inside the facility, including resident rooms at any time, this includes vapes/e-cigarettes;- Designated smoking times for those wishing to smoke will be: 8:30 A.M., 11:00 A.M., 1:30 P.M., 4:00 P.M., 6:30 P.M., and 8:30 P.M.;- There is no smoking after 9:00 P.M.;- Cigarette limit for each break is one cigarette;- If a smoking time is missed by a resident due to outside appointments or other reasons, the resident will have to wait until the next available smoking time. Review of the facility's policy titled, Smoking Policy - Residents, revised October 2023, showed:- This facility has established and maintains safe resident smoking practices;- Smoking is only permitted in designated resident smoking areas, which are located outside of the building;- Smoking is not allowed inside the facility under any circumstances;- Oxygen use is prohibited in smoking areas;- Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision. 1. Review of Resident #7's medical record showed:- admitted on [DATE];- Own responsible party;- Diagnoses of respiratory failure (lungs cannot get enough oxygen), chronic obstructive pulmonary disease (COPD - a lung disease), anxiety (persistent worry and fear about everyday situations), bipolar (a mental disorder that causes unusual shifts in mood), depression (a serious medical illness that negatively affects how you feel, the way you think and how you act), psychoactive substance abuse (drug abuse), tobacco use, post-traumatic stress disorder (PTSD - psychological distress following a traumatic event), opioid dependence (a chronic medical condition where the brain and body become accustomed to pain medication and need it to function normally) and falls. Review of the resident's last completed quarterly smoking assessment, dated 08/11/25, showed:- Requires supervision during designated smoke times;- No other quarterly smoking assessments completed after 08/11/25;- The facility failed to assess the resident's ability to smoke safely. Review of the resident's facility smoking consent form, dated 11/05/25, showed:- Smokers will only be allowed to smoke in the smoking area located in back of the building with a staff member only;- Smoking times are: 8:00 A.M., 11:00 A.M., 1:30 P.M., 4:00 P.M., 6:30 P.M. and 8:30 P.M.;- There will be no other smoking on the premises;- Resident #7 signed the consent form on 11/05/25. Review of the resident's behavior documentation from 07/31/25 - 04/30/26 showed:- On 12/07/25 at 7:49 A.M., the resident's room smelled of fresh smoke in his/her room and the resident denied smoking in his/her room;- On 12/14/25 at 6:02 A.M., the resident reported he/she hid cigarettes outside near the trash can. He/She signed his/herself out throughout the day for brief intervals leaving the property and then returning;- On 12/27/25 at 7:01 A.M., there was a strong smell of smoke throughout the hallway and it got stronger as the resident's room was approached. The resident's room smelled of smoke and freshly sprayed perfume. The room was dark and the light from the hallway shined in and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed a smoke haze. The resident did not engage in conversation or answer questions when asked about smoking in the room. The Director of Nursing (DON) was notified; - On 02/07/26 at 7:11 A.M., the resident wanted to go out and smoke at 2 A.M., and the nurse informed the resident the facility was secured for safety, and he/she would need to wait until 6 A.M., when the doors opened again. The resident wanted to be able to go out right then and smoke and said it was his/her right to do so. If the facility denied him/her this right, he/she would just go back to smoking in his/her room and lie about it. The resident was re-educated that not smoking in the facility was for the protection of everyone in the facility. The resident remained non-receptive to the education;- On 02/25/26 at 5:51 A.M., the resident wanted to sign out but was told the sign out time wasn't until 6:30 A.M. The resident said he/she was going out now and exited the facility by unlocking the front doors without staff assist. The resident had a lighter visible in his/her pocket and refused to acknowledge or turn in the lighter. The Administrator was notified; - On 03/07/26 at 12:47 A.M., the resident said he/she wanted to go out to smoke and smelled heavily of smoke. The nurse walked the resident back to his/her room and there was smoke seeping out of his/her room and a cigarette smell. The window was open, and the resident said he/she didn't smoke in the room but when he/she needed one, she needed one. Education was provided to the resident on the smoking policy and how it was unsafe to smoke in his/her room and with oxygen. The resident said he/she already knew that and to get out of his/her room; - On 03/12/26 at 8:50 P.M., the resident signed him/herself out. He/She came into the facility and yelled, Fire, fire, fire! due to lighting the wrong end of his/her cigarette and made a large open flame with his/her oxygen in use. He/She threw the lit cigarette in the smoke receptable causing it to smoke. The nurse provided education on not smoking around oxygen and how bad the situation could have been. The resident rolled his/her eyes and said he/she knew; - On 03/13/26 at 11:13 P.M., the resident openly disclosed to staff he/she had cigarettes in his/her room and often went out front to smoke half of a cigarette and kept the other half in his/her room for later. The nurse requested cigarettes and lighter from his/her room and the resident refused to surrender them;- On 3/25/26 at 2:56 A.M., the resident's room had a heavy smell of fresh cigarette smoke. The resident was awake with smoke lingering in the room and denied smoking in the room. There was oxygen use in the room via an oxygen concentrator and an oxygen tank. The resident presented a danger to him/herself, fellow residents, and staff with absolute disregard for anyone else's safety. Numerous warnings and numerous incidents of smoking in the facility have occurred. Administration was aware;- On 04/01/26 at 9:57 P.M., the resident was observed walking towards the staff entrance/exit to the vending machine with oxygen in tow and a lit cigarette in his/her mouth. Staff urged the resident to extinguish the cigarette and to leave the staff smoking are. The resident refused. The resident endangered him/herself and others without hesitation or regard. The resident was not considered safe to smoke independently. The DON was made aware and in agreement. The Administrator was notified;- On 04/15/26 at 6:01 A.M., the resident signed out saying he/she was going to smoke. The resident didn't request cigarettes and a lighter and none was given by the staff. The resident said they were outside. The resident refused to leave the oxygen tank inside the facility. The resident was warned about the risks associated with the oxygen tank and smoking but disregarded the information. The Administrator was notified. Review of the resident's care plan, revised 10/02/25, showed:- Tobacco use and a smoker;- Supervision required due to not being safe while smoking independently;- At risk for complications related to poor judgement, impaired safety awareness, and non-compliance;- Educated on not utilizing any combustible products such as petroleum or aerosol sprays while using his/her oxygen; on the smoking policy and safety guidelines; on not smoking in his/her room; on not smoking when around any supplemental oxygen, as it poses safety issues; and not smoking while using oxygen;- Monitor, document and/or report as needed (PRN) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing toeat or drink, refusing medications or therapies, sense of hopelessness or (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	helplessness,impaired judgment or safety awareness;- Did not address any updated interventions after each incident of non-compliance with smoking nor were there any changes to the interventions regarding fire safety after each re-education mentioned in the notes. Observation on 04/27/26 at 12:07 P.M., of Resident #7 showed:- He/She signed him/herself out at the nurse's station;- Certified Medication Technician (CMT) A gave the resident one cigarette;- He/She walked with an oxygen tank and stopped at the facility's front door entrance;- He/She unhooked his/her oxygen tubing from the oxygen tank and left it at the front door; - He/She exited the building and walked to the gazebo, which was the designated smoking area for the independent smokers, and smoked the cigarette without staff supervision. Observation on 04/27/26 at 12:23 P.M., of the resident showed:- He/She entered the facility;- He/She hooked his/her oxygen tubing back to the oxygen tank;- He/She walked to the nurse's station and returned the cigarette lighter to the DON;- He/She signed him/herself back in at the nurse's station. During an interview on 04/27/26 at 11: 31 A.M., Resident #7 said it wasn't fair that he/she only got to smoke one cigarette during smoking times. He/She should be able to smoke anytime he/she wanted because he/she was his/her own responsible person. During an interview on 04/30/26 at 9:36 A.M., CMT/Transporter C said there were two incidents during transport in the facility van when Resident #7 lit up a cigarette while oxygen was in use. CMT/Transporter B pulled over the van immediately and turned off the oxygen and explained the safety concern with smoking and oxygen use. During an interview on 04/30/26 at 12:11 P.M., the Social Service Director (SSD) said he/she had discussions with the resident regarding the concern with smoking safely and the danger of using oxygen when smoking. He/She had been in this role since March 2026 and should be documenting conversations with the resident regarding such concerns. During an interview on 04/30/26 at 12:37 P.M., the Administrator said she became employed at the facility in January 2026. She was aware there was a safety concern with Resident #7's smoking. Resident #7 signed out of the facility because he/she was his/her own responsibility party and smoked outside at the gazebo, which was the independent resident smoking area, located outside the front entrance of the facility. The resident also smoked at the designated smoke times at the supervised resident designated smoke area located behind the facility. The facility failed to provide adequate supervision for the resident while smoking to ensure a safe environment for the resident and other residents, provide consistent staff intervention, and revise the resident's care plan to address non-compliance with smoking and fire-safety re-education.

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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 identify, assess, and provide supportive interventions for one resident (Resident #7) with a diagnosis of post-traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event) out of one sampled resident. The facility census was 39.Review of the facility's policy titled, Trauma Informed Care and Culturally Competent Care, revised August 2022, showed:- To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice;- To address the needs of trauma survivors by minimizing triggers and/or re-traumatization;- Trauma results from an event, series of events, or sets of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being;- Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognized the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization;- All staff are provided in-service training about trauma and trauma-informed care in the context of the healthcare setting;- Triggers are highly individualized and can include: a. lack of privacy or confinement in a crowded or small space; b. exposure to loud noises, or bright/flashing lights; c. certain sights, such as objects and/or; d. sounds, smells, and physical touch;- Develop individual care plans that address past trauma in collaboration with the resident and family as appropriate. 1. Review of Resident #7's medical record showed:- admitted on [DATE];- Diagnoses of anxiety (persistent worry and fear about everyday situations), bipolar (a mental disorder that causes unusual shifts in mood), and depression (a serious medical illness that negatively affects how you feel, the way you think and how you act);- Level II screening Pre-admission Screening and Resident Review (PASSR - an in-depth person-centered assessment required for nursing facility applicants suspected of having a serious mental illness, intellectual disability, or related condition) with no diagnosis of PTSD, reviewed and dated on 09/09/25;- A new diagnosis of PTSD dated 12/05/25. Review of the resident's April 2026 physician order sheet (POS) showed: - An order for prazosin (a blood pressure medication also used for PTSD) 2 milligram (mg) 2 capsules by mouth one time a day related to chronic PTSD, dated 12/05/25. Review of the resident's care plan, revised 12/29/25, showed:- PTSD not addressed with no triggers identified and/or interventions in place. Review of the resident's Trauma Informed Consent Assessment, dated 04/15/26, showed:- No PTSD triggers indicated.During an interview on 04/27/26 at 9:42 A.M., Resident #7 said closed-in spaces and loud sudden noises triggered his/her PTSD. He/She didn't like to have his/her door to be completely shut and placed a door hanger on the door handle, so it didn't close all the way.Observations on 04/27/26 at 9:48 A.M., 04/28/26 at 9:55 A.M., and 04/29/26 at 4:26 P.M., showed:- A plastic hanger hung on the doorknob preventing the door from closing. During an interview on 04/30/26 at 1:36 P.M., the Social Services Director (SSD) said he/she wasn't sure who did the trauma assessments and was still new in his/her role, but thought it was the Administrator who completed the assessment. During an interview on 04/30/26 at 1:46 P.M., the Administrator said a resident who had a diagnosis of PTSD should have individual triggers identified and interventions in place. During an interview on 04/30/26 at 1:49 P.M., the Regional Nurse Consultant (RNC) said a resident who had a diagnosis of PTSD should have individual triggers identified and interventions in place.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary behavioral health services and implement effective behavioral interventions for one resident (Resident #7) out of one sampled resident reviewed for behavioral health needs. The facility failed to assess, monitor, care plan, and intervene for ongoing verbally aggressive, disruptive, and maladaptive behaviors that affected other residents and staff. The facility census was 39.Review of the facility policy titled, Behavioral Assessment, Intervention, and Monitoring, revised February 2025, showed the facility would identify behavioral symptoms, evaluate the severity and safety risks of behaviors, develop individualized interventions, monitor the effectiveness of interventions, and document changes in resident behavior. 1. Review of Resident #7's medical record showed:- admitted on [DATE];- Own responsible party;- Diagnoses of bipolar disorder (mood disorder that can cause intense mood swings), anxiety (persistent worry and fear about everyday situations), depression(a serious medical illness that negatively affects how you feel, the way you think and how you act), post-traumatic stress disorder (PTSD - psychological distress following a traumatic event), psychoactive substance abuse, opioid dependence, and tobacco use. Review of the resident's behavior documentation, dated 07/31/25 - 04/30/26, showed:- On 12/07/25 at 7:49 A.M., the staff documented the resident smoked in his/her room despite oxygen safety concerns and prior education;- On 12/12/25 at 11:09 A.M., the resident argued with staff and said he/she was going outside to smoke despite staff instruction not to do so at that time;- On 12/14/25 at 6:02 A.M., the resident demonstrated manipulative behaviors, split staff, repeatedly requested medications, hid cigarettes outside, signed out frequently to smoke, and dismissed staff education regarding smoking and oxygen safety;- On 01/02/26 at 6:27 A.M., the resident signed out to go smoke and staff again educated the resident regarding smoking while using oxygen including the risk of fire, injury, and death;- On 02/25/26 at 5:51 A.M., the resident attempted to leave the facility outside approved smoking/sign-out times, unlocked the front door without staff assistance, ignored staff direction, and possessed a lighter while refusing to acknowledge the behavior;- On 02/26/26 at 10:25 A.M., the resident refused pulmonary rehabilitation services saying the treatment was stupid despite staff education regarding benefits and risks;- On 02/27/26 at 4:27 P.M., the resident became angry with staff during shower care and argued when reminded the resident had not showered in one week;- On 02/28/26 at 5:56 P.M., the resident refused shower care despite staff education regarding hygiene and infection prevention;- On 03/02/26 at 10:00 P.M., the resident attempted to sign both self and another resident out to smoke after facility doors were locked, argued with staff regarding smoking rules, and challenged staff authority by saying, They let me do this all week. The resident required oxygen at 3 liters per nasal cannula (device used to deliver oxygen with two small tubes that fit into the nostrils) with oxygen saturation (percent (%) of oxygen in the blood) at 91%;- On 03/12/26 at 8:50 P.M., the resident attempted to light a cigarette near an oxygen tank. Staff repeated education safety risks. The resident rolled his/her eyes and said, I know;- On 04/01/26 at 9:57 P.M., the resident signed out and smoked near the staff entrance/vending area and refused staff requests to extinguish the cigarette despite safety concerns for the concerns for other residents and staff.- On 04/17/26 at 8:11 A.M., the resident reported ongoing conflict with the roommate and used inappropriate and socially disruptive statements regarding the roommate's bathroom habits;- On 04/25/26 at 12:31 P.M., the resident pushed another resident in a wheelchair outside to smoke and cursed at staff when staff attempted intervention. The resident verbally argued with staff regarding cigarettes and smoking access. Review of the resident's care plan, revised 10/02/25, showed:- Interventions related to smoking safety, impaired safety awareness, depression, anxiety, and mood monitoring;- Did not address individualized interventions to address the resident's ongoing verbally aggressive and disruptive behaviors toward other residents and staff nor were there (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any changes to the interventions regarding fire safety after each re-education mentioned in the notes. Observation on 04/28/26 at 8:51 A.M., of the resident showed:- The Director of Nursing (DON), Certified Medication Technician (CMT) A, and Certified Nurse Assistant (CNA) B present at the nurse's station;- Resident #7 approached Resident #30 at the nurse's station and said, Your daughter is at work. Why don't you understand that? and Because you stress me out asking all day long if your daughter will come see you, in a loud and verbally aggressive tone;- Resident #30 responded there was no reason to get frustrated;- The DON, CMT A, and CNA B remained present at the nurse's station and failed to redirect, intervene, or de-escalate the behavior. Observation on 04/28/26 at 8:54 A.M., of the resident showed:- Resident #7 loudly argued with CMT A regarding pain medication in the presence of other residents and staff;- The resident said, Tylenol. No, that is bad for my liver, and That is ridiculous, in a loud and verbally aggressive tone;- The Administrator, DON, CNA B, and CMT A remained present and failed to redirect or intervene. Observation on 04/30/26 at 1:39 P.M., of the resident showed:- Resident #7 encouraged Resident #11 to repeatedly pull the exit door handle and activate the alarm while demanding staff take residents outside to smoke;- Resident #7 said, We need to smoke and it's past 1:30 P.M., in a loud and verbally aggressive tone. During interviews on 04/27/26, 04/28/26, and 04/30/26, the Administrator said the facility was aware Resident #7 demonstrated verbally aggressive behaviors toward residents and staff. That was Resident #7's normal behavior. The Administrator said they continued to send referrals to outside facilities, however Resident #7 would call the referred facilities and be verbally aggressive and then they denied his/her admission. During an interview on 04/28/26 at 8:58 A.M., CMT A said there was no need to intervene with Resident #7 as the aggressive demeanor and behaviors were his/her baseline towards everyone. During interviews on 04/30/26, staff members including CNA B, CMT/Transporter C, Physical Therapist Assistant (PTA) D, Housekeeper D, Social Services Director (SSD), and Regional Nurse Consultant (RNC) acknowledged Resident #7 was aggressive toward other residents and staff and was disruptive with his/her behaviors. That was Resident #7's baseline behaviors and there were no interventions that worked. Rarely, staff could redirect. The resident was his/her own responsible party so there was nothing they could do. During an interview on 04/30/26 at 12:11 P.M., the SSD said he/she was only at the facility temporarily while the current SSD was on medical leave. The SSD said the facility had sent out several referrals for transfer. The resident found out where they had been sent and called those facilities until he/she was asked not to call anymore. Resident #7 continued with his/her behaviors. The SSD was unaware of any activity plan for the resident. During an interview on 04/30/26 at 12:45 P.M., the Regional Nurse Consultant (RNC) said the resident was his/her own responsible party and would not agree to any counseling or psychiatric counseling since being admitted to the facility. The facility continued to send referrals to other facilities. The RNC was aware of the resident's behaviors related to smoking safety and verbal aggressiveness toward residents and staff. The RNC did not know of any interventions in place to redirect the resident. The facility failed to implement effective behavioral interventions, provide consistent staff intervention, revise the resident's care plan to address ongoing behaviors, and protect other residents from repeated verbally aggressive and disruptive behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265632	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Manor	209 Hickory Street Licking, MO 65542

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow enhanced barrier precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO - microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) for two residents (Residents #6 and #9). The facility also failed to perform hand hygiene and change gloves during wound care for one resident (Resident #6) out of four sampled residents and during medication administration for one resident (Resident #11) out of 12 sampled residents. The facility census was 39. Review of the facility's policy titled, Enhanced Barrier Precautions, undated, showed:- EBP refer to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and gloves use during high contact resident care activities;- EBP will be initiated for residents with any of the following: Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers);- Make gowns and gloves available immediately near or outside of the resident's room;- Personal protective equipment (PPE) for EBP is only necessary when performing high-contact care activities;- High-contact resident care activities include wound care: any skin opening requiring a dressing;- EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Review of the facility policy titled, Transdermal (administer through skin absorption) Drug Delivery System Patch Application, revised July 2024, showed:Staff will: - wash hands or use facility-approved hand sanitizer; - remove the old patch from the body; - wear gloves when handling patches; and - perform hand hygiene after application. 1. Observation on 04/28/26 at 2:04 P.M., of Resident #9's wound care showed:- No EBP signage or PPE available outside of the resident's room;- The Director of Nursing (DON) and Certified Nurse Assistant (CNA)/Certified Medication Technician (CMT) I entered the resident's room, did not put on a gown, performed hand hygiene, and put on gloves;- The DON performed the resident's wound care;- The DON removed gloves, performed hand hygiene, and exited the room. 2. Observation on 04/28/26 at 2:26 P.M., of Resident #6's wound care showed:- No EBP signage or PPE available outside of the resident's room;- The DON and CNA/CMT I entered the resident's room, did not put on a gown, performed hand hygiene, and put on gloves;- The DON used wound cleanser-soaked gauze to cleanse the wound on the left shin, did not perform hand hygiene, and did not change gloves;- The DON finished the resident's wound care, removed the gloves, performed hand hygiene, and exited the resident's room. During an interview on 04/29/26 at 10:17 A.M., the DON said residents that had wounds requiring a dressing required putting on a gown and gloves before providing care. She didn't put on a gown during the wound care she provided for Resident #6 and #9. During an interview on 04/30/26 at 11:30 A.M., Licensed Practical Nurse (LPN) G said EBP was for residents with the flu or wounds with infections. He/She was unsure if EBP was used for only wounds that were open or all skin conditions requiring treatments. If a resident required EBP, he/she would put on a gown and gloves. If the infection was airborne, a mask would be put on. If a resident had any kind of infection, a resident required EBP. During an interview on 04/30/26 at 11:33 A.M., CNA/CMT I said EBP was for residents with open wounds and PPE, like gown and gloves, were worn every time staff went into the resident's room. He/She did not wear a gown during the wound observations. During an interview on 04/30/26 at 1:18 P.M., the Administrator/Infection Preventionist said residents with open wounds, catheters, and central lines required EBP. If staff were going into a resident's room to provide wound or catheter care, they should be putting on a gown and gloves. 3. Observation on 04/30/26 at 12:09 P.M., of Resident #11's transdermal pain patch (medicated adhesive patch applied to the skin to deliver a specific dose of medication) medication administration showed:- LPN G assisted the resident to his/her room, did not perform hand hygiene, put on gloves, opened the new pain patch package, and wrote the date, time and his/her initials on the (continued on next page)

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	265632	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Manor	209 Hickory Street Licking, MO 65542

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	new patch;- LPN G removed the old pain patch, placed the medicated adhesive side of the old patch directly on the bedside table, did not perform hand hygiene, and did not change gloves;- LPN G applied the new pain patch, removed his/her gloves, did not perform hand hygiene, picked up the old pain patch placed on the resident's bedside table with his/her bare hands, did not properly dispose of the old patch, did not perform hand hygiene, exited the resident's room, pushed the resident into the hallway in a wheelchair while carrying the old transdermal pain patch in his/her bare hand, disposed of the old patch in a sharps container on the medication cart in the hallway, did not perform hand hygiene, and pushed the resident down the hallway to another resident's room. During an interview on 04/30/26 at 12:45 P.M., the Regional Nurse Consultant (RNC) said staff should perform hand hygiene before the procedure, remove the old patch while wearing gloves, dispose of the patch appropriately without placing it on a bedside table, and perform hand hygiene immediately after application. Staff should not handle an old pain patch with bare hands. During an interview on 04/30/26 at 1:16 P.M., the Administrator said nursing staff should perform hand hygiene before and after medication administration. Staff should not carry used pain patches with bare hands while transporting residents in the hallway. During an interview on 05/06/26 at 10:42 A.M., LPN G said he/she normally performed hand hygiene before and after medication administration and he/she shouldn't have carried the used pain patch without gloves into the hallway before disposal.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to control the fly population in the facility. This deficient practice had the potential to affect all residents. The facility census was 39.Review of the facility's policy titled, Pest Control, dated May 2008, showed:- Our facility shall maintain an effective pest control program;- This facility maintains an on-going pest control program to ensure the building is kept free of insects and rodents. Review of the facility's pest control invoice, dated 04/23/26, showed:- Services did not target flies;- An exit door didn't close/seal properly and required installation of weather stripping. 1. Observations on 04/27/26 of the dining room showed:- At 12:25 P.M., a visitor entered the dining room with a fly swatter in his/her hand and swatted flies at the resident's table;- At 12:38 P.M., three flies buzzed around Resident #3 and crawled on his/her back;- At 12:48 P.M., three flies crawled on a resident's dining table near the back of the dining room;- At 12:50 P.M., Resident #21 ate his/her food while two flies crawled on his/her dessert bowl;- At 12:51 P.M., Resident #39 ate his/her food while a fly crawled on his/her spoon and the dessert bowl;- At 12:53 P.M., two flies lay on Resident #4's food while he/she ate his/her meal, one fly lay on Resident #26's left hand while he/she ate his/her meal, and three flies lay on exposed food trays on a food cart located near the kitchen door;- At 12:56 P.M., Resident #41 ate his/her food while flies buzzed around, and two flies crawled on his/her food in the plate;- At 1:01 P.M., flies buzzed around, and two flies crawled around Resident #3's food. 2. Observation on 04/28/26 at 8:00 A.M., showed four flies crawled on the back table while staff served residents their breakfast plates. 3. Observation on 04/29/26 at 12:00 P.M., showed Residents #21 and #41 ate lunch while two flies crawled on their food on their plates. During an interview on 04/29/26 at 12:10 P.M., Resident #21 said the flies were horrible and looked like there could be something done about all of them. During an interview on 04/29/26 at 1:10 P.M., Resident #39 said the flies sure had been bad lately and the flies sure were nasty. 4. During a group interview on 04/29/26 at 1:33 P.M., Resident #39 said the flies were terrible and he/she had reported them to staff. Resident #42 said there was a major pest issue regarding the flies in this facility. 5. Observation on 04/29/26 at 2:36 P.M., showed Resident #41 sat in his/her wheelchair visiting with other residents while a fly crawled onto his/her hand and on the left sleeve of his/her shirt. During an interview on 04/29/26 at 2:20 P.M., the Administrator said she was aware of the fly concern and would speak with the maintenance staff and see what could be done about it. The facility had a contracted pest control company that serviced the facility on a monthly basis. During an interview on 04/30/26 at 8:29 A.M., Certified Nurse Aide (CNA) K said the flies had been bad mostly in the dining room.