STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265652	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuba Manor Inc	210 Eldon Drive Cuba, MO 65453

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure five residents (Resident #3, # 5, #9, #37, and #50) out of eight residents who are unable to carry out activities of daily living received the necessary services to maintain good personal hygiene and grooming. The facility census was 62.1. Review of the facility's policy titled Care of Nails (fingers and toes) policy, undated, showed nursing assistants may perform nail care on the residents who are not at risk for complications of infection. The licensed nurse or podiatrist must perform nail care on residents suffering from diabetes or vascular disease (poor circulation). The policy did not provide guidance on when to perform nail care.Review of the facility's policy titled Perineal Care, undated, showed the purpose is to clean the perineum and prevent infection and odor. The policy did not provide guidance on when to perform perineal care. Review of the facility's Shower policy, undated, showed the policy did not contain direction or guidance for nail care. Review of the facility's Toileting Plan for Urinary Incontinence, undated showed:-Review the resident's care plan for any special needs;-This technique involves the resident resisting or inhibiting the sensation to urinate according to a timetable;-The goal is for the resident to urinate every two to three hours;-Record the resident's current urinating pattern, including times and amounts;-Plans that require resident cooperation and motivation for learning and practice to occur include bladder retraining/rehabilitation and pelvic floor muscle rehabilitation;-Plans that are relatively more dependent on staff involvement and assistance as opposed to resident function include: prompted urinating, habit training/scheduled toileting, and incontinence management;-Assess the resident for appropriate program to enhance urinary continence. -The program did not contain direction or guidance on how often to offer toileting or incontinence care. 2. Review of Resident #3's Significant Change of Status Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/17/26, showed staff assessed the resident as: -Cognitively impaired;-Did not have behaviors or reject care;-Range of motion impaired on one upper and one lower extremity;-Always incontinent of urine and bowel;-Dependent on staff for toileting, showers, dressing and personal hygiene;-Diagnoses of dementia and diabetes.Review of the resident's care plan, dated 04/07/26, showed the resident wears a brief for dignity and to provide perineal care after each incontinent episode. The care plan did not provide direction or guidance for fingernail care. Observation on 05/12/26 at 12:51 P.M., showed the resident fingernails long and jagged with dark debris under the nail. Observation on 05/13/26 at 8:35 A.M., showed the resident fingernails long and jagged. Observation on 05/13/26 at 9:41 A.M., the resident fingernails long and jagged. Observation on 05/13/26 at 1:53 P.M., showed the resident fingernails long and jagged with dark debris under the nail. Observation on 05/14/26 at 8:59 A.M., showed CNA A and CNA J transferred the resident to bed. CNA J cleansed the resident's inner and outer buttocks. CNA A and CNA B did not clean the resident's abdominal folds, inner thighs, or perineal area. During an interview on 05/14/26 at 3:27 P.M., CNA J said he/she should have provided full perineal care to include the front perineal area, abdomen and inner thighs of the resident. He/She said he/she had other things on his/her mind. CNA J said fingernails are clipped by the nurse monthly. 3. Review of Resident #5's admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired;-Did not reject (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care;-Functionally impaired range of motion in both lower extremities;-Dependent on staff for personal hygiene;-Diagnoses of dementia and diabetes. Review of the resident's care plan, dated 04/12/26, showed the care plan did not contain direction or guidance for nail care. Observation on 05/15/26 at 8:47 A.M., showed resident's toenails long and jagged. During an interview on 05/15/26 at 8:47 A.M., Licensed Practical Nurse (LPN) G said diabetic nails are trimmed by the podiatrist. He/She did not know if the resident was on the podiatry list. 4. Review of Resident #9's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired;-Did not have behaviors or reject care;-Dependent on staff for personal hygiene;-Diagnosis of dementia.Review of the resident's care plan, dated 03/27/26, showed the care plan did not contain direction or guidance for nail care. Observation on 05/12/26 at 3:04 P.M., showed the resident fingernails long and jagged.Observation on 05/13/26 at 8:27 A.M., showed the resident fingernails long and jagged with debris.Observation on 05/13/26 at 1:53 P.M., showed the resident in a group activity with fingernails long and jagged with debris.Observation on 05/14/26 at 8:18 A.M., showed the resident in the television room with long and jagged fingernails. 5. Review of Resident #37's, Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired;-Did not have behaviors of reject care;-Functionally impaired range of motion in all extremities;-Dependent on staff for personal hygiene;-Diagnosis of Parkinson Disease. Review of the resident's care plan, dated 04/28/26, showed the care plan did not provide direction or guidance for nail care.Observation on 05/12/26 at 1:32 P.M., showed the resident hands contracted with long fingernails with visible debris under the nail. Observation on 05/13/26 at 9:45 A.M., showed the resident with long fingernails. Observation on 05/13/26 at 1:53 P.M., showed the resident in the day room with long fingernails and visible debris under the nail. Observation on 05/14/26 at 8:21 A.M., showed the resident hands contracted and with long fingernails. During an interview on 05/13/26 at 9:45 A.M., CNA K said he/she gave the resident a bed bath but did not trim his/her fingernails. He/She said the nurse trims the nails. During an interview on 05/12/26 at 1:32 P.M., a family member said he/she noticed the long fingernails but knew the staff were busy and didn't say anything. 6. Review of Resident #50's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired;-Did not reject care;-Dependent on staff for toilet hygiene and dressing;-Required partial to moderate assistance of staff for toilet transfers;-Frequently incontinent of urine and occasionally incontinent of bowel;-Toileting program to manage incontinence. -Diagnosis of Dementia. Review of the resident's care plan, dated 05/10/26, showed: -Occasionally incontinent of bowel and bladder;-Provide incontinence care as needed;-One-Two staff assist with toileting upon rising in the morning;-Position the resident upright on the toilet or bedside commode;-The care plan did not contain direction or guidance to offer toileting or incontinence care prior to naps or upon rising from naps. Observation on 05/12/26 at 12:51 P.M., showed CNA A and CNA B entered the resident's room, applied a gait belt to the resident and transferred the resident to bed. CNA A and CNA B did not offer to toilet resident or provide incontinence care.During an interview on 05/14/26 at 2:50 P.M., CNA B said he/she is newer to the facility and still learning the resident routines and amount of assistance needed. He/She said the resident should have been offered toileting and assisted to be cleansed when laid down for a nap to prevent skin issues. During an interview on 05/14/26 at 3:02 P.M., CNA A said toileting and perineal should have been offered before laying the resident down for a nap. He/She said not providing toileting or care could result in skin irritation. During an interview on 05/15/26 at 9:54 A.M., the Director of Nursing (DON) said staff should offer toileting each time care is provided. He/She can also tell staff when he/she needs to go. 7. During an interview on 05/15/26 at 9:32 A.M., Licensed Practical Nurse (LPN) K said CNA's clip residents' fingernails unless they are diabetic, then the nurse does it. Nails should be clipped when needed and checked during showers. He/She said the aides have not informed him/her of any nails needing clipped. Residents who are incontinent should be offered to toilet or provided incontinent care at least every two hours to prevent skin issues. Incontinent care includes wiping all skin that was in contact with the body fluid. During an interview on 05/15/26 at 9:54 A.M., the DON said the nursing (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff should provide incontinent care on all incontinent residents every two hours or more often upon request. Incontinent care includes cleansing all skin that encounters body fluids. Fingernails should be clipped by the aides at least twice a week on shower days or as needed. The nurses are responsible for ensuring diabetic nails are clipped. The podiatrist comes monthly, and residents are added to the list when nail care is needed. He/She is not sure who is on the list. During an interview on 05/15/26 at 10:57 A.M., the administrator said fingernails should be trimmed with showers and when needed by the aides if not diabetic and the nurse if diabetic. If the aides do not have time, they are to let management know so someone can be assigned to do it. He/She said to get on the podiatrist list, the resident or the nurse will let management know and then will be added to the list. He/She is not sure who is on the list. The administrator said perineal care should include the wiping of all skin surfaces in contact with body fluids to include the front and abdominal folds to prevent infections, decrease odors, and maintain resident skin. Residents should be offered toileting or perineal care at least every two hours.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, facility staff failed to transfer two residents (Residents #3 and #62) out of three sampled residents by mechanical lift in a manner to prevent accidents. The facility census was 62.1.Review of the facility's Mechanical Lift policy, undated, showed to follow the manufacturer's instructions when using any type of lift. The policy showed the purpose is to enable one individual to lift and move a resident safely. The policy did not contain directions or guidance regarding the number of staff required during a mechanical lift transfer. Review of the Mechanical Lift Manual, dated 2022, showed although the company recommends two assistants be used for all lifting preparation and transferring-from and transferring-to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the healthcare professional for each individual case. The manual did not contain direction or guidance for guiding or hands on the resident while suspended or transferring to a bed from the wheelchair. Review of the facility's orientation Transferring the Patient guide, dated June 2012, showed the guide did not contain direction or guidance for lift transfers to bed from the wheelchair or guidance for guiding the resident while suspended in the air. 2. Review of Resident #3's Significant Change in Status Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/17/26, showed staff assessed the resident as cognitively impaired and dependent on staff for transfers. Review of the resident's care plan, dated 04/07/26, showed the resident is to be transferred by two staff and a mechanical lift.Observation on 05/12/26 at 12:51 P.M., showed Certified Nurse Aide (CNA) A and CNA B attached a mechanical lift sling to a mechanical lift. CNA A raised the resident from a reclining wheelchair. With the resident suspended over the tile floor, CNA A moved the lift over to the bed and lowered the resident onto the bed. CNA B did not guide or hold the resident as the resident was suspended over the floor. Observation on 05/14/26 at 8:59 A.M., showed CNA A and CNA J attached a mechanical lift sling to a mechanical lift. CNA A raised the resident from the reclining wheelchair. With the resident suspended over the tile floor, CNA A moved the lift over to the bed and lowered the resident onto the bed. CNA J did not guide or hold the resident as the resident was suspended over the floor. 3. Review of Resident #62's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively impaired and dependent on staff for transfers. Observation on 05/12/2026 at 02:56 P.M., showed CNA A and CNA B attached a mechanical lift sling to a mechanical lift. CNA A raised the resident from the wheelchair. The resident was not centered in the sling, CNA A assisted the resident to reposition. With the resident suspended over the tile floor, CNA A moved the lift over to the bed and lowered the resident onto the bed. CNA B did not guide or hold onto the resident as the he/she was suspended over the floor. After resident care, CNA A and CNA B attached the sling to the mechanical lift for transfer back to the wheelchair. CNA A raised the resident from the wheelchair into the air. CNA B did not guide or hold the resident as the he/she was suspended over the floor. During an interview on 05/14/16 at 2:50 P.M., CNA B said he/she has been certified for over a year. Mechanical lift transfers require two staff for safety. One staff works the lift, and the other staff should maintain the sling. He/She is not sure why the resident was not held onto but should have been for safety and so it does not tip while the resident is in it. During an interview on 05/14/26 at 3:02 P.M., CNA A said two staff should be in the room during lift transfers. One should operate the lift, and the other staff should make sure the legs go where they are supposed to go. He/She said staff should guide the residents when up in the sling to maintain safety. He/She said there wasn't enough room to maneuver the lift and do the best he/she can.During an interview on 05/14/26 at 3:27 P.M., CNA J said staff should have two people present during lift transfers to prevent accidents. One person to work the lift and the other person to keep an eye out for trouble and step in when needed. He/She said it didn't matter if staff held onto the resident while suspended in the air because the lift does the work. 4. During an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 05/15/26 at 9:54 A.M., the Director of Nursing (DON) said one staff member should operate the lift and the other should be the spotter for safety. The residents should never be suspended in the air over the floor without staff holding on to them for safety. The lift could tip over or the straps could fail.During an interview on 05/15/26 at 10:57 A.M., the Administrator said staff are trained on hoyer transfers upon hire and annually during a skills training day with return demonstrations. Staff are expected to hold the resident once they leave the surface until they get lowered to the next surface in case the lift tips over.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, facility staff failed to ensure medications not in use and expired were properly discarded. The facility census was 62.1.Review of the facility's Storage of Medication's Policy, undated, showed no discontinued, outdated or deteriorated drugs or biologicals may be retained for use. All such drugs must be returned to the issuing pharmacy or destroyed in accordance with established guidelines. Review of the facility's Destruction of Medications Policy, undated, showed two licensed nurses or one licensed nurse and facility pharmacist will destroy all medications, except controlled substances which will require Director of Nursing (DON) supervision. The medications will be placed in a sealable container such as a plastic bag. An unpalatable substance such as kitty litter or used coffee grounds will be added to the plastic bag of medications. Before sealing the plastic bag approximately one cup of fluid will be added to the plastic bag of medications. 2. Observation on 05/12/26 at 10:15 A.M., showed the East Hall medication room contained:-One opened bottle of Genteal eye drops dated 03/31/26 (eye lubricant);-A box of Lantus insulin (to treat diabetes) with an expiration date of 09/30/24;-A box of Lantus insulin with an expiration date of 09/30/25;-Five cards of discontinued Lithium 150 milligrams (mg) tablets (used for mania); -Two cards of discontinued Naproxen 500 mg tablets; -One card of discontinued Lamotrigine 100 mg tablets (used for seizures and mood); -One opened bottle of artificial tears dated 03/12/26;-One opened bottle of artificial tears dated 03/26/26;-One opened and undated vial of tuberculin solution;-Two unopened, influenza vaccine bottles with an expiration date of 06/30/25.During an interview on 05/12/26 at 10:45 A.M., Licensed Practical Nurse (LPN) M said the nurses and the medication technicians are responsible for ensuring expired, outdated and discontinued medications are returned or destroyed. He/She was not aware discontinued and expired medications were in the medication room.During an interview on 05/12/16 at 10:50 A.M., Certified Medication Technician (CMT) L said he/she pulls expired or discontinued medications and puts them into the medication room for return or destruction. He/She said the nurses are responsible for the medication room. 3. Observation on 05/14/26 at 08:28 A.M., showed a medication cart contained an unlabeled cup of pills in a drawer. At this time, CMT D said he/she prepared the medications for Resident #67, but the resident was not available to take them. CMT D said they were saved to give to the resident when available, although he/she knows it is not the correct procedure. During an interview on 05/14/26 at 10:13 A.M., LPN E said any medications not administered immediately after being pulled from the package should not be set aside for later administration. 4. During an interview on 05/15/26 at 9:54 A.M., the Director of Nursing (DON) said the charge nurse is responsible for the contents of the medication room. He/She said medications that need to be returned to the pharmacy should be returned weekly, and medications that require destruction should be destroyed immediately with two nurses present. He/She was not aware of the expired/discontinued medications stored in the east medication room. The DON said medications should be administered immediately after removal from original packaging and if the medications are not administered, they should not be stored to administer later. Disposal of medications should be completed by the charge nurse and another nurse and should not be completed by CMT's. During an interview on 05/15/26 at 10:57 A.M., the Administrator said the DON and Assistant DON are responsible for oversight of the medication room. He/She said expired, outdated or discontinued medications could be given inadvertently or would not be effective if given. The Administrator said CMT's are not allowed to dispose of medications, it should be the nurses.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when staff failed to change gloves and wash/sanitize hands during incontinence care for three residents (Resident #3, #18, and #62), and failed to clean a mechanical lift after use for two residents (Resident #3, #62). The facility census was 47.1. Review of the facility's Handwashing policy, undated, showed the policy did not contain direction or guidance on when to perform hand hygiene. The purpose of handwashing is to reduce transmission of organisms from resident to resident, nursing staff to resident, and/or resident to nursing staff.Review of the facility's Hand Cleanser policy, undated, showed the purpose is to cleanse the hands between resident contact during care and to prevent spread of infection. Review of the facility's Cleansing and Disinfecting of Environmental Surfaces policy, undated, showed environmental surfaces will be cleansed and disinfected according to current Centers for Disease Control (CDC) recommendations for disinfection of healthcare facilities and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard. Review of the CDC Recommendations for Disinfection and Sterilization in Healthcare Facilities, dated 12/07/23, showed:-Ensure, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or once weekly);-If dedicated, disposable devices are not available, disinfect noncritical patient-care equipment after using it on a patient who is on contact precautions before using this equipment on another patient.Review of the OSHA's Bloodborne Pathogen Standard Fact Sheet, dated 2011, showed staff are to implement universal precautions (treat all bodily fluids as if known to be infectious). Review of the Federal Drug Administration's (FDA) Patient Lift Safety Guide, undated, showed to always clean a patient care lift before and after each patient. 2. Observation on 05/12/26 at 12:51 P.M., showed Certified Nurse Aide (CNA) A and CNA B used a mechanical lift and transferred Resident #3 from his/her wheelchair to bed. With gloved hands, CNA B removed the residents brief and discarded it, CNA B gathered trash and soiled linens and touched the doorknob. CNA A wheeled the lift out of the room to the hallway and did not disinfect the lift. CNA A and CNA B did not perform hand hygiene prior to leaving the room. During an interview on 05/14/26 at 2:50 P.M., CNA B said hand hygiene should be performed when entering a room and when leaving a room. He/She does not know why he/she did not do perform hand hygiene, but he/she should have. He/She said the lift should be sanitized between resident use to break the spread of infections. He/She does not know why the lift was not cleaned. Observation on 05/14/26 at 8:59 A.M., showed CNA A and CNA J used a mechanical lift and transferred the resident from his/her bed to wheelchair. With gloved hands, CNA J pulled the resident's pants and brief down, wiped bowel movement from the resident's buttocks and with the soiled gloves touched the lift sling, clean brief, bed linens, gathered trash, and touched the wheelchair while the soiled trash bag touched the lift. With the same gloves, on CNA J wheeled the lift to the hall. He/She did not perform hand hygiene before he/she left the room. During an interview on 05/14/26 at 3:02 P.M., CNA A said he/she tries to keep his/her hands clean but has a heavy resident load and gets busy. He/She said the lift should be cleaned between residents, hands should be cleansed when going into the room, between dirty and clean tasks, and before leaving the room. He/She said washing hands and cleaning the lift keep germs from spreading.During an interview on 05/14/26 at 3:27 P.M., CNA J said the lifts are cleansed weekly by housekeeping. He/She said CNAs should perform hand hygiene between residents, when leaving a room and when entering the room. He/She said he/she didn't know about hand hygiene after cleansing bowel movement from a resident. 3. Observation on 05/13/2026 at 11:25 A.M. showed CNA C performed bowel incontinence care for Resident #18. With the same soiled gloves on, CNA C changed the residents' clothes. CNA C and the Assistant Director of Nursing (ADON) did not perform hand hygiene and transferred the resident with the mechanical lift to his/her wheelchair. The CNA wheeled the resident to the dining room. 4. Observation on 5/12/26 at 2:56 P.M. showed CNA A (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and CNA B used the mechanical lift and transferred Resident #62 from his/her wheelchair to bed. CNA A and CNA B wiped bowel movement from the resident's bottom. With the same soiled gloves, CNA B applied powder to the resident's bottom, touched the resident's clean clothes and lift sling. With the same soiled gloves, the CNAs transferred the resident back to his/her wheelchair, arranged the bedding and placed a blanket on the resident. CNA B did not perform hand hygiene at the completion of the tasks or before he/she propelled the resident to the television room. Staff wheeled the mechanical lift to the hall and did not clean the lift. 5. During an interview on 05/13/26 at 09:00 A.M., the Infection Preventionist (IP) said hand hygiene should be performed when entering and exiting a resident room, and when moving from a dirty task to a clean task. The IP said mechanical lifts and reusable supplies should be cleaned after each resident use. He/She said staff received training throughout the year which included hand hygiene and use of gloves.During an interview on 5/13/26 at 10:00 A.M., the Director of Nursing (DON) said hand hygiene is expected to be done when a room is entered and exited. He/She said hands should be washed and gloves changed anytime contaminated with feces. The DON said staff have received training on the use of personal protective equipment and hand hygiene at hire and throughout the year.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to promote and facilitate the right of self-determination when staff failed to honor two residents (Resident #33 and #58) preferences to sleep later in the morning for two out of eight sampled residents. The facility census was 62.1. Review of the facility's Resident Rights policy, undated, showed the resident has the right to participate in his/her own care and to be fully respected and adhered to.2. Review of Resident #33's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/08/26, showed staff assessed the resident as cognitively intact.Review of the resident's face sheet, dated 05/15/26, showed the resident is responsible for himself/herself.Review of the resident's care plan, dated 05/12/26, showed the care plan did not contain direction or guidance to residents' preference for sleeping in and/or staying in bed later in the day. Review of the resident's Patients [NAME] of Rights, signed 04/29/26, showed residents are entitled to take part in planning their care and in being informed in all aspects of their care. Residents may refuse any treatment they do not want. During an interview on 05/12/26 at 1:16 P.M., the resident said he/she feels forced to get up early in the morning. He/She tells staff every day he/she does not want to get out of bed early, but they don't listen. He/She said he/she does not feel respected as a human being. During an interview on 05/15/26 at 9:54 A.M., the Director of Nursing (DON) said the resident prefers to stay in bed all the time, and staff encourage him/her to get up. He/She has sores which make being in bed worse for him/her. The DON said if the resident did not want to get out of bed, he/she would let staff know. 3. Review of Resident #58's admission MDS, dated [DATE], showed staff assessed the resident as cognitively impaired and received hospice services.Review of the care plan, dated 04/28/26, showed the care plan did not contain direction or guidance to resident preference for sleeping in or rising later in the morning. Review of the resident's Patients [NAME] of Rights, signed 04/22/26, showed the resident is entitled to take part in planning their care in being informed in all aspects of their care. The resident may refuse any treatment they do not want. During an interview on 05/13/26 at 8:27 A.M., the resident said he/she doesn't feel well most days and is tired all the time. Everyday staff come in really early and wake him/her up and make him/her sit in a wheelchair for what feels like hours before breakfast. He/She said he/she tells staff every single day he/she does not want to get out of bed just to eat a couple of bites, but staff does not listen and gets him/her up anyway. During an interview on 05/15/26 at 9:54 A.M., the DON said if given the option, the resident would stay in bed all the time and eat jellybeans. He/She does need assistance with eating and really should not eat in bed, but staff should not force him/her to get out of bed. 4. During an interview on 05/15/26 at 9:54 A.M., the Director of Nursing (DON) said residents should have the option of sleeping in if they choose to. Facility staff do try to encourage the residents to get up though for more socialization and decreased depression. He/She said staff should never force a resident to get up when they do not want to. He/She was not aware resident #33 and #58 wanted to sleep later in the morning. He/She said residents #33 and #58 would stay in bed all day if they were allowed to.During an interview on 05/15/26 at 10:57 A.M., the administrator said staff should encourage residents to get out of bed daily to decrease depression. He/She said the residents are getting to where none of them want to get out of bed, but staff should never force them to get up. It's the resident's right to stay in bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265652	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuba Manor Inc	210 Eldon Drive Cuba, MO 65453

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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on interviews, and record review, facility staff failed to ensure dental care services were provided as recommended by a dentist for one resident (Resident #4) out of one sampled resident. The facility census was 47.1. Review of Resident #4's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/13/26, showed staff assessed the resident as:-Cognitively intact;-Diagnosed with dental caries, unspecified;-Abnormal mouth tissue, obvious or likely cavities or broken natural teeth, and mouth or facial pain, discomfort or difficulty with chewing.Review of the resident's care plan, revised 05/08/26, showed staff are to assist with dental/oral hygiene needs, and he/she has own teeth in poor condition. Review of the resident's physician's order set (POS), dated May 2026, showed the resident may be seen by dental provider as needed. Review of the resident's dental visit summary, dated 01/22/26, showed the resident has a compromised medical disposition and oral surgery should be completed under the medical license of an oral surgeon. The resident has multiple teeth that need to be removed in four to six areas of the oral cavity. Review of the resident's medical record, dated 01/26/26, showed an oral surgery referral sent to the contracted dental service provider. Review showed the record did not contain documentation staff followed up to ensure dental care services were provided. During an interview on 05/13/2026 at 9:41 A.M., the resident said he/she has loss of teeth. He/She said a dental appointment had not been requested, but an aid said he/she needs new teeth. The resident said he/she would like to have dentures because some food is hard to chew. During an interview on0 5/15/26 at 08:50 A.M., the Social Services Director (SSD) said after receiving the dentist's summary, a referral was sent to the contracted dental service provider, and the charge nurse was asked to request a dental order from the provider. He/She said the regular dentist could not accommodate the resident because of his/her mobility issues. The SSD could not locate any notes related to conversations about the residents' dental services. During an interview on 05/15/26 at 9:00 A.M., Licensed Practical Nurse (LPN) E said the progress notes showed a dental referral was received on 3/24/26. He/She said staff would call the oral surgeon's office to schedule the appointment. LPN E said the resident's medical record did not contain documentation staff called to get an appointment with the oral surgeon. During an interview on 5/15/26 at 10:00 A.M., the Director of Nursing (DON) said he/she was familiar with the resident's dental issues and was told he/she refused to go to the appointments because of mobility limitations. He/She was not familiar with the current status of the resident's dental services.