STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265698	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Nick's Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 253 East Highway 116 Plattsburg, MO 64477	

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 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. Based on interview and record review, the facility failed to honor one resident's (Resident #27) right to make choices about aspects of his/her life in the facility that were significant to the resident, when the facility failed to honor and follow through on the resident's request to transfer to a different Long Term Care (LTC) facility that would allow the resident to live closer to his/her family member. The facility census was 69.Review of the facility's Resident Rights Policy, revised 9/21/25, showed all residents have a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. The facility must protect and promote the right of each resident.Review of Resident #27's Quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 7/19/25., showed the resident's cognition was intact and was independent in activities of daily living (ADLs).Review the resident's admission Record showed:-The resident was independent with ADLs. -Diagnoses included: Insulin dependent diabetic, kidney disease, cervical cancer, and heart disease.-Had resided in the facility for the past three years.Review of the resident's undated care plan showed the resident was alert and oriented and cognition was intact. The resident had the ability to understand and make all needs known.During an interview on 10/1/25 at 10:15 A.M., the resident said he/she had been trying for months to get moved to a different facility in a nearby town where his/her son lived. The resident wanted to be closer to his/her child who was special needs and resided in a group home and said that moving to the new facility would allow him/her the ability to visit his/her child more often. The resident said that no one had followed up regarding the request and that he/she had reached out to social services and administrative staff in the front office. The resident said this had been emotionally stressful and my rights have been violated! Review of the nursing and social service progress notes, from June 2025 through October 2025, showed no documentation regarding the resident's wish to discharge to another LTC facility, no follow up regarding the request, or communication to the resident regarding the progress of the request to move.Review of the social service notes showed there was documentation in the resident's record regarding when the original referral was sent to the neighboring facility that the resident wished to be transferred to in May of 2025.Review of the resident's undated care plan showed no documentation to support the resident's wishes to discharge from the facility and move to a facility closer to the resident's child. During an interview on 10/1/25 at 11:45 A.M., the Social Services Director (SSD) said she had sent the initial admission referral to the neighboring facility in May of 2025. The SSD was unable to locate or provide documentation regarding the resident's request, the referral, the follow up, or the timeline of the admission referral request. The SSD said the Administrator had been in contact with the admissions department at the neighboring facility and that additional nursing notes had been sent, but was unable to speak to the progress of the referral. The SSD had not called the facility to inquire about the referral. The SSD said the referral should have been followed up on, documented, and (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicated with the resident. She was unsure what the holdup was on the referral the resident had requested and could not provide documentation to support the referral being worked on or that it had been communicated with the resident.During an interview on 10/2/25 at 2:15 P.M., the Administrator said he was aware of the resident's request to move to another facility to be closer to his/her child. The Administrator was unable to provide documentation from the time of the original referral to the date of this interview. The Administrator had one text message to the neighboring facility's admission person regarding the initial referral status and response was to send nursing notes to the facility to review. The Administrator had no further documentation to support the facility was actively working the referral to assist the resident with the move closer to his/her child.During an interview on 10/3/25 at 9:05 A.M., the admissions nurse at neighboring facility said she had told the referring facility to send updated nursing progress notes more than once and that the referral was no good after 30 days and would require a new referral be sent to the requested facility for admission consideration. The neighboring facility was still waiting on an updated referral to be sent and once it was received the resident would be placed on a waiting list for a LTC bed. The initial referral was sent 4 months ago.During an interview on 10/3/25 at 11:25 A.M., the Administrator and Director of Nursing said the resident's referral for admission to another facility should be followed through, documented in the clinical record, and communicated with the resident and additionally that every resident had the right to self-determination.Intake 2626895 & 2619608

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to use the correct advanced beneficiary notice of non-coverage form to notify three of three sampled residents (Residents #2, #34, and #36) of changes in coverage to items and services covered by Medicare and/or by the Medicaid State plan. The facility census was 69.Review of the facility's Medicare Advance Beneficiary and Medicare Notice, policy last revised 11/05/24, showed residents are informed in advance when changes occur to their bills. CMS (Center for Medicare/Medicaid Services) form 10055 will be provided to the resident prior to discharging from Medicare part A.1.Review of Resident #34's order summary report showed the resident was admitted to Medicare part A on 4/02/25 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), acute respiratory failure, muscle weakness, and Type II diabetes and discharged from Med A on 05/07/25.2. Review of Resident #36's order summary report showed the resident was admitted to Medicare part A on 7/07/25, for skilled nursing and/or rehabilitation care and was discharged from Med A on 07/13/25. 3. Review of Resident #2's order summary report showed the resident was admitted to Medicare part A on 8/22/25, with a diagnosis of COPD, tremors, and stroke and was discharged from Med A on 08/28/25.Review of the facility's ABN Form, (the advanced beneficiary notice of non-coverage), showed the facility used an outdated form, titled CMS-R-131. The form did not include the date that Medicare part A coverage would be ending for Resident #34, Resident #36, and Resident #2. Review of the residents' medical records showed, the facility did not have the current CMS-10055 ABN form for all three residents (Resident #2, #34, and #36). During an interview on 10/03/25 at 9:30 A.M., the Social Service Director said she was unaware that she was using the incorrect CMS form to notify residents about the discontinuance of Medicare part A benefits and should be using CMS 10055 form.During an interview on 10/03/25 at 9:40 A.M., the Administrator said he was unaware the facility was not utilizing the correct ABN form.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview, the facility failed to ensure laundry services were provided in a manner to ensure a safe/clean/ comfortable homelike environment, when laundry services did not return clean clothes to one Resident (Resident # 49) causing the resident to wear a hospital gown in the dining room. Additionally, failure to keep the dirty laundry caught up resulted in a strong urine odor outside the hall of the laundry room. The facility census was 69. The facility was unable to provide a policy regarding duties of the laundry.1.Observation on 9/30/25 at 10:45 A.M., showed the laundry room located outside the hallway of the dining room and a strong odor of urine on the hallway prior to entry of the dining room. Upon entry into the laundry room there were three large barrels overflowing the top, full of dirty linen and clothing. Both washing machines were full of clothes and clean clothes were stacked three feet high waiting to be folded. No laundry staff were in the laundry room. Observation on 9/30/25 at 2:45 P.M., showed a strong odor of urine on the hallway prior to entry of the laundry room. Large barrels overflowing the top, full of dirty linen and clothing. Both washing machines were full of clothes and clean clothes were stacked three feet high still waiting to be folded. One laundry staff was working in the laundry training a new employee. Observation on 10/1/25 at 10:15 A.M., showed a strong urine odor outside the hall of the laundry room. Inside the laundry there were large barrels full of soiled wet linen and clothes. The folding area had large amounts of resident's clothing waiting to be folded, hung, and sorted. One laundry person was working in the laundry. Review of Resident #49's Quarterly Minimum Data Set, a federally mandated assessment instrument completed by facility staff, dated 5/2/25, showed: -Cognition was intact;-Diagnoses: schizoaffective disorder, Chronic Obstructive Pulmonary Disease, and diabetes;-Independent with activities of daily living.Observation on 09/30/25 at 9:10 A.M., showed the resident in the main dining room wearing a hospital gown with some dark colored short pants.Observation on 9/30/25 at 1:05 P.M., showed the resident in the dining room for lunch in a hospital gown and brown pants.During an interview on 09/30/25 at 9:15 A.M., Licensed Practical Nurse (LPN) D said the resident did not have any of his/her own personal clothing that was clean to wear. The resident instead had to wear a facility gown until his/her clothes were cleaned. LPN D said the facility failed to maintain clean laundry for most residents due to a lack of help in the laundry room. During an interview on 9/30/25 at 9:25 A.M., the resident said he/she hated wearing hospital gowns and would prefer to wear his/her own clothes instead of a hospital gown. The resident said that this happened often and he/she did not want to come out of his/her room without his/her own clothes on. During a group interview on 10/1/25 at 10:00 A.M., the resident's voiced concerns regarding the delay of laundry being returned to them. During an interview on 10/1/25 at 9:35 A.M., the housekeeping manager said she was aware of the amount of laundry backed up in the laundry and the strong smell of urine. She said staffing the laundry had been hard and currently laundry was staffed only Monday-Friday from 7:00 A.M.-3:30 P.M. or with whoever could help with laundry. She said, we all do multiple roles in this building. She was aware that resident's needed their clean clothes and should have them returned within a couple of days. She planned to work in laundry today to help get laundry delivered to the residents. During an interview on 10/3/25 at 11:45 A.M., the Administrator said he was aware of the laundry services issues regarding large amounts of laundry and was actively hiring for laundry staff and that other departments were helping when they could start and sort laundry.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to provide sanitary conditions when the facility failed to address a fly problem in the kitchen/dining area and failed to address walls, flooring, and doors that were in need of repair. The facility census was 69. Review of the facility's Dietary Equipment, Infection Control and Sanitation policy, revised 2/2/24, showed the Dietary Manager is responsible for assembling, organizing and maintaining the needs for the operating and cleanliness of the kitchen and all dietary equipment. Review of the facility's Pest Control Program policy, dated 5/14/24, showed it was the policy of the facility to maintain an effective pest control program that eradicates common household pests such as flies. 1.Observation on 10/1/25 at 11:45 A.M., showed:-flies in the kitchen that landed on the peaches that were in bowls and on the salads being prepped; -dead flies on the floor;-the wall behind the cook stove had a section of the corner of the wall pushed in with missing dry wall. 2. Observation on 10/1/25 at 11:15 A.M., showed the kitchen flooring at the serving line peeling away from the floor. The flooring had separated from the concrete and had caked on debris lodged between the peeling laminate flooring and concrete creating a space for food build up and inability to clean the floor of the debris. 3. Observation on 10/2/25 at 12:15 P.M., showed the kitchen's back delivery door was lopsided in the frame causing a 1.5 - 2 inch gap of open visual space allowing flies and insects into the kitchen. Observation showed flies in the kitchen in clusters on all surfaces and on food being prepped and served. Additionally, a fly sticky strip was hanging in the kitchen bathroom with the door open and showed it to be covered in dead flies. Dead flies were also on the floors by all prep areas in the kitchen. During an interview on 10/1/25 at 11:55 A.M., the Dietary Manager said he/she was aware the wall behind the stove was falling in about a week ago, but had not yet reported it to maintenance to be repaired. During an interview on 10/2/25 at 11:45 A.M., [NAME] A said the flies were always a problem in the kitchen and he/she was always swatting them off food and cooking/prep food areas. The fly problem had just always been a problem at the facility even with fly traps and exterminators help. During an interview on 10/2/25 at 1:30 P.M., the Dietary Manager said she knew the flooring had been steadily coming up in pieces by the serving table line area and it was hard to keep the floors clean. She additionally had not thought to report the floor issues to maintenance. She said the exit door to the back of the kitchen did not fit correctly and that was the main reason the flies were so bad in the kitchen and dining room area. The door problem had been reported to maintenance some time ago, but was not sure when that was. She had not issued a new work order to request to have the door issue resolved. During an interview on 10/2/25 at 1:45 P.M., Resident #27 said the flies while trying to eat were ridiculous and they are annoying. Resident #27's table mate, Resident #34 said he/she did not like the flies landing on his/her food or touching his/her face when he/she was trying to eat. During an interview on 10/2/25 at 2:10 P.M., the Maintenance Director said he had just started 2 weeks ago and was unaware of the kitchen floor, back door, or the wall behind the stove. He admitted there was a fly problem in the facility, especially the kitchen and dining room area. He was not sure what the facility's plan was for managing the fly problem, but agreed it was a problem in the kitchen. During an interview on 10/3/25 at 11:25 A.M., the Administrator said he was aware of the fly problem in the facility and the issue was worse in the summer months. He was aware the kitchen door leading outside to the dumpster area did not sit level in the frame of the door, which caused an opening that allowed flies to enter into the kitchen area and then into the rest of the building. The residents have the right to live in a home without flies landing on them and their food continually. He was unaware of the wall crumbling behind the cook stove or the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	flooring peeling up from the floor in the kitchen by the serving table.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 when residents were observed with flies on them during meals, cares, and activities. The facility census was 69.Review of the facility's Pest Control Program policy, dated 5/14/24, showed it is the policy of the facility to maintain an effective pest control program that eradicates common household pests such as flies. The facility was unable to provide documentation of the last pest control services in the facility. Observation on 9/30/25 at 10:05 A.M., showed flies in the main entrance of the facility flying around residents. Observation on 9/30/25 at 12:45 P.M., showed flies landing on residents' food during the noon meal, flies on the tables where residents were eating, and flies being swatted away by residents while they ate. Observation on 10/1/25 at 9:30 A.M., showed flies in groups of clusters (more than one) on residents dining tables, landing on the residents face and hands. Observations of the kitchen on 10/1/25 at 10:45 A.M. and 10/2/25 at 11:30 A.M., showed the staff bathroom door open with a sticky fly strip hanging from the ceiling completely coated with dead flies and flies flying around the sticky fly strip. Observation of the kitchen on 10/2/25 at 12:25 P.M., showed Resident #27 and #34 in the dining room drinking beverages as noon meal trays were being passed by staff. The residents were swatting away flies while trying to drink and eat. Observation on 10/3/25 at 10:10 A.M., showed Resident #34 and #27 sat in the facility hallways with flies landing on them. Multiple flies were seen landing on doors, walls, handrails, and staff and residents swatting the flies away from their face. During an interview on 9/30/25 at 11:45 A.M., Resident #31 said the flies were always bothering him/her during meals and in his/her room. He/she wished something could be done about all the flies. During an interview on 10/2/25 at 12:30 P.M., Resident #47 said The flies drive me crazy, especially when I am trying to eat! I hate the flies. During an interview on 10/1/25 at 12:13 P.M., the Housekeeping Services Manager said the facility used to have a pest control company that came monthly, but was not sure when they last were out to the building. She said the flies are a problem, but did not know how to manage the fly problem. She was not sure where to find the information regarding pest control. During an interview on 10/3/25 at 11:25 A.M., the Administrator said he/she was aware of the fly problem in the facility. Pest control comes monthly, but was unsure when the company last provided service for flies. The issue is just worse in the summer months. The residents have the right to live in a home without flies landing on them and their food continually.