STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265746	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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 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 and interview, the facility failed to prepare and serve food in accordance with professional standards for food service safety when staff failed to use soap and water during handwashing. The facility census was 38.Review of facility policy for Food and Nutrition Services, Hand Washing, dated 2025, showed:- Employees are expected to practice proper hand hygiene;- When to wash hands: before starting work or handing food, before putting on gloves or changing gloves, after touching body (hair, face, nose, mouth), after handling raw food or garbage or chemicals or dirty dishes, after touching anything that may contaminate hands such as door handles or equipment or carts;- How to wash hands: wet hands and forearms with warm water, apply soap and work into a lather, scrub hands, wrists, and under fingernails, rinse thoroughly under running water, dry hands with disposable paper towel;1.Observation of the kitchen on 12/4/25, showed:- 9:20 A.M. Dietary [NAME] (A) used hand sanitizer upon entering kitchen and then started working with food; no handwashing was observed;- 12:10 P.M. Dietary Aide (A) used hand sanitizer in the kitchen then poured drinks in the food preparation area from a container he/she pulled from the refrigerator; no handwashing was observed;- 12:15 P.M. Dietary [NAME] (A) used hand sanitizer during a glove change and then started to plate meals; no handwashing was observed;- 12:20 P.M. Dietary [NAME] (B) entered the kitchen, used hand sanitizer then started plating pineapple fruit from a can in the kitchen; no handwashing was observed;- 12:25 P.M. Dietary Aide (A) used hand sanitizer then started plating food in the kitchen; no handwashing was observed;- 12:32 P.M. Dietary Manager entered the kitchen and used hand sanitizer, did not wash hands and then started moving boxes and touching kitchen surfaces before wrapping plates with plastic wrap.During an interview on 12/4/25 at 12:40 P.M., Dietary Aide (A) said whenever you enter the kitchen, you should wash your hands with soap and water. Hand sanitizer is used if you are delivering plates to the dining room for the residents. During an interview on 12/4/25 at 1:33 P.M., the Dietary Manager said while doing work in the kitchen all staff should used soap and water to wash their hands and it's the only authorized cleaning agent for washing hands. Hand sanitizer is not used for hand washing in the kitchen. During an interview on 12/5/25 at 2:20 P.M., the Administrator said staff cannot substitute hand sanitizer for soap and water when doing hand washing in the kitchen. She would expect only soap and water to be used by staff working in the kitchen.

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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Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, interview and record review, the facility failed to ensure residents were able to exercise their rights when the facility did not inform residents on where to find contact information for the State Survey Agency, how to file a complaint for seven residents of the resident counsel group or where to find the Ombudsman's contact information for one sampled resident (Resident #21) and seven of 14 resident council members. The facility census was 38.Review of facility Residents' Rights Policy, dated 6/10/25, showed:- A posting of names, addresses and phone numbers of all pertinent state client advocacy groups will be available in the facility;- The resident has the right to be informed of his or her rights and of all the rules and regulations governing resident conduct during his or her stay in the facility to include information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program and the protection and advocacy system. 1. Review of Resident #21's Annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 11/19/25, showed:- The Resident was cognitively intact;- The Resident required a wheelchair and could not stand;- The Resident diagnosis: chronic respiratory failure, heart failure, and anxiety disorder. During an interview on 12/02/25 at 10:00 A.M., the resident said he/she did not know how to contact the state survey agency or hotline to make a complaint and did not know where the number was located in the building. The resident also did not know how to contact the ombudsman or where the phone number was located. Observation on 12/02/25 at 11:00 A.M., showed that the Ombudsman contact information sign, and the Department of Health and Human Services sign were both located, approximately five feet high, on the upper left side of the wall in a narrow area (a section of the wall designated for information) with direct wheelchair access blocked by a chair. Residents in a wheelchair would not be able to view the sign to access the information. 2. During a group interview on 12/03/25 at 10:00 A.M., the Resident Council said:- Seven of 14 resident council members did not know how to file a complaint with the state agency or how to contact them. - Seven of 14 resident council members did not know where the Ombudsman contact information was located and was not provided any information in writing on how to contact the ombudsman or survey agency.During an interview on 12/4/25 at 6:10 A.M., Registered Nurse (RN) A said:- This is where the numbers are for the Ombudsman and Department of Health and Human Services (DHSS) and pointed to the two flyers high up on the wall in the cubby area;- Yes, it would be hard for a resident in a wheelchair to get to and see the numbers.During an interview on 12/4/25 at 9:00 A.M., the Minimum Data Set (MDS) Coordinator said:- He/She believed the Ombudsman number was given to the residents when the Ombudsman gives out cards to the residents;- He/She wasn't sure where the state survey agency number was located but the residents can ask staff for the number. During an interview on 12/4/25 at 10:06 A.M., the Administrator said:- Resident access to the Ombudsman number was on the wall in the information section area and the Ombudsman was at the facility quite often passing out cards with the Ombudsman number;- Resident access to the DHSS number was also in the information area.- She did not think the location of the information was a problem for residents in wheelchairs to see and the posting had been located in the same spot for years;- When asked if any residents had complained about not being able to see the numbers from a wheelchair, she said the staff can just let the resident know the numbers when needed.During an interview on 12/5/25 at 7:18 A.M., RN B said:- Residents would have to ask for Ombudsman information when needed and he/she was not sure where the information was located;- Residents would have to ask for the state survey agency/hotline number as well and he/she had not seen the number anywhere.

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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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a clean, comfortable, and homelike environment for two residents (Residents #26 and #28) who could not obtain hot water of at least 105 degrees Fahrenheit in their rooms and for one resident (Resident #2) who had difficulty entering his/her room due to a structural impediment at the entrance door of his/her room. This affected three out of 12 sampled residents. The facility census was 38.Review of the facility policy, Safe Water Temperatures, dated 6/15/25, showed:- Staff will report abnormal findings, such as complaints of water too cold or hot, or any problems with water temperature to the supervisor and/or maintenance staff;- Water temperatures will be set to a temperature of no more than 120 degrees Fahrenheit or the state's allowable maximum water temperature;- Maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water circuits weekly and as needed;Review of the facility policy, Resident Rights, dated 6/10/25, showed:- The resident has a right to a safe, clean, comfortable and homelike environment, including supports for daily living safely;1. Review of Resident #26's, Quarterly Minimum Data Set, a federally mandated assessment instrument completed by facility staff, dated 9/24/25, showed:- Resident was not screened for cognitive mental status;- Diagnosis: coronary artery disease, heart failure, hypertension, diabetes, and depression.During an interview on 12/5/25 at 11:30 A.M., the Resident said the water in the bathroom never got hot and was frustrated and doubtful the problem would get fixed. Observation on 12/5/25 at 11:25 A.M., showed Resident's bathroom hot water reached 96.7 degrees Fahrenheit after running the water for 4 minutes;2. Review of Resident #28's, Quarterly MDS, dated [DATE], showed:- Resident is moderately cognitively impaired:- Diagnosis: dementia, Parkinson's Disease, and depression;During an interview on 12/2/25 at 10:40 A.M., the family member said the resident had been at the facility since February 2025, and the water had never been hot. The family had reported the lack of hot water to the Administrator and was offered to switch rooms, which the family declined. The hot water was never fixed while they were there, and the Hospice nurse told the family member that he/she could not get enough hot water out of the faucet to heat a washcloth for the resident. This made the family member feel unimportant and frustrated that he/she could not provide better support to the resident. 3. Review of Resident #2's Quarterly MDS, dated [DATE], showed:- Resident had severe cognitive impairment;- Diagnosis: coronary artery disease, renal insufficiency (kidney disease), obstructive uropathy (improper urine drainage), Alzheimer's Disease, anxiety disorder, depression, and Schizophrenia;- Resident uses a walker and a manual wheelchair;- Resident required set up for eating;- Resident required moderate assistance for oral hygiene;- Resident was dependent for toileting hygiene, personal hygiene, and lower body dressing;- Resident required maximal assistance for bathing and upper body dressing.Observation on 12/3/25 at 9:57 A.M., showed;- The resident had a raised threshold across the bottom of the entrance door to his/her room;- The resident, seated in his/her wheelchair, attempted to cross the raised threshold of his/her door 10 times before successfully going over the raised area to enter his/her room;- The threshold fastens the carpet in the room to the floor.During an interview on 12/3/25 at 10:08 A.M., the Resident said it would be easier to enter his/her room if the floor threshold was not there and that he/she puts up with it because he/she likes the room overall. He/she did not know a complaint could be made about the difficulty it causes when entering his/her room. He/she does not have enough strength to push the wheelchair over the raised floor threshold easily, and it is very frustrating.4.Observation on 12/4/25 at 8:30 A.M., showed: - room [ROOM NUMBER]'s bathroom hot water reached 103.5 degrees Fahrenheit after running the water for four minutes;- room [ROOM NUMBER]'s bathroom hot water reached 102.7 degrees Fahrenheit after running the water for four minutes; Observation on 12/4/25 at 1:35 P.M., showed:- room [ROOM NUMBER]'s bathroom hot water reached 96.4 degrees Fahrenheit (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after running the water for five minutes;- room [ROOM NUMBER]'s bathroom hot water reached 103.6 degrees Fahrenheit after running the water for three minutes;Observation on 12/5/25 at 10:45, showed the Maintenance Supervisor check the bathroom water temperature of Resident #28's room was 98.8 degrees Fahrenheit and water temperature check of room [ROOM NUMBER] was 102.1 degrees Fahrenheit.5.During an interview on 12/5/25 at 11:00 A.M., the Maintenance Supervisor said:- No one ever mentioned there was a problem with the floor threshold of Resident #2's room; - After looking at it and hearing about the difficulty the resident was having getting into the room he was concerned that this should be fixed as soon as possible;- He had never noticed the resident having trouble getting into the room before;- The water system had a pump replaced in June 2025 and the water lines inspected to make sure proper flow rates and temperatures were reaching the rooms;- The only report of low temperatures that he had received this year was from Resident #28's room and other than inspecting the lines nothing else was done, no problem could be identified;- Water temperatures that he had taken ranged from 98 -103 degrees Fahrenheit for the rooms on the 20 hallway;- The Maintenance Supervisor was aware that the state limit for temperatures was 120 degrees Fahrenheit but did not know that the minimum for residents was 105 degrees Fahrenheit;During an interview on 12/5/25 at 2:20 P.M., the Administrator said:- Hot water for resident rooms should be between 105- and 120-degrees Fahrenheit.- A resident should not wait more than three to four minutes for the water to get hot in the rooms.- Resident #28 did make a complaint about the temperature of the hot water in their room saying that it wasn't hot enough. The pipes were tested and a filter changed out. The north hall pipes have been replaced.- The Administrator was not aware that numerous rooms do not reach the required minimum temperature for hot water. - The Administrator said a resident should be able to enter his/her room in his/her wheelchair without difficulty. A residents should not struggle to cross a raised threshold multiple times or need to make multiple attempts to enter his/her room. This was not acceptable.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to file grievances in writing, the right to file grievances anonymously, and the right to obtain a written decision regarding his or her grievance (Resident #28). This affected 12 out of the 14 residents who attended group meeting and one of the 12 sampled residents, (Resident #15). The facility census was 38. Review of facility policy, Residents' Rights, dated 6/10/25, showed:- The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished; and the behavior of staff and or other residents; and other concerns regarding their long-term care stay;- The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Review of the facility policy, Resident and Family Grievances, dated 6/10/25, showed:- It is the policy of this facility to support each resident's and family member's rights to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal;- Prompt efforts to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance;- Evidence demonstrating the results of all grievances will be maintained for a period of no less than three years from the issuance of the grievance decision;- The facility will make prompt efforts to resolve the grievances. 1. During a group interview on 12/2/25 at 10:00 A.M., the Resident Council said:- 10 of 14 residents did not know how to file a grievance or complaint;- 10 of 14 residents did not know where the complaint forms were located or how to file an anonymous complaint with the facility;- 10 of 14 residents did not know what the resident rights were concerning the grievance process. Observation on 12/2/25 at 11:00 A.M., showed the grievance forms were located on the back wall of the nurse's station that was not readily accessible to residents and there was no grievance box located in the facility for residents to file a grievance anonymously. During an interview on 12/4/25 at 6:10 A.M., Registered Nurse (RN) A said:- He/She didn't know how residents could file an anonymous grievance.- The facility had the grievance forms behind the nurse's station. During an interview on 12/4/25 at 9:00 A.M., the Minimum Data Set (MDS) Coordinator said:- The resident's had access to the grievance papers in the back of the nurses station;- He/She wasn't sure how a resident could submit a grievance anonymously;- He/She wasn't sure where a resident could submit a grievance anonymously. During an interview on 12/4/25 at 10:06 A.M., the Administrator said:- The grievance forms were located at the nurse's station and the residents could put them under any staff members door to be submitted;- She spoke to residents often, did rounds, and talked to the residents a lot concerning grievances. During an interview on 12/5/25 at 7:18 A.M., RN B said:- Residents could call in grievances;- There was no access to grievance forms that he/she knew about. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #15's care plan, revised 9/15/25 showed the resident required encouragement and emotional support to maintain as much independence and control as possible. Review of the resident's Quarterly MDS, dated [DATE] showed: -Cognitive skills intact -No behaviors -Independent with toilet use, dressing, personal hygiene and transfers. -Diagnoses included fractures, cancer, anxiety, depression, and low back pain. During an interview on 12/3/25 at 1:33 P.M., the Social Services Designee said: - The facility does do not keep a Grievance book kept but a log. The facility had not had any grievances filed since 2/28/25. There was a clear plastic sleeve behind the nurse's station on the wall above the counter with two blank grievance forms. Anyone could have access to it. The staff tell the residents where the forms are located at every resident council meeting. The residents are able to get a form at nurse's station, fill it out and give it to the nurse who can put it in an envelope or have them slide under the door of Social Services. After Social Services gets the grievance, he/she would discuss it with the resident, would discuss it with the Administrator and turn it into the Administrator after it was completed. During an interview on 12/3/25 at 3:51 P.M., Resident #15 said: - About six months ago, he/she woke up to LPN B yelling and cussing at Resident #16 and said to the resident if Resident #16 was not going to fucking help get his/her pants on if he/she was going to be playing with him/herself. - Resident #15 filed a grievance with the Administrator. The Administrator did not follow back up with Resident #15. During an interview on 12/4/25 at 5:37 A.M., LPN A said: - He/She gave a grievance form for Resident #15 to fill out, and it was turned into the Administrator back in July. Resident #15 wanted to fill it out because he/she said LPN B was talking mean to Resident #16. Resident #15 said the Administrator was supposed to follow back up with him/her but Resident #15 said the Administrator didn't. He/She did not think the grievance forms could be filled out anonymously because of central location in view of everyone. During an interview on 12/4/25 at 1:27 P.M., Resident #15 and Resident #16 said Resident #15 filled out a grievance and it ended up with the Administrator. The Administrator said she would go over what was going to be put in place, but no one followed up with him/her. During an interview on 12/5/25 at 7:21 A.M., RN B said Resident #15 reported LPN B had yelled at Resident #16, something about LPN B was not going to take care of him/her if the resident was going to masturbate during care. During an interview on 12/5/25 at 10:49 A.M., Social Services and the Administrator said: - The Administrator was on vacation, when Resident #15 filed the grievance. The previous DON and the Administrator from a sister facility took care of it. The Administrator talked to Resident #15 after (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she returned from vacation. She had reached out to the former DON for the investigation. During an interview on 12/5/25 at 2:12 P.M., the Administrator said: - Did not think the staff should have to document in the progress notes if a grievance had been filed. - Whenever a resident or family member has a concern, staff should fill out a grievance. The resident or family member should fill it out and turn it into SS, who would start the investigation. - SS would follow up with the resident to inform them how it was handled. - On admission, the resident and family members are told where the grievances are located, it is discussed at the resident council meetings and at the care plan meetings. - If a resident wanted to file it anonymously, the resident could ask a staff member and when it was filled out, give it to the staff member to turn into SS. 3. Review of Resident #28's, Quarterly MDS, dated [DATE], showed:- Resident was moderately cognitively impaired:- Diagnosis: dementia, Parkinson's Disease, and depression; During an interview on 12/2/25 at 10:40 A.M., Family member said:- The resident had been here since February 2025, and the water had never been hot. The family had complained to the Administrator about the issue about the hot water and the facility offered to switch resident rooms which the family declined. The issue had never been resolved.- The family member also complained to the Administrator that a medication for the resident was stopped without doctor's orders, and this caused the resident to experience increased behaviors. The family was told the error was caused by another facility's medication error.- The family member also complained about medical approvals for care being signed in his/her name without her actually agreeing or signing the documents. This issue was never responded back to the family with a result of an investigation. The time elapsed was over three weeks. - No written responses were received by the family from the facility or Administrator. During an interview on 12/5/25 at 2:20 P.M., the Administrator said:- The Administrator recalled a complaint by the family of Resident #28 pertaining to hot water in the room and this issue was addressed by maintenance staff.- The Administrator recalled a complaint by the family about medications not administered to Resident #28 and this was attributed to a medication error by another facility. - The Administrator said grievances were filled out and formal responses provided for the family of Resident #28.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure they developed and implemented a comprehensive person-centered plan of care which included measurable objectives and timeframes to address and meet each resident's specific medical, nursing, mental, and psychosocial needs for two of the 12 sampled residents, (Resident #16 and #40). The facility census was 40. Review of the facility's policy for comprehensive care plans, revised 6/30/25 showed:- It was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL serviced that are identified in the resident's comprehensive assessment and meet professional standards of quality. - The care planning process will include an assessment of the resident's strengths, and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate, culturally competent and trauma informed care as indicated. - The comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his/her right to refuse treatment. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. The resident's goals for admission, desired outcomes, and preferences and align with the resident's cultural identity, as indicated. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to mitigate or decrease the effect of the trigger on the resident. - The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: the attending physician, or non-physician practitioner designee involved in the resident's care, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. - The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS, a federally mandated assessment completed by facility staff) assessment.- The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. - The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative. - Qualified staff responsible for carrying out interventions, initially and when changes are made. 1. Review of Resident #40's care plan revised 3/6/25 showed it did not address the use of oxygen. Review of the resident's Annual MDS, dated [DATE] showed:- Cognitive skills intact.- No behaviors.- Required partial to moderate assistance with oral care and personal hygiene.- Dependent on the assistance of staff for toilet use, showers, dressing and transfers.- Always incontinent of bowel and bladder.- Diagnoses included chronic obstructive pulmonary disease (COPD), cancer, irregular heartbeat, blood clots, high blood pressure, anxiety, and Sepsis (a life-threatening medical emergency caused by the body's extreme response to an infection, leading to tissue damage and organ failure) Review of the resident's physician order sheet (POS), dated December 2025 (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed:- Order date - 11/26/25 - Oxygen (O2) at 1 - 2 Liters (L) to keep oxygen saturation above 92% as needed. 2. Review of Resident #16's care plan, revised 9/25/25 showed:- The resident had a behavior problem related to his traumatic brain injury. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Nighttime cares will be completed with two staff members in room at all times. When behaviors occur, report to charge nurse for redirection. - The resident has a communication problem related to a head injury. Anticipate and meet needs. The resident is able to make his/her needs/wants known. Monitor/document the resident's ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend. - The resident had a cognition problem. Ask the resident to repeat him/herself as needed if you cannot understand. Orientate the resident to time, day, month, year, place and situation as needed. - Bowel and bladder - The resident did not wear adult incontinent products per his/her choice. The resident was continent of bowel and occasionally incontinent of bladder. The resident was independent with toileting. - Activities of Daily Living (ADL) function - The resident was independent with walking throughout the facility. Bathing/showering: check nail length and trim and clean on bath day and as necessary. The resident was able to reposition him/herself while in bed throughout the day and night. The resident was able to dress him/herself and can complete personal hygiene without assistance. The resident was able to toilet him/herself and transfer him/herself independently. - The care plan did not address the resident's inappropriate sexual behaviors. Review of the resident's Quarterly MDS dated [DATE] showed:- Cognitive skills severely impaired.- Independent with toilet use, dressing, personal hygiene and transfers.- Supervision or touch assistance with showers.Always continent of bowel and bladder.- Diagnoses included traumatic brain injury (TBI, damage to the brain from an external force, like a blow, [NAME], or penetrating injury, disrupting normal brain function and causing temporary or permanent physical, cognitive and emotional issues. - No pain.- No falls.- No antipsychotic medications were used. During an interview on 12/4/25 at Licensed Practical Nurse (LPN) A said:- The use of oxygen should be care planned. - The resident's sexual behaviors should be care planned. During an interview on 12/5/25 at 7:12 A.M., Registered Nurse (RN) B said:- The care plan should address the use of oxygen. - Sexual behaviors should be care planned. During an interview on 12/5/25 at 10:49 A.M., the Social Services Designee said:- The care plan should address the use of oxygen. - He/She did not go into a lot of detail about the resident being sexually inappropriate because he/she did not know if that would be appropriate. During an interview on 12/5/25 at 2:12 P.M., the Administrator said:- Oxygen use should be care planned.- The care plans should be detailed and have specific information on how to care for the resident with interventions and update them as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265746	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 assure staff followed acceptable standards of practice for one sampled resident (Residents #28) when facility licensed staff did not transcribe admission orders correctly which resulted in the discontinuance of resident's Donepezil medication for dementia and placed the resident at risk for decline in mental health. Additionally, the facility failed to ensure staff administered eye drops correctly which affected Resident #9. This affected two of 12 sampled residents (Residents #9 and #28). The facility census was 38. Review of the facility's policy for medication administration, revised [DATE] showed: - Medications are administered by licensed nurses, or other staff who are legally authorized to do in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review of the facility's policy for administration of eye drops or ointments, revised [DATE] showed: - Eye medications are administered as ordered by the physician and in accordance with professional standards of practice to lubricate the eye or treat certain eye conditions. - Remove medication cap and place on clean, dry surface to prevent contamination. Steady hand holding the medication, as needed, on resident's forehead. With other hand, pull down lower eyelid to form a pouch of the conjunctival sac from the inner to outer eye. For eye drops, squeeze the prescribed number of drops into the conjunctival sac, avoiding placement of the drops directly on the eyeball. - Avoid touching the tip of the bottle to the resident's lid, lashes or surface of the eye. - Instruct resident to close eyes slowly to allow for even distribution over the surface of the eye and apply gently pressure to the tear duct or have the resident gently close the eye. - If a second medication is required in the same eye, wait appropriate amount of time per manufacturer's specifications (usually five minutes). 1. Review of Resident #9's Physician Order Sheet (POS) dated [DATE] showed: - Start date: [DATE] - Betaxolol HCL (Betoptic S) 0.5 % instill one drop in both eyes two times a day for glaucoma. - Start date: [DATE] - Brimonidine Tartrate Ophthalmic solution 0.2%, instill one drop in both eyes two times a day for glaucoma. - Start date: [DATE] - Dorzolemide HCL solution 2%, instill one drop in both eyes two times a day for glaucoma. Review of the Resident's Medication Administration Record (MAR) dated [DATE] showed: - Betaxolol HCL (Betoptic S) 0.5 % instill one drop in both eyes two times a day for glaucoma. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Brimonidine Tartrate Ophthalmic solution 0.2%, instill one drop in both eyes two times a day for glaucoma. - Dorzolemide HCL solution 2%, instill one drop in both eyes two times a day for glaucoma. Observation on [DATE] at 6:37 A.M., showed: - Licensed Practical Nurse (LPN) A placed Betoptic -S, one drop in the resident's left eye and applied lacrimal pressure for 15 seconds and placed one drop in the resident's right eye and applied lacrimal pressure for 18 seconds. The tip of the eye dropper touched the resident's eye lids and eye lashes. - At 7:07 A.M., LPN A placed one drop in the right eye and applied lacrimal pressure for 18 seconds and placed one drop in the resident's left eye and applied lacrimal pressure for 20 sec. The tip of the eye dropper touched the resident's eye lids and eye lashes. - At 7:30 A.M., LPN A placed Dorzolamide 2%, one drop in the resident's left eye and applied lacrimal pressure for 14 seconds and placed one drop in the resident's right eye and applied lacrimal pressure for 21 seconds. The tip of the eye dropper touched the resident's eye lids and eye lashes. During an interview on [DATE] at 7:40 A.M., LPN A said the tip of the eye dropper should not touch the resident's eye lids or eye lashes. He/She was not for sure about the lacrimal pressure. During an interview on [DATE] at 2:12 P.M., the Administrator said the tip of the eye dropper should not touch the eye lids or eye lashes. Staff should apply lacrimal pressure but unaware about the specific time frame. Review of facility policy, Medication Orders, dated [DATE], showed:- Documentation of Medications Orders: If using electronic medication records, input the medication order according to the electronic health record (HER) instructions and facility policy;- Transcribe newly prescribed medications on the MAR or treatment record or ensure the order is in the electronic MAR; - When a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing DC'd and the date, or discontinue the order as per the electronic software instructions and retype the new order;- Notify resident's sponsor/family of new medication order;- Written Transfer Orders (sent with a resident by a hospital or other health care facility) – Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician; 1. Review of Resident #28's, Quarterly Minimum Data Set (MDS), A federally mandated assessment completed by facility staff, dated [DATE], showed:- Resident had moderately impaired cognition;- Diagnosis: dementia, Parkinson's Disease, and depression; Record review of Resident's census report, dated [DATE], showed:- Resident was discharged on [DATE] and returned to the facility on [DATE];- Resident was discharged on [DATE] and returned to the facility on [DATE]; Record review of Resident's Hospital Discharge orders back to the facility, dated [DATE], showed to continue taking Donepezil 10 milligram tablet, 1 tablet by mouth nightly. Record review of facility medication administration record for the resident, dated 5/1-[DATE], showed:- Donepezil HCL Oral Tablet 10 milligrams not administered from 5/1-[DATE] due to resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being out of the facility;- Donepezil HCL Oral Tablet 10 milligrams discontinued by the facility on [DATE]. Record review of Resident's Hospital Discharge orders back to the facility, dated [DATE], showed Donepezil 10 milligram tablets was not listed as a prescribed medication for the resident; Record review of Resident's Order Summary Record, dated [DATE], showed:- Donepezil HCL Oral Tablet 10 milligram started on [DATE];- Donepezil HCL Oral Tablet 10 milligram one time a day related to unspecified dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, renewed [DATE];- Review of complete medical record showed resident went without Donepezil from [DATE] to [DATE]; Review of Resident's Care Plan, dated [DATE], showed Cognitive function: administer medications as ordered, monitor/document for side effects and effectiveness. During an interview on [DATE] at 11:05 A.M., RN A said:- When residents are discharged to the hospital their medical records including medications that they are currently taking are sent with the resident. The records are printed out and sent out to the hospital or facility where the resident is being transferred. Nothing is done manually except to print out the records. They are also faxed to the facility but there is no record kept that this is done when the transfer occurs. - A review by RN A showed that Donepezil was discontinued for the resident on [DATE] by the facility and restarted on [DATE] by the facility. The resident was hospitalized from [DATE] to [DATE] outside of the facility. During an interview on [DATE] at 9:15 A.M., Nurse Practitioner A said:- He/she was the Nurse Practitioner for the resident. - The sudden discontinuance of Donepezil can cause a rise in behaviors for a resident in regard to dementia control. The resident's family member alerted him/her that the resident was not being administered Donepezil as ordered which then explained to the Nurse Practitioner why the resident was having increased behaviors, being non-responsive to family members, and at times being extremely lethargic. - The Nurse Practitioner would not have ordered the medication discontinued and it was his/her intention that the resident remain on Donepezil long term due to their diagnosis of dementia. When he/she found out that the resident was not receiving Donepezil, he/she ordered it to be started back up immediately on [DATE]. During an interview on [DATE] at 10:10 A.M., Resident family member said:- He/she realized that resident was acting strangely and detached from family members in early [DATE]. Resident was lethargic and unresponsive which triggered the family member to look at the resident's medications. The family member noticed that Donepezil had been discontinued and brought the issue up to the Nurse Practitioner A and the facility. Nurse Practitioner A started the resident back up on Donepezil immediately and the facility said it was the outside hospital that discontinued the resident's medications. - This family member was extremely distraught during the interview and was crying due to the guilt he/she felt that he/she had let down their family member by not monitoring the resident's medications more closely. The family member felt responsible that when the resident expired on [DATE] that he/she had not done their best to make their remaining time alive as comfortable as possible due to the lack of proper treatment for the resident's dementia. During an interview on [DATE] at 2:20 P.M., the Administrator said:- She had received a complaint about Donepezil not being administered to the resident. The Administrator's staff investigated the incident and concluded the medication was dropped by an outside facility hospital during transfer of the resident and the orders not relayed back to the facility when the resident returned for (continued on next page)

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	265746	A. Building B. Wing	12/05/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	re-admission. - When residents are admitted into the facility the on-duty nurse enters the medication orders into the medical system. The orders come in via fax or on a written paper. They do a discharge order reconciliation to make sure the medications are correct and enter them into the system manually. If they have a question about the medications, they will contact the physician for clarification.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide proper respiratory care when staff failed to document the date when oxygen tubing was cleaned for one resident (Resident #6), failed to provide oxygen humidification for three residents (Resident #20, #21, and #22), and failed to properly store oxygen accessories at the bedside for four residents (Residents #6, #20, #21, and #22) resulting in possible exposure to dirt, dust and bacteria during oxygen usage. This affected three of 12 sampled residents. The facility census was 38. Review of facility's policy Oxygen Administration, dated 5/16/25, showed:- Oxygen is administered under orders of a physician, except in the case of an emergency;- The resident's care plan shall identify the interventions for oxygen therapy including but not limited to type of oxygen delivery system, when to administer, equipment setting for the prescribed flow rates, and monitoring;- Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include change oxygen tubing and mask/cannula weekly and as needed, change humidifier bottle when empty or as recommended by the manufacturer, and keep delivery devices covered in plastic bag when not in use. 1. Review of Resident #21's Annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 11/19/25, showed:- The Resident was cognitively intact;- The Resident required a wheelchair;- The Resident diagnoses: chronic respiratory failure, heart failure, and anxiety disorder. Review of the resident's comprehensive care plan, dated 11/28/25, showed:- The Resident's oxygen settings required oxygen via nasal cannula to be set at three liters while the resident was at rest and four to five liters with exertion;- The Resident used a wheelchair for mobility and required staff to propel due to him/her needing the oxygen concentrator at all times. Review of the resident's physician orders, dated 12/5/25, showed:- The nursing staff were to change nebulizer tubing and date weekly;- The nursing staff were to change oxygen tubing and date weekly;- The Resident was to continue using oxygen per nasal cannula at a rate of three liters at rest and four to five liters with exertion. Review of the resident's nursing progress notes for the month of November 2025, showed:- On 11/27/25 at 10:55 P.M., The resident had a nosebleed in his/her left nostril and staff offered to put the humidifier bottle on the concentrator which the resident declined and said when the humidifier bottle is attached to the concentrator, he/she didn't seem to get enough oxygen. An observation of the resident's room, on 12/2/25 at 10:00 A.M., showed:- The oxygen tubing had been dated but there was no storage bag for the tubing;- The Resident was sitting on the side of his/her bed, with oxygen applied and the oxygen concentrator running at two and a half liters;- No humidifier bottle had been attached to the concentrator. The humidifier bottle was detached and sitting on a nearby dresser. During an interview on 12/3/25 at 8:10 A.M., the Resident said:- The humidifier bottle was on his/her dresser, and he/she had staff remove it because the air wouldn't come out right;- Staff hadn't tried to find out why the air wouldn't come out right but just removed the humidifier bottle;- He/She would get a dry nose and headaches at times. (continued on next page)

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	265746	A. Building B. Wing	12/05/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #20's admission MDS, dated [DATE], showed:- The Resident was cognitively intact;- The Resident required substantial assistance from staff for toileting, hygiene, and transfers;- The Resident diagnoses: chronic respiratory failure, low blood oxygen levels, and heart failure. Review of the resident's comprehensive care plan, dated 11/28/25, showed:- The Resident's oxygen settings required oxygen via nasal prongs (cannula) to be set at two liters at all times. Review of the resident's physician orders, dated 12/5/25, showed:- The nursing staff were to change the oxygen humidifier weekly;- The nursing staff were to change and date oxygen tubing and storage bag weekly;- The Resident was to receive oxygen at two liters continuously to maintain oxygen saturation above 90%. An observation of the resident's room, on 12/2/25 at 10:15 A.M., showed:- The oxygen tubing and nebulizer tubing had been dated but there was no storage bag for the tubing;- The Resident was sitting up in a recliner, with oxygen applied and the oxygen concentrator running at two liters;- No humidifier bottle had been attached to the concentrator. During an interview on 12/3/25 at 7:10 A.M., the Resident said:- He/She doesn't think there had ever been a humidifier bottle on the oxygen concentrator;- His/her nose gets pretty dry at times. 3. Review of Resident #22's Quarterly MDS, dated [DATE], showed:- The Resident had moderate cognitive impairment;- The Resident required moderate assistance from staff for toileting, hygiene, and transfers;- The Resident diagnoses: chronic respiratory failure, Alzheimer's disease, and osteoarthritis. Review of the resident's comprehensive care plan, dated 11/28/25, showed:- The Resident's oxygen settings required oxygen via nasal prongs (cannula) at two liters continuously. Humidified. Review of the resident's physician orders, dated 12/5/25, showed:- The nursing staff were to change the oxygen tubing and label weekly;- The Resident was to receive oxygen at three liters continuously. An observation of the resident's room, on 12/2/25 at 11:46 A.M., showed:- The oxygen tubing had been dated but there was no storage bag for the tubing;- The Resident was laying in his/her bed, with oxygen applied and the oxygen concentrator running at two liters;- No humidifier bottle had been attached to the concentrator. During an interview on 12/2/25 at 3:24 P.M., the Resident said:- He/She wears the oxygen all of the time;- He/She hadn't been concerned that there was no humidifier bottle on the oxygen concentrator. During an interview on 12/4/25 at 6:10 A.M., Registered Nurse (RN) A said:- Oxygen concentrators should have humidifier bottles if the physician orders them that way;- If a resident has an order for oxygen with humidification there should definitely be a humidifier bottle attached to the concentrator;- Oxygen and nebulizer tubing do not get stored in bags. Staff keep the tubing coiled up on the concentrators. During an interview on 12/4/25 at 9:00 A.M., the MDS Coordinator said there should be humidifier bottles on the oxygen concentrators, if they, the residents prefer. During an interview on 12/4/25 at 10:06 A.M., the Administrator said there should be a humidifier on (continued on next page)

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	265746	A. Building B. Wing	12/05/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the oxygen concentrator if it had been care planned or if there was a provider order. 4.Review of Resident #6's care plan, revised 11/28/25 showed: Chronic Obstructive Pulmonary Disease (COPD) - Oxygen settings: 7 liters/nasal cannula continuously. Monitor for difficulty breathing on exertion. Review of the resident's admission MDS, dated [DATE] showed: - Cognitive skills for daily decision making intact. - Required partial to moderate assistance for toilet use and transfers. - Diagnoses included acute and chronic respiratory failure with hypoxia, irregular heartbeat, heart failure, pneumonia, depression, COPD, respiratory failure and gangrene and necrosis of the lung. Review of the resident's physician's order sheet (POS) dated December 2025 showed a start date of 11/12/25 - Oxygen at 7 L/NC continuously to maintain O2 saturation above 90% every shift for shortness of breath. Observation on 12/2/25 at 11:01 A.M. showed the resident had oxygen on at 7L/NC. The oxygen tubing was not dated. The nebulizer tubing was not dated. In the resident's bathroom was a portable O2 tank in a stand and the oxygen tubing was not dated. During an interview on 12/3/25 at 9:59 A.M., Registered Nurse (RN) A said the oxygen tubing and the nebulizer tubing should be dated and changed out weekly. During an interview on 12/4/25 at 5:37 A.M., LPN A said: - The oxygen tubing should be dated, and it should be changed weekly. - The nebulizer canisters should also be rinsed and cleaned after each treatment and should be dated and changed out weekly. During an interview on 1212/5/25 at 7:21 A.M., RN B said: - The oxygen and nebulizer tubing should be dated. - The resident's do not have to have a humidified water bottle unless there is a physician's order. - There should be a physician's order for oxygen and it should be care planned. During an interview on 12/5/25 at 2:12 P.M., the Administrator said: - The oxygen tubing should be dated. the evening shift was responsible to change it out weekly. - The staff had not dated the nebulizer tubing, but it should be dated, and so should the portable O2 tubing. - There should be a physician's order for oxygen, and it should be care planned.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation and interview, the facility failed to hire or designate a Registered Nurse (RN) to serve as the Director of Nursing (DON) on a full-time basis. The facility census was 38.The facility did not provide a policy for staffing a full-time DON. 1. Observations from 12/2/25 through 12/5/25 at various times showed the facility had charge nurses (CN) available but did not have a DON. During an interview on 12/2/25 at 10:00 A.M., the Administrator said:- The facility currently did not have a full-time DON.- The previous DON stepped down in September or October of this year. - There was always an RN scheduled eight hours a day, seven days a week during daytime hours.- A licensed nurse is scheduled on every shift. - She had three interviews this week and another one had been scheduled for this week.- The facility should have a full-time DON.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of the 12 sampled residents, (Resident #16) right to be free from verbal abuse when Licensed Practical Nurse (LPN) B cursed at the resident and refused to provide care to the resident if his/she did not change his/her behavior. The facility census was 38. Review of the facility's policy for Abuse, Neglect and Exploitation, revised 6/30/25, showed:- It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. - The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. - The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. - Prevention of Abuse, Neglect and Exploitation - Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; the identification, ongoing assessment , care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; providing residents, representatives and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed.- Identification of Abuse, Neglect and Exploitation - Possible indictors of abuse include, but are not limited to resident, staff or family report of abuse; verbal abuse of a resident overheard. - Investigation of Alleged Abuse, Neglect and Exploitation - An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include identifying staff responsible for the investigation; Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause. Providing complete and thorough documentation of the investigation. - Protection of Resident - The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: responding immediately to protect the alleged victim and integrity of the investigation. Room or staffing changes, if necessary, to protect the residents from the alleged perpetrator. Protection form retaliation. Providing emotional support and counseling to the resident during and after the investigation, as needed. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. - Reporting/Response - The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes. Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Assuring that the reporters are free from retaliation or reprisal. Taking all necessary actions as a result of the investigation, which may include, but are not limited to the following: analyzing the occurrence to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences. Defining how care provision (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265746	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will be changed and/or improved to protect residents receiving services. The Administrator will follow up with government agencies, during business hours to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies. 1. Review of Resident #16's care plan, revised 9/25/25 showed staff assessed the resident.- The resident had a behavior, communication, and cognitive problems related to his/her traumatic brain injury. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Nighttime cares will be completed with two staff members in room at all times. When behaviors occur, report to charge nurse for redirection. - Anticipate and meet needs. Monitor/document the resident's ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend. - Ask the resident to repeat him/herself as needed if you cannot understand. Orientate the resident to time, day, month, year, place and situation as needed. - Bowel and bladder - The resident did not wear adult incontinent products per his/her choice. The resident was continent of bowel and occasionally incontinent of bladder. The resident was independent with toileting. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/31/25 showed:- Cognitive skills severely impaired.- Independent with toilet use, dressing, personal hygiene and transfers.- Supervision or touch assistance with showers.Always continent of bowel and bladder.- Diagnoses included traumatic brain injury (TBI, damage to the brain from an external force, like a blow, [NAME], or penetrating injury, disrupting normal brain function and causing temporary or permanent physical, cognitive and emotional issues. Review of the resident's progress notes on 7/18/25 at 9:24 A.M. a late entry Saturday the 7/12/25 showed staff documented during morning med pass Resident #15 said Resident #16 had diarrhea last night and was still needing cleaned up. A nurse, LPN B, who the resident stated by name, yelled at Resident #16 and said, if you would quit playing with your [genitals], I would help you. Resident #16 had dried fecal material on his/her back, in his/her bed, on the recliner and had dried fecal material in the groin area and needed a clean incontinent brief. Resident #16 reported LPN B did not provide assistance to Resident #16 all night and did not get assistance until the next morning. During an interview on 12/3/25 at 9:59 A.M., Registered Nurse (RN) A said:-The roommate of Resident #16 reported to him/her that Resident #16 was yelled at by night shift nurse and frequently had to try and clean him/herself up.- He/she had frequently reported it to the Administrator. During an interview on 12/3/25 at 3:51 P.M., Resident #15 said:- About six months ago, he/she woke up to LPN B yelling and cussing at Resident #16 and said, you aren't going to get any help, and I am not going to help you if you keep playing with your [genitals].- Resident #15 filed a grievance with the Administrator. The Administrator did not follow back up.- It made him/her upset and mad when LPN B was yelling and cussing at him/her.- When Resident's incontinent of bowel, he/she could hear the staff in the hallway saying, it's your turn, it's not my turn to go in there, like they were drawing straws. It hurt Resident #16's feelings. - The Administrator does not make the staff provide cares for Resident #16 if staff refuse. During an interview on 12/4/25 at 5:37 A.M., LPN A said:- He/She gave a grievance form to Resident #15 to fill out to reported about LPN B's abusive behavior, and the grievance form was turned into the Administrator back in July. - Resident #16 has a brain injury and the staff do not like to take care of him/her. Staff have reported to the Administrator multiple times the resident does not receive the care he/she needs because the staff do not like him/her. - The resident shows inappropriate behavior at times when he/she touches his/her genitals. Some staff are very rude and abrupt with the resident and tell him/her they are not going to take care of him/her until he/she stops. - He/She expects all staff to take care of the resident and to be respectful. During an interview on 12/4/25 at 1:27 P.M., Resident #16 said:- Resident #15 filled out a grievance and gave it to the Administrator. The Administrator said she would go over what was going to be put in place, but did not follow up with the resident.- LPN B was the only one staff member who was not nice to him/her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/25 at 3:32 P.M., LPN B said:- Resident #16 has inappropriate behaviors like touching his/her [genitals] in front of staff. - He/She was not aware of any staff who refused to care for the resident and felt like the resident was aware of what he/she was doing.- He/She had not cussed at the resident and not aware of any staff who have cussed at the resident.- He/She denied being verbally abusive to the resident. During an interview on 12/5/25 at 7:21 A.M., RN B said:- The evening nurse, LPN B was very vulgar at times.- Resident #15 reported that LPN B had yelled at Resident #16, something about he/she was not going to take care of him/her if he/she was going to have his/her [genitals] in his/her hand. RN B said he/she did not know why but he/she did not document the conversation in the chart, fill out a grievance and did not notify Social Services or the Administrator. - He/She did not think the Administrator followed up on the grievance because no changes were made, the resident's behaviors continued, and LPN B still works at the facility. During an interview on 12/5/25 at 10:49 A.M., Social Services and the Administrator said:- The facility had not addressed the resident's behaviors. - When Resident #15 filed the grievance the Administrator was on vacation, - The investigations completed over the past three months were not related to an allegation of abuse. During an interview on 12/5/25 at 2:12 P.M., the Administrator said:- The residents have the right to be free from abuse and neglect.- He/she did not think the staff should have to document in the progress when a grievance had been filed. - The staff should report any allegations of abuse and neglect to the charge nurse or to him/her. - He/She completes the documentation regrading investigations and files it. - All allegations of abuse should be investigated and reported.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to implement their abuse policy when staff did not conduct a thorough investigation when one of the 12 sampled residents when (Resident #16), reported an observed allegation of verbal abuse of Resident #15 by LPN B. The facility census was 38. Review of the facility's policy for Abuse, Neglect and Exploitation, revised 6/30/25, showed:- It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. - The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. - The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. - Prevention of Abuse, Neglect and Exploitation - Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; the identification, ongoing assessment , care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; providing residents, representatives and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed.- Identification of Abuse, Neglect and Exploitation - Possible indictors of abuse include, but are not limited to resident, staff or family report of abuse; verbal abuse of a resident overheard. - Investigation of Alleged Abuse, Neglect and Exploitation - An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include identifying staff responsible for the investigation; Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause. Providing complete and thorough documentation of the investigation. - Protection of Resident - The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: responding immediately to protect the alleged victim and integrity of the investigation. Room or staffing changes, if necessary, to protect the residents from the alleged perpetrator. Protection form retaliation. Providing emotional support and counseling to the resident during and after the investigation, as needed. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. - Reporting/Response - The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes. Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Assuring that the reporters are free from retaliation or reprisal. Taking all necessary actions as a result of the investigation, which may include, but are not limited to the following: analyzing the occurrence to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences. Defining how care provision will be changed and/or improved to protect residents receiving services. The Administrator will follow up with government agencies, during business hours (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies. 1. Review of Resident #16's care plan, revised 9/25/25 showed staff assessed the resident has behavior, communication, and cognitive problems related to his/her traumatic brain injury. The resident chooses to not wear incontinent products, is occasionally incontinent of bladder, independent with Activities of Daily Living (ADL's). Staff are directed to do the following: -If reasonable, discuss the resident's behavior and explain/reinforce why behavior is inappropriate and/or unacceptable. -Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. -Nighttime cares are to be completed with two staff members in room at all times. When behaviors occur, report to charge nurse for redirection. - Anticipate and meet needs. -Monitor/document the resident's ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend. - Ask the resident to repeat him/herself as needed if you cannot understand. -Orientate the resident to time, day, month, year, place and situation as needed. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/31/25 showed:- Cognitive skills severely impaired.- Independent with toilet use, dressing, personal hygiene and transfers.- Supervision or touch assistance with showers.Always continent of bowel and bladder.- Diagnoses included traumatic brain injury (TBI, damage to the brain from an external force, like a blow, [NAME], or penetrating injury, disrupting normal brain function and causing temporary or permanent physical, cognitive and emotional issues. - No pain.- No falls.- No antipsychotic medications were used. Review of the resident's progress notes, on 7/18/25 at 9:24 A.M., a late entry for Saturday the 12th showed staff documented during morning med pass Resident #15 said Resident #16 had diarrhea last night and was still needing cleaned up. A nurse yelled at Resident #16 and said, if you would quit playing with your [genitals], I would help you. Resident #16 had dried fecal material on his back, in his bed, on the recliner and had dried fecal material in the peri area and needed a clean incontinent brief. LPN B did not provide assistance to Resident #16 all night and did not get assistance until the next morning. During an interview on 12/3/25 at 9:59 A.M., Registered Nurse (RN) A said:- The shower aides frequently refused to give the resident a shower because he/she touches his/her [genitals] during the shower. - Resident #15 had reported to him/her that Resident #16 frequently had to clean him/herself up on the evening shift because the staff refused to do it.- He/she had frequently reported it to the Administrator, but nothing gets done by the staff. During an interview on 12/3/25 at 1:33 P.M., the Social Services Designee said he/she said they keep a grievance log and they have not had any grievances filed since 2/28/25. He/she was unaware of the grievance filed by Resident #15 regarding the staff verbally abusing Resident #16 and refusing to provide cares.During an interview on 12/3/25 at 3:51 P.M., Resident #15 said: - About six months ago, he/she woke up to LPN B yelling and cussing at Resident #16 and said, you aren't going to get any help, and I am not going to help you if you keep playing with your genitals. - Resident #15 filed a grievance with the Administrator. The Administrator did not follow back up - It made him/her upset and mad when LPN B was yelling and cussing at him/her. - When Resident #16 is incontinent of bowel, he/she could hear the staff in the hallway saying, it's your turn, it's not my turn to go in there, like they were drawing straws. It hurt the resident's feelings. - The Administrator does not make the staff do any cares for Resident #16 if they refuse to.During an interview on 12/4/25 at 5:37 A.M., LPN A said: - He/She gave a grievance form to Resident #15 to fill out to report LPN B's abusive behavior, and the grievance was turned into the Administrator back in July. - Resident #16 has a brain injury and the staff do not like to take care of him/her. Staff have reported to the Administrator multiple times the resident does not receive the care he/she needs because the staff do not like him/her. - The resident shows inappropriate behavior at times when he/she touches his/her genitals. Some staff are very rude and abrupt with the resident. Staff tell the resident they are not going to take care of him/her until he/she stops. - He/She would expect all staff to take care of the resident and be respectful.During an (continued on next page)

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	265746	A. Building B. Wing	12/05/2025

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Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 12/4/25 at 10:10 A.M., CNA B said:- Resident #15 had reported to him/her about the night shift staff not providing cares for Resident #16.- The Administrator had not given the staff any guidance or instructions on how to care for Resident #16. During an interview on 12/4/25 at 12:27 P.M., RN A said the night nurse reported to him/her that Resident #15 had filed a grievance about how LPN B had talked to Resident #16 and how care was withheld by LPN B. During an interview on 12/5/25 at 7:21 A.M., RN B said: - Resident #15 said LPN B had yelled at Resident #16 and said he/she was not going to take care of him/her if he/she was going to have his/her [genitals] in his/her hand. RN B said he/she did not know why but he/she did not document the conversation in the chart, fill out a grievance and did not notify social services or the Administrator but should have. - He/She did not think the Administrator followed up on anything but said she would check into it. During an interview on 12/5/25 at 10:49 A.M., Social Services and the Administrator said: - The Administrator thought reporting to the charge nurse was sufficient and the resident did not need to fill out a grievance. The report was received on the evening and night shifts. - They have tried different things, two staff going into the room, having a male staff giving the showers and making sure the bathroom door was closed. - Staff should have documented his/her behaviors. - They had not addressed Resident #16s behaviors and implemented ways to help him/her. - -They did not think Resident #15 would approve of the resident having any magazines or providing a private place for him/her to touch him/herself.- The Administrator was on vacation, when Resident #15 filed the grievance. -The previous DON and the Administrator from a sister facility took care of it. - The Administrator reached out to the former DON for the investigation. -The Administrator talked to Resident #15 about the grievance after she returned from vacation. - The only investigations the Administrator had done in the last three months was not related to patient care or abuse. During an interview on 12/5/25 at 2:12 P.M., the Administrator said:- Residents have the right to be free from abuse.- He/she was not aware if staff should have to document in the progress notes when a grievance had been filed. - The staff should report any allegations of abuse and neglect to the charge nurse or to him/her. - The staff member involved should have been suspended until an investigation is completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene when staff did not provide complete perineal care for two of 12 sampled residents (Resident #39 and #40). The facility census was 38. Review of the facility's policy, Perineal Care, dated 5/2/25, showed:- It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown;- Perform hand hygiene and put on gloves;- Cleanse all of the genital areas in the direction from front to back;- Use a clean portion of the washcloth or new disposable wipe with each stroke;- Cleanse the bottom of the genital area and the anal area from the front to the back; - Remove gloves and discard. Perform hand hygiene. 1. Review of Resident #40's care plan, revised 2/24/25 showed: Activities of daily living (ADLs). The resident was totally dependent on two staff for toilet use. Bowel and bladder - The resident was dependent on staff for all toileting use. The resident was incontinent of bowel and bladder. Review of the resident's Annual MDS, dated [DATE] showed: - Cognitive skills intact. - No behaviors. - Required partial to moderate assistance with personal hygiene. - Dependent on the assistance of staff for toilet use, showers, dressing and transfers. - Always incontinent of bowel and bladder. - Diagnoses included chronic obstructive pulmonary disease (COPD), cancer, irregular heartbeat, blood clots, high blood pressure, anxiety, and Sepsis (a life-threatening medical emergency caused by the body's extreme response to an infection, leading to tissue damage and organ failure). Observation on 12/5/25 at 8:29 A.M., showed: - CNA E and Nurse Aide (A) used the mechanical lift and transferred the resident from the wheelchair to the bed. - CNA E and NA A removed the resident's wet left pad, wet pants and wet incontinent brief. - CNA E wiped down one side of the groin and used a new wipe and wiped down the other side of the groin. Used a new wipe and wiped down the front perineal folds. - CNA E did not separate and clean all the perineal folds. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA E and NA A turned the resident on his/her side. - CNA E wiped from front to back, used a new wipe and wiped up the inner buttocks. - CNA E did not separate and clean all areas of the skin where urine or feces had touched. - CNA E placed a clean incontinent brief under the resident and fastened it. During an interview on 12/5/25 at 9:51 A.M., CNA E said he/she should have separated and cleaned all areas of the skin where urine had touched. During an interview on 12/5/25 at 2:12 P.M., the Administrator said the staff should separate and clean all areas of the skin where urine or feces had touched. 2. Review of Resident #39's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/1/25 showed:- The Resident was cognitively intact;- The Resident was dependent on the assistance of staff for toilet use, hygiene, and transferring;- The Resident diagnoses included: hemiplegia (paralysis on one side of the body), high blood pressure, and diabetes. Review of the resident's care plan, revised 11/28/25, showed:- The Resident was dependent on two staff for toileting, transferring, and repositioning in bed;- The Resident was at risk for skin issues and nursing staff were required to keep skin clean and dry. Observation on 12/3/2025 at 2:46 P.M., showed: - Certified Nurse Aide (CNA) D and CNA E entered the resident's room.- CNA D and CNA E utilized the sit to stand lift properly, positioned the resident by the toilet, and lowered the resident's pants and brief;- CNA E wiped across the abdominal fold with one wipe then down either side of the resident's groin with a new wipe each time;- CNA E wiped once down the middle genital area with one wipe, then down the same genital area with a new wipe;- CNA D pulled the sit to stand forward a bit so CNA E could get to the resident's back side;- CNA E wiped once from front to back up the crease of the buttocks once; - CNA E did not separate and clean all areas of the skin where urine had touched;- CNA D and CNA E dressed the resident for the day and transferred him/her to his/her bed; During an interview on 12/3/25 at 2:50 P.M., CNA E said when he/she provided peri care he/she should normally clean all areas of the skin where urine had touched and yes, he/she should have done that. During an interview on 12/4/25 at 6:10 A.M., Registered Nurse (RN) A said when staff are performing peri care on a resident, they should make sure to get all areas of the skin and skin folds where urine had touched, not just wipe down the front. During an interview on 12/5/25 at 7:18 A.M., RN B said when staff are performing peri care on a resident they should get all areas of the genitals. During an interview on 12/5/25 at 7:50 A.M., Nursing Assistant (NA) A said when staff are performing peri care staff should not just wipe down the front. Staff should get all areas that are wet or soiled. During an interview on 12/5/25 at 2:18 P.M., the Administrator said when staff are performing peri care they should clean all areas of the genital area, not just the front.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary behavioral care and services for one of 12 sampled residents (Resident #16's), psychosocial well-being when staff did not address the resident's sexual behavior or offer alternative ways for the resident to deal with behaviors. The facility census was 12. The facility did not provide a policy for behaviors. 1. Review of Resident #16's care plan, revised 9/25/25 showed:- The resident had a behavior problem related to his traumatic brain injury. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Nighttime cares will be completed with two staff members in room at all times. When behaviors occur, report to charge nurse for redirection. - The resident has a communication problem related to a head injury. Anticipate and meet needs. The resident is able to make his/her needs/wants known. Monitor/document the resident's ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend. - The resident had a cognition problem. Ask the resident to repeat him/herself as needed if you cannot understand. Orientate the resident to time, day, month, year, place and situation as needed. - Bowel and bladder - The resident did not wear adult incontinent products per his/her choice. The resident is continent of bowel and occasionally incontinent of bladder. The resident is independent with toileting. - Activities of Daily Living (ADL) function - The resident was independent with walking throughout the facility. Bathing/showering: check nail length and trim and clean on bath day and as necessary. The resident is able to reposition him/herself while in bed throughout the day and night. The resident is able to dress him/herself and can complete personal hygiene without assistance. The resident is able to toilet him/herself and can transfer him/herself independently. - The care plan did not give specific interventions for the staff to implement when the resident was being sexually inappropriate. The care plan did not offer alternative ways for the resident to deal with the sexual behaviors. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/31/25 showed:- Cognitive skills severely impaired.- No behaviors.- Independent with toilet use, dressing, personal hygiene and transfers.- Supervision or touch assistance with showers.Always continent of bowel and bladder.- Diagnoses included traumatic brain injury (TBI, damage to the brain from an external force, like a blow, [NAME], or penetrating injury, disrupting normal brain function and causing temporary or permanent physical, cognitive and emotional issues. Review of the resident's progress notes showed:- 2/2/25 at 1:32 P.M., Staff walked into the resident's room and the resident walked out of the bathroom while stroking his [genitals] in front of staff. Staff asked the resident to put his [genitals] away. Staff walked out while the resident was still stroking his [genitals].- 2/2/25 at 1:37 P.M., The resident was being sexually inappropriate with staff, came out of the bathroom with genitals in hand when knew staff were in there and stood there looking at them holding genitals Resident was told to put genitals away and that it was inappropriate in front of them. - 3/26/25 at 5:40 P.M., late entry. Staff went into the resident's room to deliver supper and noticed bathroom door open with the resident inside. The resident was doing very inappropriate thing with his/her [genitals]. Staff shut the door of the bathroom to preserve privacy. Resident opened the door back up wide and stared straight into the staff's faces while fondling his/her [genitalia] in front of the staff. Staff walked out very uncomfortable and reported it to the nurse. - 7/6/25 at 9:00 P.M., The resident was in the bathroom when the nurse took medications in and exposed his/her [genitals] to staff. This nurse closed the door and told him to stop behaving that way. - 7/18/25 at 9:24 A.M., Per request from the Director of Nursing (DON), this writer is to chart what events transpired last Saturday the 12th to cause this writer to give the (continued on next page)

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	265746	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident a shower. This writer was passing morning medications when the spouse of Resident #16 said the resident had diarrhea last night and was still a mess. Per wife, the resident was told if you quit playing with your [genitals], I would help you. Resident had dried fecal material on his/her back, in his/her bed and on the pad in his/her recliner. He/She also had dried fecal material in the [groin area] and needed a clean incontinent brief. The resident was assisted to the shower with stand by assist. The shower was completed by the resident; he/she dressed him/herself and the writer changed the linens and the pad in the resident's chair. Strike out date: 7/22/25 at 12:34 P.M. strike out reason: incorrect documentation.- 10/18/25 at 8:59 P.M., While a [AGE] year-old female care partner was picking up the resident's room tray, the resident was in the bathroom. The care partner closed the door as she walked into the room. After walking by the bathroom door, the resident opened the door and stood in the bathroom doorway masturbating. Care partner left the room and asked other staff to go into the room to pick up room tray. During an interview on 12/3/25 at 9:59 A.M., Registered Nurse (RN) A said:- The shower aides frequently refused to give Resident #16 a shower because he/she touches his/her [genitals] during the shower. - Resident #15 had reported to him/her that Resident #16 frequently had to clean him/herself up on the evening shift because the staff refused to do it.- He/she had frequently reported it to the Administrator, but nothing gets done. During an interview on 12/3/25 at 3:51 P.M., Resident #15 said:- About six months ago, he/she woke up to LPN B yelling and cussing at Resident #16 and said, he/she was not going to help Resident #16 get his/her pants on if he/she was going to be playing with his/her [genitals]. - When Resident #16 was incontinent of bowel, he/she could hear the staff in the hallway saying, it's your turn, it's not my turn to go in there, like they were drawing straws. - The Administrator does not make the staff do any cares for Resident #16 if they refuse to. During an interview on 12/4/25 at 10:10 A.M., CNA B said:- Resident #16 liked to blow kisses and had kissed his/her shoulder before. He/she asked Resident #16 to stop. - When the resident kissed him/her on the shoulder, he/she reported it to the charge nurse.- Resident #15 had reported to him/her about the night shift staff not providing cares to Resident #16.- The Administrator had not given the staff any guidance or instructions on how to care for Resident #16. During an interview on 12/4/25 at 5:37 A.M., LPN A said:- Resident #16 had a brain injury and the staff do not like to take care of him/her. - He/She had told the Administrator multiple times that Resident #16 does not get the care he/she needed because the staff do not like him/her. -He/She did not know if the Administrator actually did anything about it or not. - Resident #16 was inappropriate at times. He/She touched his/her [genitals] in front of others. Some staff are very rude about it. Some staff are very abrupt with the resident and tell him/her they are not going to take care of him/her until he/she stops touching him/herself. - It's not acceptable for staff to not to take care of Resident #16, it's their job.-There had been no education regarding the best way to manage the resident's behaviors. During an interview on 12/4/25 at 12:27 P.M., RN A said the other day when he/she went into the resident's room, Resident #16 was on the toilet. When asked if he/she needed assistance, the resident pointed down towards his/her [genitals]. He/she informed him/her that it was inappropriate, and he/she quit. He/she did not document it. During an interview on 12/4/25 at 3:32 P.M., LPN B said:- Resident #16 had inappropriate behaviors like fondling his/her [genitals] while staff are in the room or in the shower room. - He/she had observed Resident #16 fondling his/her [genitals] and had documented this in the progress notes. During an interview on 12/5/25 at 10:49 A.M., Social Services and the Administrator said:- Social Services said Resident #16 had inappropriate behaviors in the shower room and during toileting. The staff may have reported the issues to the charge nurse, but he/she did not know for sure. Social Services said he/she did not go into detail on the resident's care plan regarding the sexual behaviors because he/she did not know if it was appropriate to document that. - The Administrator said the physician had tried different medications but Resident #16 refused to take them. The care plan should address the resident's needs and direct staff on how to care for him/her. They have tried different things, two staff going into the room, having a male staff giving the showers and making sure the bathroom door was closed. Staff should have documented Resident (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#16s behaviors. - Social Services said the facility had not addressed the residents' behaviors in the care plan with interventions or sought outside resources. During an interview on 12/5/25 at 2:12 P.M., the Administrator said:- The care plans should be detailed and have specific information on how to care for the resident with appropriate interventions that are updated as needed. - Resident #16 was on behavioral services and then refused them. - Resident #16's care plan should address his/her behaviors and have specific interventions in place when the resident is sexually inappropriate.- She would expect the staff to document in the progress notes when the resident was sexually inappropriate and how it was addressed.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to submit the Payroll Based Journal data (PBJ, a report that provides staffing data set information submitted by nursing homes on a quarterly basis) correctly for Quarter 3, 2025 (April 1 to June 30) which had the potential to affect all residents. The facility census was 38. The facility did not have a policy for reporting direct care staffing information. Review of the facility's PBJ Staffing Data Report, showed the facility failed to have licensed nursing coverage 24 hours per day on 4/2/25, 4/12/25, 4/15/25 and on 6/6/25.Review of the daily staffing sheets shoed the facility did have licensed nursing coverage 24 hours per day on 4/2/25, 4/12/25, 4/15/25 and on 6/6/25.During an interview on 12/2/25 at 10:00 A.M., the Administrator said:The facility always had a licensed nurse on duty for eight hours on every shift.The facility does not fill out the staffing information for the PBJ, that it done by the corporate office. It should be filled out correctly.

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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 ensure staff provided care in a manner to prevent infection or the possibility of infection when staff did not properly set up enhanced barrier protection for one resident (Resident #29) and failed to ensure catheter tubing and dignity bag did not drag on the ground while resident was in a wheelchair (Resident #29). This affected one of 12 residents sampled. The facility census was 38. Review of facility policy, Enhanced Barrier Precautions, dated 4/10/25, showed:- It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms;- All staff receive training on enhanced barrier precautions upon hire and as needed and are expected to comply with all designated precautions;- All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions;- An order for enhanced barrier precautions will be obtained for residents with pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, indwelling medical devices (urinary catheters, feeding tubes, tracheostomy/ventilator tubes, midline catheters);- Implementation of Enhanced Barrier Precautions: Make gowns and gloves available immediately near or outside of the resident's room. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.- Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. 1. Review of Resident #29's Annual Minimum Data Set, a federally mandated assessment instrument completed by facility staff, dated 11/26/25, showed:- Resident was cognitively intact;- Diagnosis: cancer, atrial fibrillation, neurogenic bladder (nerve function of the bladder does not work), depression and thyroid disorder;- Resident has an indwelling catheter; Review of Resident's Care Plan, dated 11/21/25, showed the Resident had an indwelling catheter in place and will show no signs of urinary infection; Review of Resident's Order Summary Sheet, dated 12/4/25, showed:- Order dated 12/8/25 change catheter for leakage, blockage, or becoming dislodged;- Order dated 6/12/25 change urinary catheter drainage bag as required for blockage or leakage;- No orders for EBP for the resident; Review of Resident's Progress Notes showed:- 8/14/25 Resident returned to facility with new orders for Levaquin 500 milligram daily for 10 days for treatment of a urinary tract infection (UTI);- 8/14/25 New orders for Macrobid Oral Capsule 100 milligrams, one capsule by mouth at bedtime related to UTI; Observation on 12/2/25 at 10:41 A.M., showed the Resident sat in a wheelchair with catheter bag dragging on the floor underneath the wheelchair with tubing also dragging on the ground. Observation in dining room on 12/3/25 at 8:09 A.M., showed:- Resident in wheelchair with dignity bag containing catheter bag dragging on the ground;- Tubing from dignity bag also dragging on the ground, no staff intervention; Observation of resident's room on 12/4/25 at 1:15 P.M., showed:- Resident had an indwelling catheter;- There was no enhanced barrier protection (EBP) sign displayed at the entrance of the room;- There was no gloves or extra PPE (Personal Protective Equipment) available;- There was no trash can designated for PPE disposal after cares are conducted in the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/25 at 1:40 P.M., NA (A) said:- EBP is for infectious control of C-diff, viral contagious situations, and catheters;- When cares are preformed staff need to wear gloves and gown, mask and face shield if its airborne and always wash hands. During an interview on 12/5/25 at 9:45 A.M., RN (A) said for EBP protection staff need to wear a gown with gloves and a mask is required if it's airborne. Some reasons for EBP are hepatitis C, C diff, COVID, tracheotomy tube, or a feeding tube. EBP is not required if a resident has a catheter. During an interview on 12/5/25 at 2:20 P.M., the Administrator said she would not expect a resident's catheter dignity bag and tubes to be dragging on the ground. During an interview on 12/05/2025 at 7:18 A.M., RN B said: - EBP should be worn with direct contact with catheters, wound care, or if the resident was sick; - EBP signs should be up and the EBP supplies are hung on back of the resident room doors. During an interview on 12/05/2025 at 7:50 A.M., NA A said: - Regarding EBP, he/she used gloves anytime and especially during peri care; - Gowns are worn with infectious stuff like viruses; - Gowns you don't wear with catheters, but would put a paper towel down for barrier for the graduate and wipe with catheter port with an alcohol wipe. During an interview on 12/05/2025 at 2:18 P.M., the Administrator said: - Staff should use EBP when performing direct cares on residents with catheters; - There was signage now on the door of the resident's room that required EBP; - EBP were now hanging on the back of the door.