STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265778	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Manor Health & Rehabilitation	2012 Nifong Boulevard Columbia, MO 65201

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to notify the physician and resident representative for one resident (Resident #1) out of one sampled resident, when staff assessed the resident with a lump to his/her forehead, and when the resident refused all his/her scheduled medications. The facility census was 41.1.Review of the facility's Change in a Resident's Condition or Status policy, revised 02/2021, showed staff are directed to promptly notify the resident, his or her attending physician, and the resident's representative of changes in the resident's medical/mental condition, and/or status. The nurse will notify the attending physician or physician on call when there has been a: -Discovery of injuries of unknown source;-Significant change in the resident's physical/emotional/mental condition;-Refusal of treatment or medications two or more consecutive times. 2. Review of Resident #1's Electronic Medical Record (EMR), dated 02/18/26 through 02/23/26, showed the resident with diagnoses to include Parkinsonism unspecified, essential tremors, and Atrial Fibrillation (AFib), admitted to facility from home on [DATE] with coordinated hospice services for a planned five-day stay, and had a documented resident representative. Review of the resident's incident report, dated 02/21/26 at 6:30 P.M., showed Licensed Practical Nurse (LPN) A documented Certified Nursing Assistant (CNA) B asked LPN A if he/she was aware the resident had a lump on his/her forehead. LPN A assessed the resident as alert and oriented, with a lump to his/her left forehead, no discoloration, denied pain or discomfort, and no identified injuries. The report did not contain documentation the nurse notified the physician or resident representative of the identified skin concern, or potential injury of unknown source. Review of the resident's Physician's Order Sheet (POS), dated 02/18/26 through 02/23/26, showed physician's orders as followed: -Aspirin Oral Tablet 325 milligrams (mg); Give 325 mg by mouth one time a day for pain;-Midodrine hydrochloride (HC)l Oral Tablet 2.5 mg; Give 2.5 mg by mouth one time a day for headaches;-DiazePAM Oral Tablet 2 mg; Give 2 mg by mouth two times a day for anxiety/tremors;-Propranolol HCl Oral Tablet 60 mg; Give 60 mg by mouth two times a day for hypertension related to essential tremors;-Senna-Plus Oral Tablet 8.6-50 mg; Give 1 tablet by mouth two times a day for constipation hold if has diarrhea;-Tamsulosin HCl Capsule 0.4 mg; Give 0.4 mg by mouth two times a day for Benign Prostatic Hypertrophy until 02/23/2026;-Carbidopa-Levodopa Oral Tablet 25-100 mg; Give 1 tablet by mouth three times a day related to Parkinsonism, unspecified. Review of the resident's Medication Administration Record (MAR), dated 02/23/26, showed staff documented the resident refused his/her Aspirin, Midodrine, Diazepam, Propranolol, Senna, Tamsulosin, and Carbidopa-Levodopa. During an interview on 02/27/26 1:03 P.M., the administrator said after thorough investigation, staff could not determine what caused the lump to the resident's forehead. The administrator said he/she would expect the nurse to notify the on-call physician, the hospice physician, and resident representative of the lump to the resident's forehead, and staff to also notify the physician and resident representative that the resident refused all his/her (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications the day of discharge. During an interview on 02/27/26 at 1:17 P.M., LPN A said he/she did not know what caused the lump to the resident's forehead, and he/she should have notified the resident's physician and resident representative of the lump, but he/she got busy and forgot to notify anyone. During an interview on 02/27/26 at 3:31 P.M., the resident representative said he/she expected staff to notify him/her of any skin changes or if the resident did not take his/her medications. He/She said staff did not notify him/her about the lump to the resident's forehead, and the resident refused his/her medications on 02/23/26 prior to discharging home. During an interview on 03/02/26 at 9:56 A.M., the attending physician said he/she had not seen the resident during his/her stay at the facility but would have expected staff to notify him/her or the on-call physician of the lump to the resident's forehead, and that the resident had refused his/her medications. The physician said he/she would also expect staff to notify the Hospice Physician/staff as well. During an interview on 03/02/26 at 3:36 P.M., the Hospice Physician said he/she would expect facility staff to notify him/her of the lump/swelling to the resident's forehead, as well as the medication refusals prior to discharge so the hospice staff could better monitor and follow up at their next home assessment of the resident. Intake #2789733 & complaint #2786826

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, facility staff failed to report an allegation of bruises and injury of unknown origin for one resident (Resident #1) to the Department of Health and Senior Services (DHSS) within the 24-hour required timeframe. The facility's census was 41.The administrator was notified on 2/27/26 of past Non-Compliance, which occurred on 02/25/26, when the resident representative called the facility and made a follow-up report of the allegations. Staff immediately started an investigation, contacted the resident's Hospice Provider, Regional Staff, in-serviced facility staff on the abuse and neglect policy which included to report injury of unknown origin within 24 hours, and reported the allegations to DHSS on 02/26/26. The resident's representative reported the concerns to the DON on 2/24/26 and called again on 2/25/26 to talk to the administrator, where he/she again reported the concerns. 1. Review of the facility's Abuse Investigation and Reporting policy, revised 07/2017, showed an alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. 2. Review of Resident #1's Electronic Medical Record (EMR), dated 02/18/26 through 02/23/26, showed the resident admitted to the facility from home on [DATE], had a documented resident representative, and discharged back to home on [DATE] after a planned five-day stay. Review of the facility's investigation, dated 2/25/26, showed staff documented: -On 02/24/26, the resident representative reported to the Director of Nursing (DON), allegations of bruises and injuries of unknown origin to the resident;-On 02/25/26 at 9:40 A.M., the resident representative made a second report to the administrator, that when the resident returned home from the facility, the resident had a lump to his/her left forehead, laceration above his/her left ear, bruising to his/her left side/underarm, and excoriation to his/her genitals. Staff began an investigation;.-On 02/26/26, residents were interviewed, staff were in-serviced on the abuse and neglect policy, and the administrator reported the allegations to DHSS. The report did not contain documentation facility staff contacted DHSS within the 24-hour required timeframe after the resident representative reported the allegations. Review of the DHSS complaint/facility self-report database did not contain a report facility reported allegations of bruises and injury of unknown origin for over 48 hours after the resident representative reported the allegations to facility staff. During an interview on 02/27/26 at 10:31 A.M., the administrator said staff should have probably made an initial report to DHSS within two hours after the resident representative initially reported the allegations on 02/24/26, but since there was no suspicion of abuse, and rather bruises and injury of unknown origin, staff should have notified DHSS within 24 hours (on 02/25/26). The administrator said he/she first became aware of the allegations on 02/25/26, and should have notified DHSS within 24 hours, but he/she got busy with the investigation and did not realize the 24 hours timeframe had passed before he/she submitted the report to DHSS. During an interview on 02/27/26 at 11:19 A.M., the DON said the resident representative reported to him/her on the morning 02/24/26 the resident had an abrasion to his/her left side, a laceration approximately 0.5 inches above his/her left ear, bruising under his/her left armpit, and a [NAME] to his/her back, but did not specify abuse/neglect or accuse anyone. The DON said the resident was no longer at the facility, and he/she immediately started to interview staff regarding any known incidents or falls, and none were reported. The DON said based on the information received from the resident representative, and interviews from staff, he/she should have notified DHSS within 24 hours of the allegations of bruises and injury of unknown origin. Intake #2789733 & complaint #2786826

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to meet professional standards of care when staff failed to document a skin assessment for one resident (Resident #1) out of one sampled resident, when staff assessed the resident with a lump to his/her forehead. The facility census was 411. Review of the facility's admission Assessment and Follow up: Role of the Nurse policy, revised 09/2012, showed staff are directed to conduct a physical assessment on admission, including the eyes, ears, nose, throat, head, neck, and skin. Conduct supplemental assessments (following facility forms and protocol) including skin assessment. The policy did not specify the frequency for which staff should complete a skin assessment. 2. Review of Resident #1's Electronic Medical Record (EMR), dated 02/18/26 through 02/23/26, showed the resident with diagnoses to include Parkinsonism unspecified, essential tremors, and Atrial Fibrillation, admitted to facility from home on [DATE] with coordinated hospice services for a planned five-day stay, and discharged back to home on [DATE]. Review of the resident's incident report, dated 02/21/26 at 6:30 P.M., showed Licensed Practical Nurse (LPN) A documented the resident had a lump on his/her left forehead, no discoloration, denied pain or discomfort, and no identified injuries. Review of the resident's EMR, dated 02/21/26 through 02/23/26, did not contain documentation staff completed a skin assessment after staff reported the lump to the resident's forehead, or a skin assessment prior to the resident's planned discharge on [DATE]. Review of the facility's investigation, dated 2/25/26, showed staff documented the resident representative reported to the administrator, that when the resident returned home from the facility on 02/23/25, the resident had a lump to his/her left forehead, laceration above his/her left ear, bruising to his/her left side/underarm, and excoriation to his/her genitals. During an interview on 02/27/26 at 11:19 A.M., the DON said it was standard protocol for the nurse to complete a skin assessment with any identified skin changes, and the day of a resident's planned discharge. The DON said he/she was not sure why LPN A or the nurse at discharge did not complete a skin assessment. During an interview on 02/27/26 at 12:07 P.M., LPN C said the nurse is expected to complete a head-to-toe assessment and document a skin assessment prior to a resident's planned discharge. LPN C said he/she was responsible to complete the resident's skin assessment prior to discharge but he/she did not. During an interview on 02/27/26 at 1:03 P.M., the administrator said although it is not specified in the facility policy, he/she expects the nurses to complete a skin assessment on admission, with any identified skin changes, and prior to a planned discharge as standard nursing protocol. During an interview on 02/27/26 at 1:17 P.M., LPN A said he/she should have completed a skin assessment to follow up on the incident report on 02/21/26, but he/she got busy and forgot. During an interview on 03/02/26 at 3:36 P.M., the Hospice Physician said he/she would expect facility staff to complete a skin assessment on the resident prior to discharge as standard procedure, particularly since he/she was only there for a short stay, to ensure there were no new skin concerns during his/her stay. Intake #2789733 & complaint #2786826