| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265778 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/17/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Columbia Manor Health & Rehabilitation | 2012 Nifong Boulevard<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on interview, and record review facility, staff failed to administer medications as ordered and failed to document a reason medication was on hold for one resident (Resident #30). The facility census was 44. 1. Review of the facility's Administering Medications policy, revised April 2019, showed the facility will ensure medications are administered in a safe and timely manner and as prescribed. Medication is administered in accordance with prescribers' orders, including any required time frame. If a dosage is believed to be inappropriate of excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the residents attending physician or the facility's medical director or discuss the concerns. 2.Review of Resident #3's quarterly Minimum Data Set, a federally mandated assessment tool, dated 3/4/26, showed staff assessed the resident as cognitively intact with diagnoses of hypertension, renal failure, hyperlipidemia and stroke.Review of the resident's physician order sheet (POS), dated January 2026, showed orders as follows:-Amlodipine Besylate Oral Tablet 5 Milligram (MG) one tablet by mouth one time a day for hypertension;-Atorvastatin Calcium 20 MG one tablet by mouth at bedtime for hyperlipidemia;-Cranberry Capsule 450 MG one capsule by mouth one time daily for supplement;-Melatonin Tablet 3 MG one tablet by mouth at bedtime related to insomnia;-Pantoprazole Sodium Tablet (Delayed Release) 40 MG by mouth one time daily for GERD;-Potassium Chloride tablet 20 (extended release) milliequivalent (MEQ) one tablet by mouth one time daily dietary supplement;-Spironolactone Oral Tablet 25 MG one tablet by mouth one time daily diuretic;-Thiamine HCl Tablet 100 MG one mouth one time daily dietary supplement;-Vitamin D3 Tablet 20 MCG (800 UNIT) one tablet by mouth one daily dietary supplement;-ZyrTEC Allergy Tablet (Cetirizine HCl) 5 mg by mouth one time daily allergies;-Eliquis Tablet 5 MG (Apixaban) five mg by mouth two times a day for prevention related to stroke;-House shake two times a day for nutrition;-Gabapentin Capsule 300 MG one capsule by mouth three times a day related to chronic pain;-Lactulose Oral Solution 10 GM/15ML 30 ml by mouth three times a day related to encephalopathy.Review of the resident's Medication Administration Record (MAR), dated January 2026, showed staff documented they held resident's medication, and they did not contain documentation of reason or new orders from physician to hold the medication for: -1/17/26- Atorvastatin Calcium 20 Mg, Melatonin Tablet 3 Mg, House shake, Gabapentin 300 Mg, and Lactulose 30 ml;-1/18/26- Amlodipine Besylate Oral Tablet 5 MG one daily, Cranberry Capsule 450 Mg one daily, Pantoprazole Sodium 40 mg one daily, Potassium Chloride, House Shake, Spironolactone 25 mg one daily, Thiamine HCl 100 Mg one daily, Vitamin D3 20 Mcg one daily, Zyrtec 5 mg one daily, Eliquis 5 mg one twice daily, and Lactulose 30 ml oral three times per day;-1/19/26- Atorvastatin Calcium 20 Mg;-1/22/26- Gabapentin Capsule 300 Mg.Review of the resident's POS, dated February 2026, contains orders as follows:-Spironolactone Oral Tablet 25 MG one tablet by mouth one time daily;-Gabapentin Capsule 300 MG one capsule by mouth three times daily.Review of the resident's MAR, dated February 2026, showed staff documented they held resident's medication, and they did not contain documentation of reason or new orders from physician to hold the medication for: -2/16/26 Gabapentin 300 Mg;-2/20/26 Gabapentin 300 Mg;-2/23/26 Spironolactone 25 Mg.Review of<br>(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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| NAME OF PROVIDER OR SUPPLIER Columbia Manor Health & Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 2012 Nifong Boulevard Columbia, MO 65201 | |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the resident's POS, dated March 2026, contains orders as follows:-Spironolactone Oral Tablet 25 MG one tablet by mouth one time a day;-Ondansetron HCl Tablet 4 MG by mouth three times a day.Review of the resident's MAR, dated March 2026, showed staff documented resident's medication , held and ,did not contain documentation of reason or new orders from physician to hold the medication for: -3/4/26 Spironolactone 25 MG one daily;-3/8/26 Spironolactone 25 MG one daily and Ondansetron HCl Tablet 4 mg. During an interview on 3/23/26 at 12:21 A.M., Certified Medication Technician (CMT) B said he/she does not recall why he/she used code 5 (hold medication / see progress notes for documentation) on the MAR for the resident multiple times. He/She said in some cases if blood pressure was low, residents had loose stools or were not feeling good medications would be held. He/She said it depends why the medication is being held if the physician needs to be contacted, he/she said he/she does not need orders to hold blood pressure medications or stool softeners, even if there are not parameters of when to hold in the orders. He/She said most of the medications at the facility do not have parameters. He/She said he/she does not recall notifying the physician to hold medication for Resident #3 because the charge nurse would need to do it. He/She said he/she does not know why he/she did not document why he/she held the resident's medications. During an interview on 3/17/36 at 10:30 A.M., the administrator said he/she expects all staff to follow physician orders and if a medication is held, they should have a physician's order to do so, he/she also expects if a medication is temporarily held with a physician order that the reason is documented. Complaint #2799285 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on interview and record review, facility staff failed to ensure residents remained free of significant medication errors when staff administered Resident #2's medication to Resident #1. The facility census was 44.1.Review of the facility Administering Medications policy, revised April 2019, showed the facility will ensure medications are administered in a safe and timely manner and as prescribed. The individual administering the medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include checking the identification band, checking photograph attached to the medical record and if necessary, verifying the resident's identification with other facility personnel. Medication errors are documented, reported and reviewed by QUAPI committee to inform process changes and the need for additional staff training. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medications. 2. Review of Resident #1's quarterly minimum data set (MDS), a federally mandated assessment tool, dated 7/14/25, showed staff assessed the resident as cognitively intact with a diagnosis of anxiety and depression.Review of the resident's physician order sheet (POS) , dated February 2025, did not contain orders for Oxycodone. Review of the resident's progress notes, dated 3/17/26, did not contain documentation of a medication error. Review of the facility provided records, dated 3/17/26, did not contain documentation of a facility investigation for a medication error. Review of Certified Medication Technicians (CMT) A personal file, dated 2/23/26, showed CMT A was given a corrective action form for a medication error when staff gave the resident two oxycodone with no order, when the resident was ordered two Ativan. During an interview on 3/17/26 at 8:53 A.M., the administrator said they recently had one medication error for the resident, he/she said he/she was out on leave and does not know the details of the medication error. During an interview on 3/17/26 at 9:13 A.M., CMT A said he/she had one medication error when he/she gave Resident #1, Resident #2's Oxycodone. During an interview on 3/17/26 at 10:30 A.M, the administrator said the Director of Nursing (DON) gave CMT A his/her corrective action plan, another nurse in management who is no longer with us did the full investigation, but we have no proof of what he/she did. He/She said he/she expects all medication errors to be documented in the resident's chart, what happened, when it happened, corrective action taken and when family and physician were notified. He/She expects staff watch for and document all adverse reactions. He/She said Resident #1 is not ordered Oxycodone at all.During an interview on 3/17/36 at 10:46 A.M., Resident #1 said he/she is prescribed two Ativan, and he/she took two little white pills from CMT A but then started feeling really funny. He/She said the nurse told him/her that he/she was given 10 milligrams of Oxycodone instead of his/her Ativan. He/She said facility staff called the physician and continued to check his/her blood pressure. He/She said CMT A apologized to him/her for the medication error. He/She said he/she now uses a magnifying glass to check all his/her medications because he/she is so anxious to get the wrong medications again. Complaint #2799285 |