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	08/07/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, facility staff failed to allow sanitized dishes to air dry prior to stacking in storage to prevent the growth of food-borne pathogens. This failure has the potential to affect all residents. The facility census was 38.1.Review of the facility's policy titled Cleaning Dishes/Dish Machine, dated 2021, showed the policy directed staff to air dry washed dishes on dish racks and to inspect the dishes for cleanliness and dryness before they are put away. Review showed Dishes should not be nested unless they are completely dry. Observation on 08/05/25 at 10:10 A.M., showed wet six plates stacked together on a service cart in the mechanical dishwashing area. During an interview on 08/05/25 at 10:10 A.M., the Certified Dietary Manager (CDM) said he/she washed the plates that morning. The CDM said washed dishes should be air dried before they are put away and he/she did not realize they were still wet when he/she stacked them on the cart. Observation on 08/05/25 at 10:22 A.M., showed nine wet metal food service pans, 12 wet plastic service trays and 15 wet plastic plate covers stacked together in the service station. Observations on 08/05/25 at 12:04 P.M., during the lunch meal service showed the CDM used the wet stacked plate covers and trays to serve food to residents. During an interview on 08/05/25 at 1:09 P.M., the administrator said washed dishes should be air dried before they are stacked into storage or used. The administrator said the person washing the dishes is responsible to ensure the dishes are dry before they put them away and the CDM should monitor dish washing and storage periodically for compliance. The administrator said staff, especially the CDM who had worked at the facility for 30 years, were trained on the requirement to air dry washed dishes.

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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(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, facility staff failed to ensure residents had complete, accurate and individualized care plans, to address the care needs for four residents (Residents #3, #7, #32, and #34) out of 12 sampled. The facility census was 38.1. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016, showed the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan will incorporate identified problem areas. The care plan will incorporate risk factors associated with identified problems. The care plan will reflect currently recognized standards of practice for problem areas and conditions. Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's condition change. The IDT must review and update the care plan when there has been a significant change in the resident's condition.2. Review of Resident #3's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/31/25, showed staff assessed the resident as cognitively impaired.Review of the resident's Physician Order Sheet (POS), dated August 2025, showed the physician ordered the resident to be a Full Code (desire to receive all possible life-saving measures in the event of heart or lung arrest). Review of the resident's care plan dated 08/07/25, showed the care plan did not contain guidance or direction for advanced care planning, to include the Full Code order. 3. Review of Resident #7's admission MDS, dated [DATE], showed staff assessed the resident as cognitively impaired.Review of the resident's POS, dated August 2025, showed 0n 06/13/25, the physician ordered the resident to be a Do Not Resuscitate ((DNR) the desire to prevent staff or caregivers to perform resuscitative measures if a person's heart or breathing stops). Review of the resident's medical record showed a DNR order, dated 06/12/25, signed by the resident and/or family and physician.Review of the resident's care plan dated 08/04/25, showed the care plan did not contain guidance or direction for advanced care planning, to include the DNR order.4. Review of Resident # 32's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:-Cognitively intact;-Diagnoses of aphasia, a brain disorder that affects how you speak and understand language; stroke, seizure disorder, and malnutrition;-Did not include the use of a percutaneous endoscopic gastrostomy (PEG) tube, a feeding tube inserted into the stomach through the abdominal wall to deliver nutrition -Did not include a therapeutic diet;-Did not receive antibiotics.Review of the resident's care plan, dated 06/27/25, showed staff documented is on Enhanced Barrier Precautions (EBP) related to PEG tube; is on Amoxicillin, (an antibiotic) for prophylaxis, (preventive care), for possible aspiration pneumonia.Review of the resident's POS, dated 08/07/25, showed the resident did not have orders for PEG tube management, therapeutic diet, EBP, or amoxicillin.Review of resident's nurse's notes, dated 07/10/25, showed staff documented the resident came out with his/her feeding tube site open holding his/her gastric tubing in his/her hands. During an interview on 08/07/25 at 11:00 A.M., the resident said he/she does not have a PEG tube anymore. During an interview on 08/07/2025 at 11:52 A.M. Certified Medication Technician (CMT) E said he/she reviewed the electronic medication record (eMAR) and the resident is not receiving Amoxicillin. It was discontinued a long time ago.During an interview on 08/07/2025 at 1:22 P.M., the MDS Coordinator said the resident's care plan had been reviewed in the past two months and the Amoxicillin and PEG tube were not removed because there was an end date. The MDS Coordinator said he/she is new in the role and did not know discontinued treatments with an end date should be removed from the care plan.During an interview on 08/07/2025 at 4:15 P.M. the Director of Nursing (DON) said the resident does not have a PEG tube, is not on EBP, and currently does not have an order for Amoxicillin. 5. Review of Resident #34's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively impaired.Review of the resident's (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	POS, dated August 2025, showed on 04/15/25, the physician ordered the resident to be a DNR. Review of the resident's medical record showed a DNR, dated 12/19/24, signed by the resident and/or family and physician.Review of the resident's care plan, dated 08/04/25, showed the care plan did not contain guidance or direction for advanced care planning, to include the order for DNR.6. During an interview on 08/07/2025 at 1:22 P.M., the MDS Coordinator said he/she is responsible to revise care plans, and he/she reviews them every two weeks. The MDS Coordinator said care plan changes are triggered by changes discussed in the daily clinical meetings, discussions with family and reported changes in condition; and should include cognition, diet, wounds, antibiotics, preferences, and medication risks.During an interview on 08/07/2025 at 4:15 P.M. The DON said it is the responsibility of the MDS Coordinator to revise care plans, but he/she is still learning and did not know to remove discontinued treatments. The DON said advanced code status should be included on the care plan per physician order.During an interview on 08/07/2025 at 04:43 P.M., the Administrator said care plans are the responsibility of the MDS Coordinator, who pulls information from assessments, referrals, and clinical meetings. The Administrator said PEG tube, EBP, medication changes, and code status should be care planned.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to follow infection control protocols for COVID-19 (an infectious disease caused by severe acute respiratory syndrome coronavirus2 (SARS-CoV-2) when staff did not wear eye protection while inside the room of two residents (Resident #10 and #24) of three sampled residents who tested positive for COVID-19. Facility staff failed to use appropriate hand hygiene during wound care for two residents (Residents #38 and #41) of two sampled residents. The facility census was 38. 1.Review of the facility's COVID-19 policies and procedures guide, dated 09/26/25, showed symptomatic residents, regardless of vaccination status, suspected or confirmed with COVID-19, are encouraged to stay restricted to their rooms and cared for by staff using a respirator, eye protection, gloves and a gown. Review of the Centers for Disease Control (CDC) Infection Control Guidance: SARS-CoV-2 (COVID-19), dated 6/24/24, showed:-This guidance applies to all United States settings where healthcare is delivered, including nursing homes;-The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency;-Health Care Providers (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 (COVID-19) infection should adhere to standard precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). 2. Review of Resident #10's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 06/26/25, showed staff assessed the resident as cognitively intact. Review of the resident's medical record showed staff documented the resident tested positive for COVID-19 on 07/28/25.During an interview on 08/05/25 at 1:00 P.M., the resident said staff does not wear eye protection during his/her care. Observation on 08/05/25 at 2:13 P.M., showed Certified Nurse Aide (CNA) F applied a gown, gloves, and respirator mask and entered the resident's room to provide care. Observation showed the CNA did not wear eye protection. During an interview on 08/05/25 at 2:33 P.M., CNA F said he/she uses what PPE is available. He/She said eye wear is not available, so he/she doesn't wear it.3. Review of Resident #24's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact.Review of the resident's medical record showed staff documented the resident tested positive COVID-19 on 07/28/25.During an interview on 08/05/25 at 1:17 P.M., the resident said staff does not wear any eye protection during his/her care. Observation on 08/05/25 at 2:13 P.M., showed CNA F applied a gown, gloves, and respirator mask and entered the resident's room to provide care. Observation showed the CNA did not wear eye protection. During an interview on 08/05/25 at 2:33 P.M., CNA F said he/she uses what PPE is available. He/She said eye wear is not available, so he/she doesn't wear it.4. During an interview on 08/07/25 at 3:18 P.M., Registered Nurse (RN) G said he/she would expect staff to wear eye protection during care of those residents who tested positive for COVID-19. He/she said he/she knew the face-shields and goggles were ordered but staff were just wearing gown, gloves and respirators. He/She said the eyes are very susceptible for germs and that is the reason staff should wear eye protection. Eye protection guards from flying germs. During an interview on 08/07/25 at 4:14 P.M., the Director of Nursing (DON) said staff caring for residents in COVID-19 positive rooms should wear gowns, gloves, booties, and goggles or a face-shield. The DON said he/she did know staff were not wearing face shields, because they had been ordered but he/she did not know if the face shields had been delivered. During an interview on 08/07/25 at 4:42 P.M., the administrator said staff caring for COVID-19 positive residents should wear booties, gloves, gowns, appropriate N95 mask and eyewear to protect from droplets. He/She did not know the eye wear was unavailable until staff asked about it. The Charge nurse and DON should double check the staff have the equipment they need. 5. Review of the facility's policy titled Handwashing/Hand Hygiene, revised August 2019, showed wash hands with soap and water when hands are visibly soiled. Use alcohol-based hand rub or soap and water before donning (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves, before handling clean or soiled dressings, gauze, pads, etc., before moving from a contaminated body site to a clean body site during resident care, after handling used dressings, and after removing gloves.Review of the facility's policy titled Wound Care, revised 10/2010, showed:-Wash and dry hands thoroughly;-Put on exam glove. Remove dressing;-Pull glove over dressing and discard. Wash and dry hands thoroughly;-After applying treatment and dressing, remove gloves and wash and dry hands thoroughly.6. Observation on 08/07/25 at 08:24 A.M. showed Licensed Practical Nurse (LPN) A touched the wound on Resident #38's left ankle with a gloved hand, applied ointment and a dressing to the wound, and did not change his/her gloves or perform hand hygiene from dirty to clean. 7. Observation on 08/06/2025 at 09:22 A.M. showed Resident #41's pannus (abdominal folds) with open wounds and sores. Observation showed LPN A entered the resident's room and applied gloves. LPN A applied powder and barrier cream to the resident pannus and with the same soiled gloves, placed the barrier cream on the bedside table. Observation showed the LPN removed his/her gloves and placed the treatment supplies in the resident's bedside table. Observation on 08/07/25 at 08:35 A.M. showed LPN A entered the residents room and applied his/her gloves. Observation showed the LPN removed a soiled dressing from the resident's right lower leg. With the same soiled gloves, the LPN touched the clean dressing and treatment supplies. The LPN removed his/her gloves, did not wash his/her hands and applied clean gloves. The LPN applied a clean dressing to the resident's right buttock wound, reached into his/her pocket for keys, handed Certified Nurse Aide (CNA) D the keys. With the same soiled gloves, the LPN applied the clean dressing to the resident's left leg. The LPN changed his/her gloves, cleaned the resident's pannus, applied the treatment to the resident and reached into his/her pocket and removed his/her keys. The LPN handed the keys to Certified Medication Technician (CMT) E, and removed perineal care supplies from the resident's drawer. 8. During an interview on 08/07/25 at 10:00 A.M., LPN A said hand hygiene and glove changes should be done when moving from a dirty site to a clean site. LPN A said he/she got nervous and did not perform good hand hygiene during care.During an interview on 08/07/2025 at 4:15 P.M. the DON said LPN A is the facility's wound care nurse. The DON said it is expected staff perform hand hygiene when moving from a dirty site to clean site during care. During an interview on 08/07/2025 at 4:43 P.M., the administrator said staff is expected to follow the facility policy for hand hygiene and wound care.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to ensure the wireless call light system was fully operational twenty-four hours per day, seven days a week, and failed to ensure direct care staff always carried and utilized the wireless nurse call pagers for three residents (Resident #3, #10, and #24) out of five sampled residents when the call-light response time was greater than 30 minutes. The facility census was 38.1. Review of the facility's policy titled, Answering the Call Light, dated March 2021, showed be sure the light is plugged in and functioning at all times. The policy did not contain direction or guidance for the use of paging devices to audibly alert staff of a residents call for assistance.2. Review of the facility's Past Call's log dated 08/02/25 showed:-At 7:19 A.M., room [ROOM NUMBER] call light response time of 30 minutes and 37 seconds;-At 9:33 A.M., room [ROOM NUMBER] call light response time of 56 minutes and 47 seconds;-At 1:31 P.M., room [ROOM NUMBER] call light response time of 52 minutes and 16 seconds;-At 7:20 P.M., room [ROOM NUMBER] call light response time of 37 minutes and 45 seconds;-At 7;29 P.M., room [ROOM NUMBER] call light response time of 37 minutes and 13 seconds;-At 10:10 P.M., room [ROOM NUMBER] call light response time of 1 hour, 4 minutes and 10 seconds;-At 10:16 P.M., room [ROOM NUMBER] call light response time of 1 hour, 14 minutes and 15 seconds;-At 10:21 P.M., room [ROOM NUMBER] call light response time of 1 hour, 5 minutes and 35 seconds;-At 10:54 P.M., room [ROOM NUMBER] call light response time of 36 minutes and 59 seconds. Review of the facility's Past Call's log dated 08/03/25 showed:-At 6:38 A.M., room [ROOM NUMBER] call light response time of 1 hour, 53 minutes and 20 seconds;-At 6:47 A.M., room [ROOM NUMBER] call light response time of 40 minutes and 40 seconds;-At 7:15 A.M., room [ROOM NUMBER] call light response time of 1 hour, 1 minute and 29 seconds;-At 8:02 A.M., room [ROOM NUMBER] call light response time of 1 hour, 33 minutes and 29 seconds;-At 8:35 A.M., room [ROOM NUMBER] call light response time of 2 hours, 12 minutes and 37 seconds;-At 8:39 A.M., room [ROOM NUMBER] call light response time of 39 minutes and 36 seconds;-At 8:41 A.M., room [ROOM NUMBER] call light response time of 36 minutes and 41 seconds;-At 9:33 A.M., room [ROOM NUMBER] call light response time of 1 hour, 46 minutes and 44 seconds;-At 9:59 A.M., room [ROOM NUMBER] call light response time of 43 minutes and 33 seconds;-At 10:42 A.M., room [ROOM NUMBER] call light response time of 30 minutes and 32 seconds;-At 1:20 P.M., room [ROOM NUMBER] call light response time of 1 hour, 1 minute and 2 seconds;-At 1:30 P.M., room [ROOM NUMBER] call light response time of 47 minutes and 59 seconds;-At 5:19 P.M., room [ROOM NUMBER] call light response time of 45 minutes and 37 seconds;-At 5:26 P.M., room [ROOM NUMBER] call light response time of 31 minutes and 47 seconds;-At 9:30 P.M., room [ROOM NUMBER] call light response time of 46 minutes and 44 seconds.Review of the facility's Past Call's log dated 08/04/25 showed:-At 3:25 A.M., room [ROOM NUMBER] call light response time of 41 minutes and 52 seconds;-At 5:19 A.M., room [ROOM NUMBER] call light response time of 36 minutes and 59 seconds;-At 5:49 A.M., room [ROOM NUMBER] call light response time of 1 hour, 27 minutes and 33 seconds;-At 7:29 A.M., room [ROOM NUMBER] call light response time of 1 hour 1 minute and 47 seconds;-At 8:09 A.M., room [ROOM NUMBER] call light response time of 2 hours, 4 minutes and 40 seconds;-At 9:05 A.M., room [ROOM NUMBER] call light response time of 33 minutes and 55 seconds;-At 9:05 A.M., room [ROOM NUMBER] call light response time of 49 minutes and 8 seconds;-At 9:08 A.M., room [ROOM NUMBER] call light response time of 31 minutes and 35 seconds;-At 12:24 P.M., room [ROOM NUMBER] call light response time of 1 hour, 19 minutes and 47 seconds;-At 1:03 P.M., room [ROOM NUMBER] call light response time of 30 minutes and 34 seconds;-At 2:57 P.M., room [ROOM NUMBER] call light response time of 46 minutes and 3 seconds;-At 3:13 P.M., room [ROOM NUMBER] call light response time of 33 minutes and 23 seconds;-At 5:35 P.M., room [ROOM NUMBER] call light response time of 1 hour, 13 minutes and 34 seconds;-At 5:59 P.M room [ROOM NUMBER] call light response time of 42 (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minutes;-At 6:21 P.M., room [ROOM NUMBER] call light response time of 1 hour 2 minutes and 13 seconds;-At 6:34 P.M., room [ROOM NUMBER] call light response time of 52 minutes and 50 seconds;-At 10:50 P.M., room [ROOM NUMBER] call light response time of 32 minutes and 51 seconds.3. Review of Resident #3's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/06/25 showed staff assessed the resident as cognitively intact.During an interview on 08/05/25 at 11:08 A.M., the resident said it can take up to one to two hours before staff answers the call light. He/she said he/she must lay in his/her waste for long periods of time. 4. Review of Resident #10's Annual MDS, dated [DATE], showed staff assessed the resident as cognitively intact.During an interview on 08/05/25 at 1:00 P.M., the resident said call light wait times are long and it bothers him/her. He/She said he/she cannot hold their urine and needs staff to help keep them clean. He/She said he/she does not like to smell of urine and its not good for the skin.5. Review of Resident #24's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact.During an interview on 08/05/25 at 1:15 P.M., the resident said he/she wears a depend and if staff take too long he/she has to sit in his/her urine and that's just not good. He/She said sometimes it takes up to and hour to an hour and a half to get help. 6. Observation on 08/05/25 from 12:56 P.M. to 1:58 P.M., showed the centralized call light monitor altered for room [ROOM NUMBER] and did not have an audible sound. Observation showed several staff passed by the monitor and pager noise could not be heard. 7. Observation on 08/05/25 at 2:06 P.M., showed Certified Nurse Aide (CNA) D did not wear a pager.During an interview on 08/05/25 at 2:06 P.M., CNA D said he/she forgot to get a pager. The pagers are kept in a drawer at the nurse desk. He/She said he/she usually just walks up the hall and checks the monitor at the desk. 8. Observation on 08/05/25 at 02:08 P.M., showed CNA F did not wear a pager. During an interview on 08/05/25 at 2:08 P.M., CNA F said he/she does not wear a pager and didn't know anything about the pagers. He/She walks up the hall to the desk to check for call lights. 9. During an interview on 08/07/25 at 4:14 P.M., the Director of Nursing (DON) said the nursing staff are expected to carry a pager, so they know if the resident needs something and has initiated a call light. A call light wait time of 20 minutes for a resident is unacceptable. He/She said it is his/her responsibility to ensure staff are wearing their pagers and did not know they weren't.During an interview on 08/07/25 at 4:42 P.M., the Administrator said when he/she started at the facility, staff were not wearing their pagers so a sign in and out sheet was set up. He/She said he/she just found out the staff were not doing it. The call lights do alarm at the monitor at the nurse station, but staff would have to walk down the hall to hear it and see what call light is sounding. He/She would expect staff to answer call lights within 20 minutes and was unaware call light times were longer than that. He/She said anything could happen to those who must wait.