STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265840	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighborhoods Rehab & Skilled Nursing by Tigerplac	3003 Falling Leaf Court 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 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 interview and record review, facility staff failed to report to the Department of Health and Senior Services (DHSS) neglect of one resident (Resident #1), when facility staff failed to initiate Cardiopulmonary Resuscitation (CPR) for the resident with a signed full code physician order. The facility's census was 86. Review of the facility's policy titled, Abuse, Neglect, and Exploitation, undated, showed staff are directed as follows: -Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress; -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 report all alleged violations to the state agency within specified time frames: immediately, but not later than two hours after the allegation is made, if the events that cause the allegations 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. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Diagnosis of Dementia, Alzheimer's, Non Traumatic Brain Disorder, Coronary Artery Disease, and Heart Failure; -Expired [DATE] in facility. Review of the resident's care plan, revised [DATE], showed staff documented the resident as a full code. Review of medical records showed the Physician Order Sheet (POS), dated [DATE], showed a physician order for full code. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nurses notes, dated [DATE], showed staff documented at 5:00 A.M. the resident did not have a pulse and confirmed resident had expired. Review of the facility's investigation, dated [DATE], showed staff documented they entered the resident's room, found the resident unresponsive and vital signs were low. Review showed staff documented they could not find the resident's code status and thought the resident was a DNR (do not resuscitate). Review showed staff did not verify the resident's code status, did not perform CPR and the resident expired. Review showed staff terminated Registered Nurse (RN) A from the facility on [DATE] for not following facility code status policy. During an interview on [DATE] at 10:14 A.M., RN A said he/she was the only nurse on the unit and the medication technician had given him/her report. The Medication technician had told him/her the resident was on hospice or was going on hospice. RN A entered the resident's room for the 5:00 A.M., medication pass and the resident was unresponsive. RN A said he/she was confused and did not know what to do or who to call when the resident was unresponsive and he/she thought the resident would be a DNR code status, because he/she was going on hospice. RN A said he/she knew where to look in the computer and on the book for a resident's code status, but did not look. He/She said he/she felt' the resident was already gone because he/she was unresponsive and he/she was not thinking straight. RN A said he/she had never experienced this scenario before. RN A said when the resident no longer had a pulse he/she did not initiate CPR. During an interview on [DATE] at 9:25 P.M., the Director of Nursing (DON) said he/she did not believe this was neglect and therefore not reportable to DHSS. The DON said he/she would expect staff to perform CPR if the resident was a full code and had no pulse. During an interview on [DATE] at 11:08 A.M., the administrator said the incident did not meet the criteria for reporting to DHSS, because the investigation showed it was not neglect. He/She said the nurse would have provided CPR if he/she had checked accuracy of the information he/she was given. The administrator said if a resident is a full code staff need to initiate CPR when the resident has no pulse MO00251856

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to initiate Cardiopulmonary Resuscitation (CPR) for resident (Resident #1) with a signed full code physician order. The facility census is 86. The administrator was notified on [DATE] of past noncompliance Immediate Jeopardy (IJ) which occurred on [DATE]. Administration immediately in-serviced nursing staff on CPR, code status, and two-way radio communication policies. The IJ was corrected on [DATE]. Review of the facility's CPR policy, undated and reviewed/revised on [DATE], directed staff to adhere to residents' rights to formulate advance directives. The facility will follow current American Heart Association (AHA) guidelines regarding CPR. If a resident experiences cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, in accordance with the resident's advance directives. Review of the facility's Communication of Code status, undated, directed to follow facility policy regarding a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate and advance directive. When an order is written pertaining to a resident's presence or absence of an Advanced Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to: -Full Code; -Do Not Resuscitate (DNR); -Do Not Hospitalize. The designated sections of the medical record are: -Outside of the hard chart - Red = DNR, [NAME] = Full Code; -Face sheet - Advanced Directives; -Point Click Care - Code status. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Diagnoses to include Dementia (a general term for memory loss and other cognitive declines that interfere with daily life), Alzheimer's (a neurodegenerative disorder that primarily affects the brain, causing a progressive decline in cognitive function, particularly memory and language), Non Traumatic Brain Disorder (brain damage caused by internal factors rather than external trauma like a blow to the head), Coronary Artery Disease, and Heart Failure; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Expired [DATE] in facility. Review of the resident's care plan, revised [DATE], showed the resident was a full code. Review of the resident's Physician Order Sheet (POS), dated [DATE], showed a physician order for a full code. The record did not contain orders for hospice services. Review of the resident's nurses notes, dated [DATE], showed staff documented at 5:00 A.M. the resident did not have a pulse and confirmed resident had expired. Review of the facility's investigation, dated [DATE], showed staff documented staff entered the resident's room, found the resident unresponsive and vital signs were low. Review showed staff documented they could not find the resident's code status and thought the resident was a DNR. Review showed staff did not verify the resident's code status, did not perform CPR and the resident expired. Review showed staff terminated Registered Nurse (RN) A from the facility on [DATE] for not following facility policy. During an interview on [DATE] at 10:14 A.M., RN A said he/she was the only nurse on the unit and the medication technician had given him/her report. The medication technician had told him/her the resident was on hospice or was going on hospice. RN A entered the resident's room for the 5:00 A.M., medication pass and the resident was unresponsive. RN A said he/she was confused and did not know what to do or who to call when the resident was unresponsive and he/she thought the resident would be a DNR code status, because he/she was going on hospice. RN A said he/she knew where to look in the computer and on the book for a resident's code status, but did not look. He/She said he/she felt' the resident was already gone because he/she was unresponsive and he/she was not thinking straight. RN A said he/she has never experienced this scenario before. RN A said when the resident no longer had a pulse he/she did not initiate CPR. During an interview on [DATE] at 1:49 P.M., Certified Medication Technician B said he/she gave report to RN A and they discussed that the resident's family was considering hospice services due to decline, but he/she was not on hospice at that time. During an interview on [DATE] at 8:03 P.M., the resident's durable power of attorney said the resident was not on hospice and was a full code, he/she was not made aware that CPR was not performed and he/she would have expected CPR to be administered. During an interview on [DATE] at 6:41 P.M., the administrator said the resident was found unresponsive and staff failed to start CPR once the resident no longer had a pulse. The staff believed the resident was on hospice and was not a full code, if a resident is a full code staff need to initiate CPR when the resident has no pulse. The administrator said the resident was not on hospice. During an interview on [DATE] at 9:25 P.M., the Director of Nursing (DON) said RN A thought the resident was a DNR and did not do CPR once the resident no longer had a pulse. He/She said all facility staff should verify code status even if the resident is on hospice and perform CPR if they are a full code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:36 P.M., the physician said he/she was aware the resident had expired, but was not aware of the circumstances. He/She expects all facilities and staff to follow the resident's wishes on code status and perform CPR. He/She said residents on hospice can still be a full code, staff need to ensure the resident's code status regardless of hospice or not. MO00251856