

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Neighborhoods Rehab & Skilled Nursing by Tigerplac		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to monitor one resident (Resident #1) at least every two-hours per facility policy and based on resident needs. Staff did not monitor the resident between the hours of 11:00 P.M. and 3:10 A.M. Resident #1 was found entrapped in the bedrail, face down in the mattress, unresponsive, and he/she passed away. The facility census was 89. The administrator was notified on [DATE] of Past Non-Compliance Immediate Jeopardy (IJ) which occurred on [DATE]. The Administrator immediately terminated Licensed Practical Nurse (LPN) C, suspended Certified Nursing Assistant (CNA) B pending the results of the investigation, conducted an investigation, and in-serviced all staff on rounding on [DATE]. Review of the facility's walking rounds shift report policy, undated, showed staff are directed that rounds will be made during each shift according to resident care needs and individual preferences following nursing standards of practice (typically at least every two hours dependent on situations occurring throughout the shift). Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated [DATE], showed staff assessed the resident as follows:-Moderately cognitively intact;-Required two staff for bed mobility and transfers; -Manual wheelchair use;-No paralysis on either side;-Staff did not assess bed rails and/or grab bars as used by resident. Review of the Physician's Order Sheets (POS), dated [DATE], showed a physician's order for enablers to both sides of the bed. Review of the resident's baseline care plan, dated [DATE], showed staff assessed the resident as follows:-Required mechanical lift for transfers;-Required assist of two staff for bed mobility, transfers, and toileting;-Had enablers/grab bars to both sides of the bed;-Exhibited behaviors to include hollering. Review of the resident's nurse's notes, dated [DATE] 3:15 A.M., showed LPN A documented CNA B came to LPN A for assistance with the resident. LPN A found the resident kneeling on the floor with his/her head against the bedrail and mattress. LPN A assessed the resident with no pulse, unresponsive Cardiopulmonary Resuscitation (CPR) initiated by LPN A. While he/she performed CPR, LPN A called emergency medical services (EMS) via personal cell phone to summon for assistance. EMS arrived and assisted with CPR. Review of Resident #1's nurses notes, dated [DATE] at 11:29 A.M., showed staff documented time of death called at 3:57 A.M. by the local emergency department and Information relayed to local funeral home. Review of the facility's investigation, undated, showed facility staff documented CNA B did not lay eyes on the resident from 11:00 P.M. on [DATE] to 3:10 A.M. on [DATE]. CNA B said he/she said went into the resident's room and observed the resident on his/her left side of his/her bed with his/her neck on the bed and bed rail. He/She said the resident was not moving. LPN A documented CNA B requested the nurse for assistance with the resident. LPN A found the resident knelt on the floor with his/her head rested against the bed rail and mattress. LPN A assessed the resident with no pulse, unresponsive and CPR initiated by LPN A. While LPN A performed CPR, LPN A called EMS via personal cell phone for assistance. EMS arrived and assisted with CPR. During an interview on [DATE] at 10:04 A.M., LPN A said CNA B came to get him/her because the resident was on the floor. When he/she entered the room the resident was on the left side of the bed, on his/her knees, with his/her head resting between the siderail and the mattress. He/She said he/she had to take the palm of his/her hand and forcefully remove the resident's head from between the rail and the mattress. He/She said the residents head was trapped and he/she was unsure if the resident suffocated, but the resident was face down. He/She called 911 on his/her personal phone on speaker and started chest compressions because the resident was unresponsive. He/She said all residents should be checked every two hours. During an interview on [DATE] at 12:24 P.M., LPN C said he/she last laid eyes on the resident around 10:30 P.M. when he/she started the resident's Cefazolin Sodium (first generation cephalosporin antibiotic) two gram Intravenous ((IV fluids, medications, or nutrients directly into the body's bloodstream through a vein using a small tube called a catheter). He/She said CNA B was responsible for rounds and should perform rounds every two hours. LPN C said he/she forgot to return to the resident and disconnect his/her IV from his/her Peripherally Inserted Central Catheter (PICC) line. He/She said CNA B and LPN A told him/her the resident was found with his/her head between the bed rails. LPN C said he/she should have removed the resident's antibiotic at 11:00 P.M., but that he/she forgot. During an interview on [DATE] at 1:51 P.M., CNA B said he/she is responsible for rounds every two hours, but he/she last laid eyes on the resident around 10:00 P.M. or 11:00 P.M. He/She thought the nurse would go back in the room to unhook the resident's IV medication, but he/she never did. CNA B said he/she walked into the resident's room around 3:10 A.M. and saw the IV pole hanging across</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to re-assess bedrail use after a significant change in condition per policy for one resident (Resident #1). Resident #1 was found entrapped in the bedrail, found face down in the mattress and unresponsive, resulting in his/her death. The facility census was 89. The administrator was notified on 09/03/2025 of an Immediate Jeopardy which began on 08/26/2025. The IJ was removed on 09/03/2025, as confirmed by surveyor onsite verification. 1. Review of the facility's Proper Use of Bed Rails policy, undated, showed staff are to ensure the bed frame, bed rail, and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, or depth. Review showed responsibilities of ongoing monitoring and supervision are specified as follows:-Direct care staff will be responsible for care and treatment in accordance with the plan of care; -A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail;-The interdisciplinary team will make decisions regarding when the bed rail will be used or discontinued, or when to revise the care plan to address any residual effects of the bed rail;-The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. Review of the facility's bed rail safety guidance form, undated, showed staff are directed as follows:-Zone one (entrapment within the rail) is measured within the rail and recommendation are less than 4 and 3/4 inches;-Zone two (entrapment under the rail, between the rail supports or next to a single rail support) is measured under bed rail and between rail supports recommendation less than 4 and 3/4 inches;-Zone three (entrapment between the rail and the mattress) is measures between rail and mattress recommendation less than 4 and 3/4 inches;-Zone four (entrapment under the rail, at the end of rail) is measured under rail at ends of the rail recommendation is less than 2 and 3/8 inch and greater than 60 degree angle;-Zone five (entrapment between split bed rails) did not contain recommended measurements;-Zone six (entrapment between the end of the rail and the side edge of the head or footboard) did not contain recommended measurements;-Zone seven (entrapment between head or foot board and the mattress) did not contain recommended measurements. Review of the Guide to Bed Safety Rails in Hospitals, Nursing Homes and Home Health Care, dated 12/11/27, showed The Facts as to the proper dimensions and distances apart of various parts of the bed such as distance between bed frames and mattresses, bed rails and mattress to prevent entrapment by users of the bed showed to prevent entrapment, bed rails, mattresses, and bed frames must be configured so there are no gaps between the mattress and the rail, and no gaps between rails, and that the mattress fits snugly. Specifically, there should be no more than 4.75 inches (12.1 cm) between the mattress and the bed rail, and no more than 9.5 inches (24.2 cm) between bed rails, according to United States Food and Drug Administration (FDA) guidelines. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 6/26/25, showed staff assessed the resident as follows:-Moderately cognitively intact;-Required two staff for bed mobility and transfers; -Manual wheelchair use;-No paralysis on either side;-Staff did not assess bed rails and/or grab bars as used by resident. Review of the resident's care plan, dated 10/13/24, showed staff documented the resident had bilateral side positioning rails. Positioning rails will be measured by maintenance before application, maintenance to ensure that the rail is in good repair and working function. Nursing to ensure that rail is being used properly. Review of Resident #1's therapy notes, dated 10/16/24, showed therapy staff documented a recommendation of a second bed rail be placed on resident's bed to right side to assist with rolling. Staff documented he/she already has bed rail on left side of bed. Review of the Physician's Order Sheets (POS), dated 07/18/25, showed a physician's order for enablers to both sides of the bed.Review of the resident's bed rail assessment, dated 07/18/25, showed staff assessed the resident with weakness, and required increased safety measures due to medications. Review showed staff documented a pass rating from a pass/fail rating for zone one (within the rail), zone two (under the rail), zone three (between the rail and mattress), zone four (under the rail at the end of the rails), zone five (between split bed rail), zone six (between the end of the rail and the end of the rail and the side edge of the head or foot board), and zone seven (between the head or foot board and the end of the mattress) for the left bed rail. Review showed the bed rail assessment form did not contain documentation bed rails were appropriate for the resident. Review of the resident's nurse's notes, dated 8/5/25 at 11:11 A M showed staff</p>		