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	11/18/2025

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 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. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, facility staff failed to meet professional standards of practice when facility staff failed to transcribe physician's orders for one resident (Resident #3) and failed to complete weekly skin assessments for three residents (Resident #2, #3, and #5) out of five sampled residents. The facility census was 86. 1. Review of the facilities Physician Orders policy, undated, showed staff are directed as follows:-All physicians orders should be carried out as ordered upon the signed order of a person lawfully authorized to prescribe;-Each order should be noted and processed according to the standards of practice;-The order will be input into the electronic medical record system and then will populate into the proper areas for administration. 2. Review of Resident #3's Significant Chage Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/30/25, showed staff assessed the resident with severe cognitive impairment. Review of the resident's care plan, revised 11/03/25, showed staff assessed the resident as:-Cognitive deficit;-Required assistance for all Activities of Daily Living (ADL's), transfers, and mobility;-At risk for skin breakdown.Review of the resident's Physician's Order Sheet (POS), dated 11/18/25, did not contain documentation for Hydrocolloid sheet apply once weekly and as needed: if saturated, soiled, or dislodged to left medial upper back. Review of the resident's wound consultant orders, dated 11/13/25, showed an order for Hydrocolloid sheet apply once weekly and as needed: if saturated, soiled, or dislodged for 23 days to left medial upper back.Review of the resident's wound consultant orders, dated 11/06/26, showed an order for Hydrocolloid (a substance used for wound care that forms a gel when they absorb moisture) sheet apply once weekly and as needed: if saturated, soiled, or dislodged for 30 days to left medial upper back. Review of the resident's nurse's notes, dated 11/04/25, showed staff documented a new stage two pressure ulcer to the resident's thoracic spine.Review of the residents Treatment Administration Record (TAR), dated 11/01/25 through 11/18/25, did not contain documentation of Hydrocolloid sheet apply once weekly and as needed: if saturated, soiled, or dislodged to left medial upper back. Review of the resident's weekly skin assessments, dated October 2025, did not contain documentation a weekly skin assessment was completed on 10/1/25 and 10/29/25.During an interview on 11/18/25 at 1:35 P.M., Registered Nurse (RN) A said the purpose of physician's orders is to ensure a resident gets the proper care they need. RN A said if a physician's order for wound care is not followed it could result in the wound getting worse, infection, or new wound development. RN A said the charge nurse is responsible to transcribe and enter any new orders to the resident's POS. RN A said the wound consultant physician comes to the facility and makes rounds with the facility wound nurse. RN A said the wound consultant physician's documentation is automatically uploaded to the resident's chart under miscellaneous. RN A said it is the charge nurse's responsibility to look at that consult note and enter any new wound care orders as the physician prescribes them on to the resident's POS. RN A said he/she does not know why the resident's wound care orders were not entered as he/she only works two days a week and does not work the day they are there. RN A said if something is not documented it did not get done . During an interview on 11/18/25 at 2:30 P.M., the facility wound care nurse said he/she has many roles at the facility including the wound nurse, He/She makes rounds with the wound consultant physician every Thursday and assist him/her to change each resident's dressing at that time of service. The wound care nurse said he/she does not enter any new orders into the resident's chart, that the wound care consultant's documentation is automatically uploaded to the resident's chart under the miscellaneous tab. The wound care nurse said it is the charge nurse's responsibility to pull that document up and enter any new orders into the resident's POS. The wound care nurse said it is his/her responsibility to go behind the charge nurse to ensure those orders are entered correctly. The wound care nurse said he/she did not follow up with the resident's new orders like he/she should have and was not aware the resident's new orders were not entered. The wound care nurse said he/she should have followed up, but he/she is very busy with all his/her roles and didn't. The wound care nurse said the consequences of not entering those orders or following them could result in the wound getting infecting, getting larger in size, getting deeper, and overall decline of the wound. 3. Review of Resident #2's Significant Change MDS, dated [DATE], showed staff assessed the resident as having moderate cognitive impairment. Review of the resident's care plan, dated 08/06/25, showed staff assessed the resident as:-Cognitive deficit;-Required assistance for all ADL's, transfers, and mobility;-At risk for skin breakdown.Review of the resident's POS, dated 11/18/25, showed orders to complete a licensed weekly skin assessment every Tuesday day shift