STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cotton Point Living Center	609 South Railroad Street Matthews, MO 63867

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to monitor and consistently implement interventions, including adequate supervision consistent with resident needs, goals, and current professional standards of practice, in order to eliminate or reduce the risk of falls and accidents, failed to document an assessment after a fall, to notify the provider and the on-call nurse after a fall, and to update the care plan with new interventions to prevent additional falls for one resident (Resident #49) out of two sampled residents. The facility census was 47.Review of the facility policy titled, Falls and Fall Risk, Managing, dated March 2018, showed:- Based on previous evaluations and current date, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling;- A fall is unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming force (a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred;- The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling;- The nurse shall assess and document/report the following: a. Vital signs; b. Recent injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; d. Change in cognition or level of consciousness; e. Neurological status; f. Pain; g. Frequency and number of falls since last physician visit; h. Precipitating factors, details on how fall occurred; i. All current medications, especially those associated with dizziness or lethargy; j. All active diagnoses. 1. Review of Resident #49's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/24/26, showed:- Cognition intact;- Partial to moderate assistance of staff for toileting and sitting to standing position;- Substantial to maximal assistance of staff for sitting to lying and lying to sitting positions;- Resident used a wheelchair. Review of the resident's medical record showed:- No documentation of a fall on 05/08/26;- No documentation of an assessment of the fall on 05/08/26;- No documentation the resident's provider and the on-call nurse were notified of the fall on 05/08/26. Review of the resident's care plan, last updated on 04/24/26, showed:- At risk for falls;- History of falls;- Works with the restorative program for strengthening and balancing;- Monitor, document, and report as needed to the physician for signs and symptoms of pain, change in condition, or new onset of confusion;- Physical therapy (PT) consult for strength and mobility as needed;- Did not address the fall on 05/08/26 with new interventions. Observation on 05/11/26 at 12:43 P.M., of the resident showed:- Resident sat at a table in the dining room with a plate of food in front of him/her;- Resident did not touch his/her food;- Medical Records (MR) staff asked the resident why he/she was not eating;- The resident told the MR staff he/she did not feel well, had a fall over the weekend, and didn't feel like eating. During an interview on 05/11/26 at 12:45 P.M., the resident said he/she was not eating because of soreness from a fall he/she had over the weekend. He/She fell on Friday and reported the incident to staff. During an interview on 05/11/26 at 12:17 P.M., Certified Nurse (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant (CNA) I said if a resident fell, he/she immediately would assist the resident and call for help. The charge nurse was always informed so the resident could be assessed immediately. During an interview on 05/11/26 at 12:21 P.M., Certified Medication Technician (CMT) J said if a resident fell, he/she stayed with the resident and called for help. The charge nurse was always informed so the resident could be assessed immediately. During an interview on 05/12/26 at 8:37 A.M., Restorative Nurse Aide (RNA) F said if a resident fell, he/she would call for help. The charge nurse was always informed so the resident could be assessed immediately. During an interview on 05/12/26 at 9:15 A.M., the MDS Coordinator was unaware of the resident's fall. During an interview on 05/13/26 at 10:20 A.M., CNA K said the resident had mentioned he/she was sore but did not mention anything about a fall. During an interview on 05/13/26 at 2:20 P.M., the Assistant Director of Nursing (ADON) said the resident had left the facility by ambulance. During an interview on 05/14/26 at 2:12 P.M., the Director of Nursing (DON) said she would expect staff to call the on-call nurse, notify the resident's family, and notify the physician of a fall. If there was an injury, the resident should be sent out by the physician's order to be evaluated. She expected staff to document any resident's fall and then follow-up, whether it be vitals, neurological checks, etc. During an interview on 05/14/26 at 2:17 P.M. the Administrator said he would expect staff to assess the resident after a fall, to follow-up, to notify the provider and the guardian if the resident had one, and to try to send the resident out to be evaluated. The facility always had an on-call physician and an on-call nurse. He expected staff to document resident falls and follow-up after a fall. During an interview on 05/19/26 at 11:40 A.M., Licensed Practical Nurse (LPN) L said when he/she arrived on the day shift on 05/08/26, the resident was on the floor. LPN L had other staff in there with him/her assisting with the resident, but he/she could not remember who it was. The resident was assessed, assisted to the wheelchair, and then assisted to the resident's bed. He/She did check the resident out to make sure the resident was not hurt, but failed to document anything about the fall, to notify the provider, or the on-call nurse.Complaint #3000359