STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265862	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delta South Nursing & Rehabilitation	640 Colonel George E Day Parkway Sikeston, MO 63801

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to create an environment respectful of the rights of each resident to make choices about specific aspects of their lives which included food choices and dislikes. This affected two residents (Resident #2 and #14) out of 12 sampled residents and eight residents (Residents #18, #21, #33, #42, #43, #44, #50, and #51) outside the sample. The facility census was 48.Review of the facility's policy titled, Resident Food Choices, revised July 2017, showed:- Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team (IDT - a group of healthcare professionals from diverse fields who work in a coordinated effort toward a common goal for a resident);- Upon the resident's admission (or within 24-hours after admission) the dietitian or nursing staff will identify a resident's food preferences;- When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes;- Nursing staff will document the resident's food and eating choices in the care plan;- The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night;- The facility's quality assurance assessment and performance improvement (QAPI - a systemic data-driven approach used in healthcare facilities to monitor, evaluate, and improve the quality of care and the overall quality of life for residents) committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparations, etc. 1. Review of Resident #2's medical record showed: - admitted on [DATE];- Diagnoses of type II diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), heart failure, urinary tract infection (UTI (a bacterial infection in the kidneys and/or bladder causing the urge to urinate) and depression (a serious medical illness that negatively affects how you feel, the way you think and how you act)). Review of the resident's Care Plan, revised 08/05/25, showed:- Independent for meeting social needs and activities of daily living (ADLs);- Dietary consult for nutritional regimen and ongoing monitoring;- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of food likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/06/26 at 2:42 P.M., the resident said he/she did not like pulled pork and potato salad, but still received it at meals. He/She would love to have a sandwich at lunch or a cup of soup instead of what was served. Staff had never asked what his/her food dislikes were since admission and was not aware of an alternative list of food choices. 2. Review of Resident #14's medical record showed:- admitted on [DATE];- Diagnoses of stroke, hypertension (high blood pressure), anxiety (a natural feeling of unease, worry or fear), and depression. Review of the resident's Care Plan, dated 11/20/25, showed:- Independent for meeting social needs and activities of daily living (ADL's);- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of food likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/05/26 at 12:15 P.M., staff had never asked what his/her dislikes were so he/she didn't know how the kitchen staff were aware of them. 3. Review of Resident #18's medical record (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed: - admitted on [DATE];- Diagnoses of type II DM, UTI, depression, and anxiety. Review of the resident's Care Plan, revised 12/02/25, showed:- Requires staff assistance with ADLs;- Dietary consult for nutritional regimen and ongoing monitoring;- Provide and serve diet as ordered;- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/06/26 at 2:28 P.M., the resident said he/she didn't like onions, tomatoes, or dill pickles and would push those foods to the side of the plate. Staff took the food tray and didn't ask questions. Staff had never asked what his/her likes and dislikes in food choices were that he/she could remember. It was a shame to throw away good food that someone else could eat. He/She didn't know what the alternative food choices were in the kitchen. 4. Review of Resident #21's medical record showed:- admitted on [DATE];- Diagnoses of hypertension and depression. Review of the resident's Care Plan, dated 12/12/25, showed:- Requires staff assistance with self-care performance due to weakness;- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/07/26 at 1:10 P.M., the resident said staff had never asked what his/her dislikes were. 5. Review of Resident #33's medical record showed: - admitted on [DATE];- Diagnoses of hypertension, congestive heart failure (heart is too weak to pump blood effectively causing fluid to back up and build in the lungs), and depression. Review of the resident's Care Plan, revised 09/23/25, showed:- Requires staff assistance with self-care performance due to weakness;- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/06/26 at 1:47 P.M., the resident said he/she did not like mixed vegetables because of the butter beans and carrots. He/She had never been asked what his/her dislikes were since admission and didn't know he/she could ask for something else in its place. He/She did not know there was alternative food choices. 6. Review of Resident #42's medical record showed:- admitted [DATE];- Diagnoses of hypertension, heart failure, and DM. Review of the resident's Care Plan, dated 12/19/25, showed:- Requires staff assistance with self-care performance;- Dietary consult for nutritional regimen;- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/07/26 at 1:20 P.M., the resident said staff never discussed food items whether it be likes or dislikes with him/her. 7. Review of Resident #43's medical record showed: - admitted on [DATE];- Diagnoses of weight loss, hypertension, depression, and UTI. Review of the resident's Care Plan, revised 08/13/25, showed:- Requires staff assistance with self-care performance due to weakness;- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/06/26 at 1:57 P.M., the resident said the food didn't taste the same since his/her teeth had been pulled back in October 2025. He/She didn't like green beans, carrots, and didn't want lettuce because he/she couldn't chew it. These food items were often served on his/her plate. Staff had not asked what his/her dislikes were since admission or after his/her teeth were pulled. 8. Review of Resident #44's medical record showed:- admitted [DATE];- Diagnoses of hypertension, anxiety, and depression, Review of the resident's Care Plan, dated 11/14/25, showed:- Independent for meeting social needs and ADL's;- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/07/25 at 1:25 P.M., the resident said staff had not discussed his/her likes and dislikes of food with him/her. 9. Review of Resident #50's medical record showed: - admitted on [DATE];- Diagnoses of hypertension, depression, anxiety, and rheumatoid arthritis (a chronic disease marked by inflammation of multiple joints). Review of the resident's Care Plan, revised 08/13/25, showed:- Independent for meeting (continued on next page)

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	social needs and activities of daily living (ADLs);- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/06/26 at 2:17 P.M., the resident said he/she skipped some meals because there was no variety to the meals. He/She did not like the precooked eggs or sour kraut. Staff had never asked what his/her likes/dislikes were since admission and did not want to say anything because he/she didn't want to be a problem. He/She was aware there were food substitutions, but didn't know what they were. 10. Review of Resident #51's medical record showed:- admitted on [DATE];- Diagnoses of hypertension, DM, and kidney failure (when the kidneys lose the ability to filter waste). Review of the resident's Care Plan, dated 12/22/25, showed:- Requires staff assistance with self-care performance;- Dietary consult for nutritional regimen;- Did not address diet, food likes or dislikes. Review of the resident's Dietary Card showed:- No documentation of likes and/or dislikes;- The facility failed to address the resident's food likes and/or dislikes. During an interview on 01/07/25 at 1:30 P.M., the resident said facility staff had not discussed his/her dislikes of food with him/her at all since admission to the facility. Observation on 01/05/26 at 10:32 A.M., of the kitchen showed:- A Resident Alternative Foods and/or Substitutions Always Available list located on the DM's office door. Observations on 01/05/26 at 10:58 A.M. and 01/06/26 at 1:29 P.M., of the facility showed:- No posting of the Resident Alternative Foods and/or Substitutions Always Available list for the residents to view. Review of the Resident Alternative Foods and/or Substitutions Always Available list, undated, showed:- Chef salad with turkey, chicken salad, baked chicken, deli sandwich, tuna salad sandwich, grilled cheese sandwich, hamburger on a bun, cheeseburger on a bun, cottage cheese, fresh fruit, ice cream, cookie, and pudding. During an interview on 01/05/26 at 3:18 P.M., the Dietary Manager (DM) said the dietary cards were updated when he/she received a new dietary communication form. Dietary cards should include a resident's current likes/dislikes and updated as needed. Residents should be informed of the alternative foods and/or substitutions if there was a certain food he/she didn't like. During an interview at 01/08/26 at 9:40 A.M., the Assistant Director of Nursing (ADON) said she would expect a resident's food likes/dislikes to be included on the dietary card with his/her food preferences and updated as needed. Residents should be informed of alternative foods and/or substitutions if there was a certain food he/she didn't like. During an interview at 01/08/26 at 9:47 A.M., the Director of Nursing (DON) said she would expect a resident's food likes/dislikes to be included on the dietary card with his/her food preferences and updated as needed. Residents should be informed of alternative foods and/or substitutions if there was a certain food he/she did not like. During an interview at 01/08/26 at 10:10 A.M., the Administrator said she would expect a resident's food likes/dislikes to be included on the dietary card with his/her food preference and updated as needed. Residents should be informed of alternative foods and/or substitutions if there was a certain food he/she did not like.

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to electronically transmit a Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) in a timely manner and in accordance with guidelines for six residents (Residents #6, #7, #14, #16, #22, and #45) out of 12 sampled residents. The facility census was 48. Review of the facility's policy titled, Electronic Transmission of the MDS, revised November 2019, showed: - All MDS assessments (admission, annual, significant change, quarterly review, etc) and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to Center for Medicare and Medicaid Services (CMS) Quality Improvement and Evaluation Service (QIES) Assessment Submission and Processing (ASAP) system in accordance with current (omnibus Budget Reconciliation Act (OBRA) regulations governing the transmission of MDS data; - All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the MDS Resident Assessment Instrument (RAI) Instruction Manual is maintained by the resident assessment coordinator; - The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking. 1. Review of Resident #6's MDS record showed: - admitted on [DATE]; - Quarterly MDS with a completion date of 11/27/25 and accepted/transmitted date of 01/07/26 (41 days late). 2. Review of #7's MDS record showed: - admitted on [DATE]; - Quarterly MDS with a completion date of 11/27/25 and accepted/transmitted date of 01/07/2026 (39 days late). 3. Review of 14's MDS record showed: - admitted on [DATE]; - Quarterly MDS with a completion date of 11/28/25 and accepted/transmitted date of 01/07/26 (40 days late). 4. Review of 16's MDS record showed: (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- admitted on [DATE]; - Quarterly MDS with a completion date of 11/27/25 and accepted/transmitted date of 01/07/26 (39 days late). 5. Review of 22's MDS record showed: - admitted on [DATE]; - Quarterly MDS with a completion date of 11/27/25, and accepted/transmitted date of 01/07/26 (41 days late). 6. Review of 45's MDS record showed: - admitted on [DATE]; - Quarterly MDS with a completion date of 12/18/25, and accepted/transmitted date of 01/13/26 (26 days late). During an interview on 01/08/26 at 10:23 A.M., the Social Service Director (SSD) said he/she assisted with the MDS process and notified the MDS Coordinator when a resident's assessment was completed and ready for review. The assessment should be reviewed by a Registered Nurse (RN) for accuracy and submitted within 14 days of completion. During an interview on 01/08/26 at 10:39 A.M., the Assistant Director of Nursing (ADON) said a resident's MDS assessment should be reviewed for accuracy and submitted upon completion in a timely manner. During an interview on 01/08/26 at 10:51 A.M., the Director of Nursing (DON) said a resident's MDS assessment should be reviewed for accuracy and submitted upon completion in a timely manner. The MDS Coordinator was responsible for submitting the resident's assessment in a timely manner. During an interview on 01/08/26 at 11:49 A.M., the Administrator said a resident's MDS assessment should be reviewed for accuracy and submitted upon completion in a timely manner. The MDS Coordinator was responsible for ensuring resident assessments were completed, reviewed, and submitted within 14 days of completion. During an interview on 01/08/26 at 1:00 P.M., the MDS Coordinator said he/she checked the system to see when an assessment was due. He/She waited until there was a batch of assessments due, completed, and then would submit them. He/She forgot sometimes and did not always submit resident assessments in a timely manner. MDS assessments should be submitted upon completion within 14 days and in a timely manner.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for two residents (Residents #59 and #60) out of two sampled residents that included the instructions needed to provide effective and person-centered care to meet professional standards of quality care. The facility census was 48.Review of the facility's policy titled, Care Plans - Baseline, revised March 2022, showed:- A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission;- The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meets professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, discussion with the resident/representative and physician orders;- The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed;- Provision of the summary to the resident and/or resident representative is documented in the medical record. 1. Review of Resident #59's medical record showed:- admission date of 01/02/26:- No documentation of a baseline care plan;- The facility did not complete the resident's baseline care plan within 48 hours after admission to the facility. 2. Review of Resident #60's medical record showed:- admission date of 01/02/26:- No documentation of a baseline care plan;- The facility did not complete the resident's baseline care plan within 48 hours after admission to the facility. During an interview on 01/06/26 at 2:21 P.M., the Assistant Director of Nursing (ADON) said he/she would expect a resident to have a baseline care plan completed upon admission and within 48 hours with care areas addressed. The charge nurse on duty should start the baseline care plan and complete it if able on his/her shift. If not, the oncoming charge nurse should follow up and complete it in a timely manner.During an interview on 01/06/26 at 2:21 P.M., the Director of Nursing (DON) said she would expect a baseline care plan to be completed within 48 hours of a resident being admitted to the facility with care areas addressed so proper care could be given. Baseline care plans were not completed in a timely manner for these two residents because she thought since both admissions were on a Friday, there would be enough time to finish them on Monday.During an interview on 01/08/26 at 2:21 P.M., the Administrator said she would expect a baseline care plan to be completed within 48 hours of a resident being admitted to the facility with care areas addressed so proper care could be given. The charge nurse on duty should be initiating the baseline care plan upon admission, and a designee should be following up to make sure it had been completed in a timely manner.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents with limited range of motion (ROM) received appropriate treatment and services to increase their ROM and/or prevent a further decrease in their ROM for four residents (Resident #3, #6, #7, and #45) out of five sampled residents. The facility census was 48. Review of the facility's policy titled, Restorative Nursing Services, revised July 2017, showed: - Residents will receive restorative nursing care as needed to help promote optimal safety and independence; - Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services such as physical, occupational, or speech therapies; - Residents may be started on a restorative nursing program upon admission, during the course of stay, or when discharged from rehabilitative care; - Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care; - Restorative goals may include, but are not limited to supporting and assisting the resident in: a. adjusting or adapting to changing abilities; b. developing, maintaining, or strengthening his/her physiological (body functions) and psychological (mental or emotional) resources; c. maintaining his/her dignity, independence, and self-esteem; d. participating in the development and implementation of his/her plan of care. 1.Review of Resident #3's medical record showed: - admitted on [DATE]; - Diagnoses of fracture of unspecified part of the neck of the left femur (a break in the upper part of the thigh bone), congestive heart failure (a condition where the heart cannot pump blood properly), dislocation of unspecified parts of left shoulder girdle (when the upper arm bone pops out of socket of the shoulder blade), and dementia (a decline in the mental ability affecting the memory and daily life). Review of the resident's Care Plan, revised 12/19/25, showed: - Limited physical mobility related to weakness; - Monitor, document, and report any signs or symptoms of worsening immobility; - Physical Therapy (PT) and Occupational Therapy (OT) referrals as needed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Restorative Nursing Plan, dated 07/30/25, showed: - Therapy program to include: ROM, bed mobility/walking, transfers, dressing grooming, and toileting; - Frequency: two to three times weekly; - Precaution: fall risk and dementia; - Goal: maintain level of functioning/strength/independence; - Interventions: lower extremity strengthening/standing – three sets of 10 repetitions, standing balance/tolerance activities, and transfers – three sets of five repetitions. Review of the resident's Restorative Nursing Services documentation, dated 12/01/25 - 01/08/26, showed: - November 2025 calendar with 12 missed opportunities out of 12 opportunities for restorative nursing services; - December 2025 calendar with 12 missed opportunities out of 12 opportunities for restorative nursing services; - January 2026 calendar with six missed opportunities out of six opportunities for restorative nursing services. 2. Review of Resident #6's medical record showed: - admitted on [DATE]; - Diagnoses of paraplegia (inability to move in the lower half of the body), edema (a buildup of fluid), osteoporosis (a disease that weakens the bone), peripheral vascular disease (PVD - a slow and progressive disorder of the blood vessels) and depression (a serious medical illness that negatively affects how you feel, the way you think and how you act). Review of the resident's Care Plan, revised 12/19/25, showed: - Limited physical mobility; - Monitor, document, and report any signs or symptoms of worsening immobility; - Provide gentle ROM as tolerated with daily care; - Provide supportive care and assistance with mobility as needed; - Document assistance as needed. Review of the resident's Restorative Nursing Plan, dated 08/18/25, showed: - Physical therapy program to include: ROM and transfer training; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Frequency: three times a week; - Precaution: fall risk; - Goal: maintain strength, transfers, endurance, and bed mobility; - Interventions: bilateral lower extremity ([NAME]) strengthening with two-pound weights - two sets of 15 repetitions, sit-to-stand exercises, parallel bars exercises, seated forward leans - two sets of 10 repetitions, and seated reaching activities. Review of the resident's Restorative Nursing Services documentation, dated 11/01/25 - 01/08/26, showed: - November 2025 calendar with 12 missed opportunities out of 12 opportunities for restorative nursing services; - December 2025 calendar with 12 missed opportunities out of 14 opportunities for restorative nursing services; - January 2026 calendar with five missed opportunities out of six opportunities for restorative nursing services. During an interview on 01/06/2026 at 9:27 A.M., Resident #6 said he/she did not get restorative nursing services on a regular basis. He/She might get restorative services once every other week if that. The restorative aide took him/her to the therapy room and placed her legs on a chair for stretching. After about 15 minutes, he/she was taken back to his/her room. He/She would like to have more exercises than just stretching his/her legs. No other exercises were provided. 3. Review of Resident #7's medical record showed: - admitted on [DATE]; - Diagnoses of kidney failure (when kidneys lose ability to effectively filter waste), bilateral above the knee amputation (removal of both legs above the knee), PVD, and atrial fibrillation (the heart's upper chambers beat irregularly causing an unsteady rhythm). Review of the resident's Care Plan, revised 12/22/25, showed: - Limited physical mobility related to bilateral above the knee amputations; - Monitor, document, and report any signs or symptoms of worsening immobility; - Provide gentle ROM as tolerated with daily care; - Document assistance as needed. Review of the resident's Restorative Nursing Plan, dated 10/08/25, showed: - Therapy program to include: ROM, bed mobility/walking, transfers, dressing grooming, and toileting; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Frequency: three times weekly; - Precaution: fall risk and bilateral above the knee amputations; - Goal: maintain level of functioning/strength/mobility; - Interventions: seated reaching activity, upper extremity bike – endurance, wheelchair propulsion (walking and pushing with hands on wheelchair handles) 100 -150 feet independently, postural exercise – two sets of 10 repetitions, scapula (shoulder blade) squeeze, roll shoulders forward/backward, and shoulder shrugs. Review of the resident's Restorative Nursing Services documentation, dated 12/01/25 - 01/08/26, showed: - November 2025 calendar with 12 missed opportunities out of 12 opportunities for restorative nursing services; - December 2025 calendar with 12 missed opportunities out of 12 opportunities for restorative nursing services; - January 2026 calendar with six missed opportunities out of six opportunities for restorative nursing services. 4. Review of Resident #45's medical record showed: - admitted on [DATE]; - Diagnoses of stroke, abnormalities of gait (walk) and mobility, muscle weakness, osteoarthritis (joint pain where cartilage wears down causing bones to rub), hemiplegia (paralysis of one side of the body) of the left side, and abnormal posture. Review of the resident's Care Plan, revised 11/14/25, showed: - Decreased physical mobility related to stroke; - Monitor, document, and report any signs or symptoms of worsening immobility; - Provide gentle ROM as tolerated with daily care; - Document assistance as needed. Review of the resident's Restorative Nursing Plan, dated 04/30/25, showed: - Therapy program to include: ROM, bed mobility/walking, and transfers; - Frequency: three times weekly; - Precaution: fall risk and left lower/upper extremity weakness; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265862	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delta South Nursing & Rehabilitation	640 Colonel George E Day Parkway Sikeston, MO 63801

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Goal: maintain current strength and mobility; - Interventions: sit to stands, Nu-step (a type of exercise machine), lower extremity generalized strength exercises, encourage use of the left side, left sided stretches, and range of motion. Review of the resident's Restorative Nursing Services documentation, dated 12/01/25 - 01/08/26, showed: - November 2025 calendar with 12 missed opportunities out of 12 opportunities for restorative nursing services; - December 2025 calendar with 12 missed opportunities out of 12 opportunities for restorative nursing services; - January 2026 calendar with six missed opportunities out of six opportunities for restorative nursing services. During an interview on 01/07/26, at 1:11 P.M., Resident #45 said he/she did not get restorative services on a weekly basis. He/She received restorative services today for the first time in probably six months and would like to do restorative therapy on a regular basis because he/she needed the exercise. During an interview on 1/08/26, at 10:06 A.M., the Restorative Nurse Aide (RNA) said there were weeks he/she was pulled to the floor and missed completing the restorative nursing services for the residents. He/She did not tell anyone when restorative was getting missed because he/she felt like the nursing department should know because they were the ones that pulled him/her to the floor. He/She had not been properly trained and was under the impression activities of daily living (ADLs) would count as restorative exercises. During an interview on 01/08/26 at 10:32 A.M., the Rehabilitation Director said residents were screened quarterly and when there was a change in condition. A restorative plan was put in place by the therapist with the duration, frequency, and the individualized exercises for the resident. The individualized program was given to the restorative aide who in return ensured the resident received the plan of care. He/She would expect the restorative aide to follow the plans given for restorative therapy and make someone aware when they were unable to be followed. He/She felt the restorative program needed to be revamped to ensure better communication between nursing and therapy. During an interview on 01/08/26 at 11: 28A.M., the Assistant Director of Nursing (ADON) said a resident should receive restorative nursing services based on how many times it was recommended by the therapist. If the restorative aide was pulled to the floor to work for a particular day, restorative nursing services should be provided to the resident the next day based on the frequency. During an interview on 01/08/26 at 11:33 A.M., the Director of Nursing (DON) said a resident should receive restorative nursing services based on how many times it was recommended by the therapist. If the restorative aide was pulled to the floor to work for a particular day, restorative nursing services should be provided to the resident the next day based on the frequency. During an interview on 01/08/26 at 11:48 A.M., the Administrator said residents on restorative nursing services should receive what was outlined in the therapy recommendation including the exercises (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	listed, the duration, and the frequency of services. The RNA should be documenting when restorative services were given, refused by the resident, and notifying nursing if restorative services couldn't be provided if pulled to the floor. In those cases, a designee from the therapy department could possibly assist the residents with their restorative nursing services.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to reconcile narcotics (a process to count and document the exact narcotic inventory on hand) for seven residents (Residents #9, #18, #39, #42, #43, #50, & #58) out of 13 sampled residents. The facility census was 48.Review of the facility's policy titled, Controlled Substances, revised July 2017, showed:- Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up;- The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the following:A. Records of personal access and usage;B. Medication administration records;C. Declining inventory records;D. Destruction, waste, and return to pharmacy records. 1. Review of Resident #9's January 2026 Physician Order Sheet (POS) showed:- An order for alprazolam (an anxiety medication) 0.5 milligrams (mg) by mouth three times a day for anxiety, dated 09/05/25. Review of the resident's Medication Administration Record (MAR), dated 01/06/26, showed: - The resident's alprazolam 0.5 mg dose administered on 01/06/26 at 8:00 A.M. Review of the 300 Hall Certified Medication Technician (CMT) Narcotic Medication Count Log on 01/06/26 at 1:32 P.M. showed: - One card of alprazolam 0.5 mg with 42 tablets remained for the resident. Observation of the 300 Hall CMT medication cart on 01/06/26 at 1:32 P.M. showed:- One card of alprazolam 0.5 mg with 41 tablets remained for the resident. 2. Review of Resident #18's January 2026 POS showed:- An order for tramadol (a pain medication) 25 mg by mouth every 12 hours as needed for pain, dated 09/30/25. Review of the resident's MAR, dated 01/06/26, showed:- The resident's tramadol 25 mg dose administered on 01/06/26 at 8:00 A.M. Review of the 300 Hall CMT Narcotic Medication Count Log on 01/06/26 at 1:33 P.M. showed:- One card of tramadol 25 mg with 14 tablets remained for the resident. Observation of the 300 Hall CMT medication cart on 01/06/26 at 1:33 P.M. showed:- One card of tramadol 25 mg with 13 tablets remained for the resident. 3. Review of Resident #39's January 2026 POS showed:- An order for tramadol 50 mg by mouth every 6 hours as needed for pain, dated 05/07/25. Review of the resident's MAR, dated 01/06/26, showed:- The resident's tramadol 50 mg dose administered on 01/06/26 at 8:00 A.M. Review of the 300 Hall CMT Narcotic Medication Count Log on 01/06/26 at 1:36 P.M. showed:- One card of tramadol 50 mg with 19 tablets remained for the resident. Observation of the 300 Hall CMT medication cart on 01/06/26 at 1:36 P.M. showed:- One card of tramadol 50 mg with 18 tablets remained for the resident. 4. Review of Resident #42's January 2026 POS showed:- An order for tramadol 50 mg by mouth two times a day for pain, dated 04/25/25. Review of the resident's MAR, dated 01/06/26, showed:- The resident's tramadol 50 mg dose administered on 01/06/26 at 8:00 A.M. Review of the 300 Hall CMT Narcotic Medication Count Log on 01/06/26 at 1:35 P.M. showed:- One card of tramadol 50 mg with 35 tablets remained for the resident. Observation of the 300 Hall CMT medication cart on 01/06/26 at 1:35 P.M. showed:- One card of tramadol 50 mg with 34 tablets remained for the resident. 5. Review of Resident #43's January 2026 POS showed:- An order for alprazolam 0.5 mg by mouth two times a day for anxiety, dated 04/23/25. Review of the resident's MAR, dated 01/06/26, showed:- The resident's alprazolam 0.5 mg dose administered on 01/06/26 at 8:00 A.M. Review of the 300 Hall CMT Narcotic Medication Count Log on 01/06/26 at 1:34 P.M. showed:- One card of alprazolam 0.5 mg with 44 tablets remained for the resident. Observation of the 300 Hall CMT medication cart on 01/06/26 at 1:34 P.M. showed:- One card of alprazolam 0.5 mg with 43 tablets remained for the resident. 6. Review of Resident #50's January 2026 POS showed:- An order for alprazolam 0.5 mg by mouth every 6 hours for anxiety, dated 10/21/25. Review of the resident's MAR, dated 01/06/26, showed:- The resident's alprazolam 0.5 mg dose administered on 01/06/26 at 12:00 P.M. Review of the 300 Hall CMT Narcotic Medication Count Log on 01/06/26 at 1:37 P.M. showed:- One card of alprazolam 0.5 mg with 27 tablets remained for the resident. Observation of the 300 Hall CMT medication cart on 01/06/26 at 1:37 P.M. showed:- One card of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alprazolam 0.5 mg with 26 tablets remained for the resident. 7. Review of Resident #58's January 2026 POS showed:- An order for Ativan (an anxiety medication) 0.5 mg by mouth in the morning, dated 12/26/25. Review of the resident's MAR, dated 01/06/26, showed:- The resident's Ativan 0.5 mg dose administered on 01/06/26 at 8:00 A.M. Review of the 300 Hall CMT Narcotic Medication Count Log on 01/06/26 at 1:38 P.M. showed:- One card of Ativan 0.5 mg with 20 tablets remained for the resident. Observation of the 300 Hall CMT medication cart on 01/06/26 at 1:38 P.M. showed:- One card of Ativan 0.5 mg with 19 tablets remained for the resident. During an interview on 01/06/26 at 1:48 P.M., CMT C said he/she knew medications should be signed off in the book as soon as they were given, but he/she got busy and did not have time to chart the medications administered yet. During an interview on 01/06/26 at 3:36 P.M., the Director of Nursing (DON) said she would expect the CMT to chart medications as soon as they were given. The residents' medication count log should always reconcile with the correct number of medications in the facility. During an interview on 01/07/26 2:42 P.M., the Administrator said she would expect the CMT and all nursing staff to chart immediately after giving a controlled scheduled or an as needed medication.