STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265844	A. BUILDING _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	1200 MCCUTCHEN ROAD ROLLA, MO 65401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth A. Kubo — TITLE: Administrator — (X6) DATE: 4/11/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AURORA HEALTH AND REHABILITATION	1200 MCCUTCHEN ROAD ROLLA, MO 65401

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews and record review, facility staff failed to notify the physician and family/resident representative in a timely manner of a change in condition for one resident (Resident #1) who had a medical emergency, and failed to notify the family/resident representative for one resident (Resident #1) who sustained a fall. The facility census was 71. 1. Review of the facility's Notification of Changes policy, revised 9/1/21, shows the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his/her authority, resident representative when there is a change requiring notification. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 1/16/25, showed staff assessed the resident as follows: -Cognitive impairment; -Diagnosis of a Stroke, (when blood flow to the brain is interrupted, causing brain cells to die), high blood pressure, and Dementia.	F 580		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	1200 MCCUTCHEN ROAD ROLLA, MO 65401

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F 580	Continued From page 2 Review of the resident's nurses notes, dates 2/22/25, showed staff documented the resident found on his/her floor in his/her room. Resident noted to be laying on the floor on his/her back in the doorway to the bathroom. Review of the resident nurses notes did not contain documentation staff notified the residents family of the fall. Review of the resident's nurses notes, dated 2/24/25, showed staff documented, the resident had episodes of nausea and projectile vomiting at noon meal. Resident unresponsive for approximately two minutes. Review of the residents nurses notes did not contain documentation staff notified the physician of the change in condition. During an interview on 3/11/25 at 8:20 A.M., the Director of Nursing (DON) said the resident had an episode in the dining room where he/she vomited, but when he/she assessed the resident back in his/her room the resident was already alert and speaking. The DON said he/she believed the Nurse Practitioner was notified because he/she was in the building but did not know who notified him/her. The DON said he/she does not know if the residents guardian was notified for the change in condition or the residents fall. During an interview on 3/11/25 at 8:20 A.M., the administrator said he/she is unaware if the residents family was notified of the change in condition or the fall but they are supposed to be. During an interview on 3/11/25 at 10:19 A.M., the residents guardian said he/she was not aware the resident had a medical episode. The guardian	F 580		

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	265844	A. BUILDING _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	1200 MCCUTCHEN ROAD ROLLA, MO 65401

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F 580	Continued From page 3 said he/she would have requested the resident be sent to the hospital because he/she has a history of strokes. The guardian said he/she did not know the resident had a fall on 2/22/25 and would like to be notified of his/her falls because the resident has dementia and can not relay this information. During an interview on 3/11/25 at 10:44 A.M., Licensed Practical Nurse (LPN) A said he/she was the charge nurse on duty and would have been responsible to notify the physician and the family but he/she can not remember if it was done. During an interview on 3/11/25 at 11:15 A.M., the Nurse Practitioner said he/she was notified of the residents fall on 2/22/25 but was not notified of the residents medical episode on 2/24/25, The Nurse Practitioner said he/she was in the building that day and there was no reason for staff not to have informed him/her.	F 580		
F 584 SS=D	MO00249720 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		

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	265844	A. BUILDING _____ B. WING _____	C 03/20/2025

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AURORA HEALTH AND REHABILITATION	1200 MCCUTCHEN ROAD ROLLA, MO 65401

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F 584	Continued From page 4 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, facility staff failed to maintain wheelchairs for three residents (Resident #5, #7 and #8) of nine sampled residents. The facility census was 76. 1. Review of the facility's policy, "Physical Environment: Space and Equipment", dated 02/03/25, showed staff were directed inspection of resident care equipment will be completed	F 584		

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F 584	Continued From page 5 routinely and as needed to maintain and ensure safe operating conditions according to manufacturer's recommendations. 2. Review of Resident #5's Quarterly MDS, dated 03/02/25, showed staff assessed the resident as follows: -Moderate cognitive impairment; -Uses a wheelchair. Observation on 03/20/25 at 12:11 P.M., showed Resident #5 in his/her wheelchair with both arm rest torn. 3. Review of Resident #7's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 12/30/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Uses a wheelchair. Observation on 03/20/25 at 12:46 P.M., showed Resident #7's wheelchair armrest were worn with sections of missing vinyl. 4. Review of Resident #8's Quarterly MDS, dated 03/10/25, showed staff assessed the resident as follows: -Cognitively intact; -Uses a wheelchair. Observation on 03/20/25 at 1:48 P.M., showed Resident #8 in his/her wheelchair and the wheelchair had a bent metal piece connecting the chair to the leg rest. Observation showed	F 584		

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F 584	Continued From page 6 medical bandage wrapped around the metal connecting piece. During an interview on 03/20/25 at 1:51 P.M., the maintenance director said he/she did not know the resident had a maintenance issue with his/her wheelchair. He/She said the resident owned his/her wheelchair, so staff did not provide repairs to personal wheelchairs. He/She said it was possibly a safety issue and believed the bandage placed on the chair to hold the leg rest to the chair. During an interview on 03/20/25 at 1:56 P.M., the administrator said he/she did not know about the condition of the resident's wheelchair. He/She said staff should have ordered him/her a new wheelchair. He/She said staff should have immediately reported the concern with the wheelchair, due to the potential to harm the resident. 5. During an interview on 03/20/25 at 1:38 P.M., the maintenance director said staff were directed to document wheelchair concerns in the maintenance book, which he/she checked daily. He/She said he/she did not know any of the resident chairs were in need of repair. He/She said there was a concern with skin abrasions if the resident had a worn arm rest. During an interview on 03/20/25 at 2:23 P.M., Registered Nurse (RN) C said staff are directed to report issues with wheelchairs to the maintenance department or document in the maintenance log book. During an interview on 03/20/25 at 1:56 P.M., the administrator said staff should check the	F 584		

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AURORA HEALTH AND REHABILITATION	1200 MCCUTCHEN ROAD ROLLA, MO 65401

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F 584	Continued From page 7 condition of resident's wheelchairs daily and report to his/her supervisor to document any issues in the maintenance book or report to the appropriate person. He/She said if the wheelchair arm rest are torn, there was a potential for skin tears. During an interview on 03/20/25 at 2:41 P.M., the Director of Nursing (DON) said staff are directed to check the wheelchair every time in use or weekly when being cleaned by staff. He/She said staff should document concerns in the maintenance book. He/She said if it's the resident's personal wheelchair, staff should notify family and/or guardian for a replacement. He/She said if the wheelchair arm rest are torn, there was a potential for skin tears. MO00250878	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to provide care to meet the hygiene needs for four residents (Resident #3, #5 and #6) out of seven sampled residents when staff did not provide nail care and assist with facial hair. The facility census was 76. 1. Review of the facilities policy, "Activities of Daily Living", dated 01/01/25, showed staff are directed to assist a resident who is unable to	F 677		

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F 677	Continued From page 8 carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The policy did not provide direction for staff in regard to when and how to provide personal hygiene. 2. Review of Resident #3's Quarterly MDS, dated 01/18/25, showed staff assessed the resident as follows: -Severe cognitive impairment; -Did not exhibit behavior of rejecting care; -Required partial to moderate assistance from staff for personal hygiene. Review of the resident's care plan, dated 01/27/25, showed staff assesed the resident required moderate to maximum assistance with the majority of his/her ADL's due to impaired mobility related to right side hemiparesis. The care plan showed resident required moderate assistance from one staff member with personal hygiene and oral care. The plan did not contain documentation the resident had behaviors of rejecting care. Observation on 03/20/25 at 12:05 P.M., showed the resident nails long, a hole in his/her shirt, white debris on his/her shirt and pants, and unbrushed hair. 3. Review of Resident #5's Quarterly MDS, dated 03/02/25, showed staff assessed the resident as follows: -Moderate cognitive impairment; -Did not exhibit behavior of rejecting care; -Required partial to moderate assistance from staff for personal hygiene.	F 677		

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F 677	Continued From page 9 Review of the resident's care plan, dated 01/07/25, showed staff assessed the resident required moderate assistance for personal hygiene and oral care. The care plan showed the resident had limited physical mobility due to hemiparesis. The plan did not contain documentation the resident had behaviors of rejecting care. Observation on 03/20/25 at 12:11 P.M., showed the resident nails long and with debris, unbrushed hair and unkempt facial hair. 4. Review of Resident #6's Quarterly MDS, dated 01/02/25, showed staff assessed the resident as follows: -Severe cognitive impairment; -Did not exhibit behavior of rejecting care; -Required substantial to maximum assistance from staff for personal hygiene. Review of the resident's care plan, dated 06/17/24, showed staff assessed the resident required maximum assistance with personal hygiene and oral hygiene. The plan did not contain documentation the resident had behaviors of rejecting care. Observation on 03/20/25 at 12:15 P.M, showed the resident with facial hair, a hole in his/her shirt and his/her hair matted. 5. During an interview on 03/20/25 at 2:10 P.M., Certified Nurse Aide (CNA) B said the aides were responsible to dress resident's and brush the resident's hair daily and as needed. The CNA said CNA's are to provide nail care and facial hair	F 677		

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F 677	Continued From page 10 shaves on shower days and as needed. He/She said he/she did know resident's needed their nails trimmed and facial hair shaved. During an interview on 03/20/25 at 2:23 P.M., Registered Nurse (RN) C said nursing staff are to provide facial hair shaves and nail care on shower days or as needed. He/She said staff are directed to change resident's clothing and brush hair daily and as needed. During an interview on 03/20/25 at 2:41 P.M., the administrator said staff were directed to shower resident's twice a week, but they did not have enough shower aides until recently, so resident's were showered once a week. He/She said staff are educated to provide nail care and facial hair on shower days and as needed. He/She said staff changed clothing daily and brushed hair when gotten up and as needed. During an interview on 03/20/25 at 2:42 P.M., the Director of Nursing (DON) said they recently hired two shower aides to assist with personal hygiene needs. He/She said staff are directed to provide nail care and facial hair shaving on shower days and as needed. He/She said staff are directed to brush hair and change clothing when assisted out of bed or as needed. He/She said the nursing staff was responsible to provide care and should be checking the resident's grooming needs daily. MO00250878	F 677		

Missouri Department of Health and Senior Services

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	08862A	A. BUILDING: _____ B. WING _____	C 03/20/2025

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A3038	19 CSR 30-85.032(38) Furniture/Equip, Provide Comfort & Safety The facility shall maintain furniture and equipment in good condition and shall replace it if broken, torn, heavily soiled or damaged. Rooms shall be designed and furnished so that the comfort and safety of the residents are provided for at all times. II/III This regulation is not met as evidenced by: Class III Refer to F584	A3038		
A4077	19 CSR 30-85.042(68) Res Groomed/Dressed Appropriately Taking into consideration the resident's preferences, residents shall be well-groomed and dressed appropriately for the time of day, the environment and any identified medical conditions. II/III This regulation is not met as evidenced by: Class III Refer to F677	A4077		
A4088	19 CSR 30-85.042(79) Notify Responsible Party-Change in Condition In the event of accident, injury, or significant change in the resident's conditions, facility staff shall immediately notify the person designated in the resident's record as the designee or responsible party. III This regulation is not met as evidenced by:	A4088		

Missouri Department of Health and Senior Services

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A4088	Continued From page 1 Class II. see F580.	A4088		

PLAN OF CORRECTION

Provider/Supplier Name:	Aurora Health and Rehabilitation
Street Address, City, Zip:	1200 McCutchen Rd, Rolla, MO 65401
Date of Survey:	3/20/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265844

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of faulty by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 580	**1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** Resident #1 was assessed, and no negative outcome was noted.	
	2) The corrective actions for the resident(s) having potential to be affected by the same deficient practice include: Residents who reside at the facility have the potential to be affected by this alleged deficient practice. No others were identified.	
	3) Measures put into place to ensure that the deficient practice does not recur include: Director of Nursing or Designee will provide education to the facility nursing staff regarding notification of physician/provider and the resident's family/representative in the event of a change in condition.	
	4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following: The Director of Nursing or Designee will complete random audits to ensure that residents' change of condition includes notification to provider and family/representative and record of such. This will be done weekly X 4 weeks and then monthly X 2 months.	
	Any findings will be addressed immediately and taken through the facility's Quality of Assurance Performance Improvement process by the Administrator for review and revision as needed.	
	5) The corrective actions will be completed on or before:	4/11/25
A4088	See F580	

PLAN OF CORRECTION

Provider/Supplier Name:	Aurora Health and Rehabilitation
Street Address, City, Zip:	1200 McCutchen Rd, Rolla, MO 65401
Date of Survey:	3/20/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265844

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of faulty by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 584	**1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** Resident #5 and #7 wheelchairs were immediately repaired or switched out with different wheelchairs that were free of tears or defects. Resident #8 was offered a new wheelchair. Resident refused. The wheelchair part was ordered through our Medical Equipment vendor. We received two replacements. The wheelchair piece has been replaced as of 3/31/25. The facility now has a backup piece available in storage.	
	2) The corrective actions for the resident(s) having potential to be affected by the same deficient practice include: Residents who reside at the facility have the potential to be affected by this alleged deficient practice. No others have been identified.	
	3) Measures put into place to ensure that the deficient practice does not recur include: Administrator or Designee will provide education to the facility staff regarding using the maintenance log binder to record any needs for repairs or maintenance requests.	
	4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following: Audits of all wheelchairs will be done weekly X 4 weeks and then monthly X 2 months.	
	Any findings will be addressed immediately and taken through the facility's Quality of Assurance Performance Improvement process by the Administrator for review and revision as needed.	
	5) The corrective actions will be completed on or before:	4/11/25
A3038	See F584	

PLAN OF CORRECTION

Provider/Supplier Name:	Aurora Health and Rehabilitation
Street Address, City, Zip:	1200 McCutchen Rd, Rolla, MO 65401
Date of Survey:	3/20/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265844

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
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F 677	**1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** Resident # 3, #5, and #6 were provided staff assistance with hygiene and grooming, including nail care and facial hair.	
	2) The corrective actions for the resident(s) having potential to be affected by the same deficient practice include: Residents who reside at the facility have the potential to be affected by this alleged deficient practice. No others have been identified.	
	3) Measures put into place to ensure that the deficient practice does not recur include: Director of Nursing or Designee will provide education to the facility nursing staff regarding offering and documenting assistance with hygiene and grooming needs of residents based upon their personal preferences.	
	4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following: The Director of Nursing or Designee will monitor for compliance by conducting random audits, weekly x 4 weeks and then month X 2 months.	
	Any findings will be addressed immediately and taken through the facility's Quality of Assurance Performance Improvement process by the Administrator for review and revision as needed.	
	5) The corrective actions will be completed on or before:	4/11/25
A4077	See F677	