STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	100 West Thomas Avenue Waverly, MO 64096

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to prevent verbal and physical abuse for two sampled residents (Resident #2 and Resident #3) out of 7 sampled residents. On 12/26/25 Resident #2 and Resident #3 yelled and hit each other when staff left the behavioral unit unsupervised. The facility census was 43 residents.Review of the facility Abuse and Neglect Policy revised on 9/2021 showed:-The residents have the right to be free of abuse, neglect or mistreatment.-As a facility will be actively protect our resident from abuse. -To the extent possible, nurse aid assignments will be consistent so that the resident is most comfortable with the employee and the employee most knowledgeable about the needs of the resident. -Residents are most likely to strike out when they are in a situation where they feel like may not have control over. 1.Review of Resident #2's admission Face Sheet showed the resident admitted with the following diagnoses:-Paranoid Schizophrenia (is Schizophrenia with paranoid features, is a severe mental illness characterized by intense delusions (false beliefs, often persecutory) and hallucinations (especially auditory, like hearing voices), coupled with significant paranoia, distrust, anxiety, and social withdrawal).-Schizoaffective disorder (is a serious, chronic mental illness blending symptoms of schizophrenia (psychosis like hallucinations/delusions) with a mood disorder (mania or depression), causing significant impairment in thinking, perception, mood, and behavior, requiring combined treatment with medication, therapy, and support for effective management). Review of Resident #2's Brief Interview for Mental Status (BIMS) Evaluation dated 12/11/25 showed he/she was moderately cognitively impairment. Review of Resident #3's admission Record showed he/she was admitted with the following diagnoses: -Bipolar disorder (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Major depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living) Review of Resident #3's BIMS Evaluation dated 12/11/25 showed he/she was cognitively intact. Review of the resident's Facility Physical Aggression Initiated report dated 12/26/25 at 7:00 P.M. showed:-Resident #2 was involved in altercation with Resident #3 in the hallway of the behavioral health locked unit. -On 12/26/25 at approximately 7:00 P.M. Resident #3 was upset over not receiving his/her medications. Resident #2 explained to the resident that his/her medication was not going to be given yet due to the facility internet being out. Resident #3 approached Resident #2 with a raised voice and cursing. Resident #2 yelled back asking Resident #3 to get out of his/her face. Resident #2 then struck at Resident #3 in his/her upper arm. -Resident #2 said he/she told Resident #3 what Certified Medication Technician (CMT) A said to him/her about the facility internet being down and medications not being done yet. Resident #3 got in his/her face and started yelling. Resident #2 told Resident #3 to get out of his/her face and then Resident #2 hit Resident #3. -The facility internet had gone down, and the Director of Nursing (DON) was in the facility printing Medication Administration (MAR) and Treatment Administration Records (TAR) for all residents so medications could be administrated. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	100 West Thomas Avenue Waverly, MO 64096

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation summary dated 12/26/25 showed:-Resident #2 said he/she told Resident #3 that CMT A had told him/her about the facility internet being down and medication administration was not being done yet. Resident #3 got in Resident #2's face and started yelling. Resident #2 told Resident #3 to get out of his/her face and Resident #2 hit Resident #3. He/she did not remember where he/she had hit Resident #3. -Resident #3 said he/she did not do anything, and Resident #2 hit him/her in upper arm.-Resident #4 said Resident #3 went to the door. Resident #2 tried telling Resident #3 the medications was late, and Resident #3 started swinging. -Resident #5 said Resident #2 hit Resident #3 in his/her arm and Resident #3 was cussing at him/her because Resident #2 told Resident #3 the medication was going to be late that night.-Upon completion of the investigation, it was determined Resident #2 had attempted to redirect Resident #3 out of his/her personal space. Resident #2 yelled get out of my face and struck Resident #3 in the right upper arm. Review of the Resident #5's BIMS Evaluation dated 12/23/25 showed he/she was moderately cognitively impaired. During an interview on 12/29/25 at 12:58 P.M. Resident #5 said: -There was just an argument and misunderstanding between Resident #2 and Resident #3.-No staff member was on the unit at the time of disagreement between Resident #2 and Resident #3. Review of Resident #4's BIMS Evaluation dated 12/15/25 showed he/she was cognitively intact. During an interview on 12/29/25 at 12:59 P.M. Resident #4 said:-He/she had witnessed the altercation in the hallway between Resident #2 and Resident #3.-Resident #2 and Resident#3 were yelling at each other, as Resident #2 punched/hit Resident #3 in his/her arm. -There were no facility staff on the locked unit at the time.-He/she had to pound on the locked double door to get a staff members attention on the other side of the locked door. CMT A responded to the pounding. -He/she informed CMT A there was a fight on the locked unit while he/she was off the unit. During an interview on 12/29/25 at 11:09 A.M. Resident #2 said:-He/she lives on the behavioral locked unit. -It was a holiday, and the staffing was short that evening.-CMT A was on the behavioral unit when the facility internet went down. -CMT A was not able to provide medications and left the unit to get printed copies of all resident's MAR. -No facility staff were on the locked behavioral unit at time of the incident.-He/she tried to explain to Resident #3 that the internet was down and CMT A was not able to give the evening medications at that time. -Resident #3 him/her to shut the fuck up and then came toward him/her.-He/she exchanged words with Resident #3 and when he/she turned around to walk away Resident #3 punched him/her in the right upper arm. During an interview on 12/29/25 at 11:13 A.M. Resident #3 said: -Resident #2 punched him/her in his/her right arm during the evening shift on 12/26/25 in the locked unit hallway.-He/she was trying to get his/her medication from CMT A, and he/she had exchanged words with Resident #2. -He/she reported to staff that his/her arm was hurting after he/she got hit. Review of CMT A's undated witness statement showed: -He/she was starting to prepare for the medication pass and heard banging on the locked behavioral unit door. -He/she went to see what was going on and Resident #5 said Resident #2 and Resident #3 were fighting and throwing punches. -After talking to each resident separately, Resident #2 admitted he/she punched Resident #3 because he/she was screaming and yelling at him/her. -Resident #3 stated he/she yelled but did not hit anyone. -Resident #5 who was a witness said both Resident #2 and Resident #3 hit each other. During interview on 12/29/25 at 1:15 P.M. CMT A said:-He/she was assigned to pass medications for both units. -He/she came into the facility to assist with the evening medication pass. -He/she was off the unit when the incident happened between Resident #2 and Resident #3 because he/she was trying to print the resident MAR's so he/she could administer the resident medications. -He/she was not aware of who was assigned as the CNA for the behavioral unit. -There was no staff on the unit at the time of the resident-to-resident incident. -Resident #5 had notified nursing staff by banging on the locked (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	100 West Thomas Avenue Waverly, MO 64096

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	door of behavioral unit, requesting staff to come assist due to Resident #2 and Resident #3 fighting. -After talking to the two residents involved, Resident #2 had hit Resident #3 in his/her arm after a verbal argument related to medications not being given yet due to the facility internet was down. During an interview on 12/29/25 at 7:36 P.M. Licensed Practical nurse (LPN) B said. -He/she heard CMT A yell for assistance on the locked behavioral unit. -Resident #3 was hit on his/her right arm by Resident #2. There was no redness or swelling noted. -Resident #3 said he/she was only yelling and cursing at Resident #2. During an interview on 12/30/25 at 1:30 P.M., Administrator said CMT A was not on the locked unit when the resident to resident altercation happened. -He/she would expect the unit to supervised by facility staff all times to prevent altercation and provide protective oversight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	100 West Thomas Avenue Waverly, MO 64096

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on interview and record review, the facility failed to ensure adequate staffing coverage to provide supervision and oversight for two sampled residents (Resident #2 and Resident #3) who reside on the secure behavioral locked unit. On 12/26/25 Certified Medication Technician (CMT) A left the secured behavioral health unit unsupervised resulting in a physical and verbal altercation between Resident #2 and Resident #3 out of 7 sampled residents. The facility census was 43 residents.The facility was not able to provide a staffing policy at the time of exit. 1. Review of Resident #2's admission Face Sheet showed the resident admitted with the following diagnoses: -Paranoid Schizophrenia (is Schizophrenia with paranoid features, is a severe mental illness characterized by intense delusions (false beliefs, often persecutory) and hallucinations (especially auditory, like hearing voices), coupled with significant paranoia, distrust, anxiety, and social withdrawal).- Schizoaffective disorder (is a serious, chronic mental illness blending symptoms of schizophrenia (psychosis like hallucinations/delusions) with a mood disorder (mania or depression), causing significant impairment in thinking, perception, mood, and behavior, requiring combined treatment with medication, therapy, and support for effective management). Review of Resident #2's Brief Interview for Mental Status (BIMS) Evaluation dated 12/11/25 showed he/she was moderately cognitively impairment. Review of Resident #3's admission Record showed he/she was admitted with the following diagnoses: -Bipolar disorder (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Major depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living) Review of Resident #3's BIMS Evaluation dated 12/11/25 showed he/she was cognitively intact. Review of the resident Facility Physical Aggression Initiated report dated 12/26/25 at 7:00 P.M. showed:-Resident #2 was involved in altercation with Resident #3 in the hallway of the behavioral health locked unit. -On 12/26/25 at approximately 7:00 P.M. Resident #3 was upset over not receiving his/her medications. Resident #2 explained that his/her medication was not going to be given yet due to the facility internet being out. Resident #3 approached Resident #2 with a raised voice and was cursing. Resident #2 yelled back at the resident telling him/her to get out of his/her face. Resident #2 then struck at Resident #3 in his/her upper arm. -Resident #2 said he/she told the resident that CMT A told him/her that the facility internet was down and medications were not done yet. Resident #3 got in his/her face and started yelling. Resident #2 told Resident #3 to get out of his/her face and then Resident #2 hit Resident #3. -The facility internet had gone down, and the Director of Nursing (DON) was in the facility printing Medication Administration (MAR) and Treatment Administration Records (TAR) for all residents in order to administer medications. Review of the facility investigation summary dated 12/26/25 showed:-Resident #2 said he/she told Resident #3 that CMT A had told him/her about the facility internet being down and medication administration was not being done yet. Resident #3 got in Resident #2's face and started yelling. Resident #2 told Resident #3 to get out of his/her face and Resident #2 hit Resident #3. Resident #2 did not remember where he/she hit Resident #3. -Resident #3 said he/she did not do anything, and Resident #2 hit him/her in upper arm.-Resident #2 tried telling Resident #3 why the medications were late, and Resident #3 started swinging. -Resident #5 said Resident #2 hit Resident #3 in the arm and Resident #3 was cussing at him/her because Resident #2 told Resident #3 the medications was going to be late that night.-Upon completion of the investigation, it was determined Resident #2 had attempted to redirect Resident #3 out of his/her personal space. Resident #2 yelled get out of my face and struck Resident #3 in the right upper arm. During an interview on 12/29/25 at 11:09 A.M. Resident #2 said:-He/she resided on the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	100 West Thomas Avenue Waverly, MO 64096

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavioral locked unit. -It was a holiday, and staffing was short that evening.-CMT A was on the behavioral unit when facility internet went down. -CMT A was not able to provide medications and left the unit to get printed copies of all resident's MAR's. -No facility staff were on the locked behavioral unit at time of the incident. Review of CMT A's undated witness statements showed: -He/she was starting to prepare for the medication pass and heard banging on the locked behavioral unit door. -He/she went to see what was going on and Resident #5 said Resident #2 and Resident #3 were fighting and throwing punches. -After talking to with each resident separately, Resident #2 admitted he/she punched Resident #3 because he/she was screaming and yelling at him/her. -Resident #3 stated he/she yelled but did not hit anyone. -Resident #5 said both Resident #2 and Resident #3 hit each other. During interview on 12/29/25 at 1:15 P.M. CMT A said:-He/she was assigned to the medication pass for both units. -He/she came into the facility to assist evening medication pass. -He/she was off the unit when the incident happened between Resident #2 and Resident #.-he/she was trying to print the MARs to administer all the resident medications. -He/she was not aware of who assigned as the CNA for the behavioral unit. -There was no staff on the unit at the time of the resident-to-resident incident. -Resident #5 had notified nursing staff by banging on the locked door of behavioral unit, requesting staff to come assist due to Resident #2 and Resident #3 fighting. -After talking to the two residents involved, Resident #2 had hit Resident #3 in his/her arm after an verbal argument between the two residents related to medications not being given yet due to internet was down. -He/she should have waited for the MARs/TARs to have been brought to him/her or found someone to sit on the behavior unit while he/she retrieved the paperwork. During an interview on 12/29/25 at 7:36 P.M. Licensed Practical nurse (LPN) B said. -LPN B and the DON heard CMT A yell for assistance, so they went onto the locked behavioral unit. -Resident #3 was hit in right arm by Resident #2. There was no redness or swelling noted. -Resident #3 said he/she was only yelling and cursing at Resident #2.-He/she could not verify where staff were at time of the incident.-LPN B said the CNA assigned to the behavioral unit had called in sick.-He/she was not sure who was initially assigned to locked behavioral unit.-At 6:30 P.M. the facility internet went down and had another resident situation at the same time. -Normally the daytime nurse will work over until 7:30 P.M. to assist with behavioral health coverage. -That day the nurse left the facility around 6:15 P.M. that evening. -He/she would expect the locked unit have staff coverage all times. -Resident #3 has a history of outbursts when any schedule daily activity routine is delayed. -Resident #3 wanted his/her nighttime medication exactly at 7:00 P.M., and then goes smoke at 7:30 P.M., and if any his/her medication are delayed or he/she cannot go outside smoke at 7:30 P.M., he/she will become agitated and start yelling and cursing at staff. -Due to the facility internet being down this cause the misunderstanding between the residents. During an interview on 12/29/25 at 11:20 A.M. LPN A said:-The behavior unit should never be left unsupervised. -He/she would expect to have at least one staff member on unit all times. During an interview on 12/29/25 at 1:12 P.M. Certified Nurse Aide (CNA) A said the behavioral locked unit should always have at least one facility staff on the locked unit at all times. During an interview on 12/30/25 at 1:30 P.M. Administrator said:-On 12/26/25 CMT A was scheduled for medication administration for both units. -LPN B was initially assigned to the locked unit after CMT A had completed medication pass on the locked unit.-CMT A was not on the locked unit when the resident-to-resident altercation happened. -He/she would have expected the unit to be supervised by facility staff all times.-CMT A had left the behavioral unit unattended prior to the incident to get the resident's paper MARs. During interview on 12/29/25 at 2:20 P.M. the Staffing Coordinator said:-He/she would expect nursing staff and care staff to ensure have one staff member coverage on behavioral unit all times. -The behavioral locked unit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Ridge Care Center	100 West Thomas Avenue Waverly, MO 64096

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should never be left unattended by facility staff members. During an interview on 12/29/25 at 2:26 P.M. the DON said:-The facility locked behavioral unit should not be left unattended by facility staff. -Resident #3 tends to get upset easily when medications or other cares are delayed. -Resident #3 was very demanding in wanting his/her medications on time, which can cause him/her to become upset. During an interview on 12/29/25 at 3:08 A.M. CNA C said: -He/she had been instructed to never leave the behavioral unit unsupervised. -At least one staff is on the unit all times. -The behavioral unit is normal staffed with at least a licensed nurse or CMT and one CNA. During an interview on 12/29/25 at 3:30 P.M. CNA B said the behavioral locked unit always requires staff to remain on the unit.