STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265455	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLARD CARE CENTER	400 WEST WALNUT LANE WILLARD, MO 65781

(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 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide an ongoing program of activities designed to meet the needs, interests, and physical, mental, and psychosocial well-being for residents when the facility to provide meaningful activities for all residents, including two residents (Resident #1 and #2), and failed to care plan one resident's (Resident #2) specific activity interest. A sample of 8 residents was selected for review. The facility census was 31. Review of the facility's policy titled "Role of the Activity Director," dated 03/2012, showed the following: -The activity director provides a key role in enhancing the quality of a resident's daily life. The activity director plans and promotes meaningful activities based on the resident's interests and desires to provide a more homelike atmosphere in the facility; -Chart daily checklist of each resident's activities; post calendar of events where everyone can see	F 679		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 3-14-25

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.

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F 679	Continued From page 1	F 679		

it; secure entertainment well in advance and check with entertainers the day before; and schedule activities that will involve as many residents as possible.

Review of the facility's policy titled "Documentation," dated 03/2012, showed the following:

-The following records must be kept by the activity director: progress notes maintained in resident's clinical record; participation attendance records maintained in resident's clinical record (when the form is complete; until form is complete activity director may keep in their office); activity calendar required to keep one year; and assessments - includes initial assessment, quarterly assessment, annual assessment and significant change.

Review of the facility's policy titled "Activity Programming," dated 03/2012, showed the following:

-The activities services of each facility will plan, organize, and carry out a program of activities to meet individual resident needs. The program is designed to give residents entertainment, communication, exercise, relaxation and an opportunity to express their creative talent. Through the activities, residents can fulfill basic psychological, social and spiritual needs;
-The activity director plans and organizes a program of approved activities for residents on a group
level and for individuals, to meet the needs of the residents. A calendar of events will be posted on the
activity bulletin board to inform residents, visitors

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F 679	Continued From page 2 and staff of scheduled activities. All staff is responsible for assisting residents to activities of their choice; -An activity program is planned for each resident as part of their total resident care by the activity director, in cooperation with nursing service and with physician approval; -The activity director will develop a monthly activity calendar based on the resident's needs and interests. The calendar should include a wide variety of activities to meet all aspects of daily living. activities should include, physical, spiritual, emotional, cognitive, sensory, work service related and fun recreational. Activities should be planned for both large and small groups; -When movies and trips are planned, the activities staff is responsible for obtaining film, VCR/DVD, TV, arranging transportation, arranging supervision of the activity, and encouraging resident participation. 1. Review of the facility's activity calendar, posted at the end of 400 Hall near the activities office, dated 02/2025, showed the following: -On 02/02/25, 02/03/25, 02/06/25, 02/07/25, 02/10/25, 02/13/25, and 02/14/25 no activities were scheduled; -On 02/01/25 and 02/08/25, movie was listed with no time noted; -On 02/04/25 and 02/11/25, Bingo was listed with no time noted; -On 02/05/25, at 2:00 P.M., birthday party; -On 02/05/25, pet therapy listed with no time noted; -On 02/09/25, at 1:00 PM., church; -On 02/12/25, from 1:00 P.M. to 2:00 P.M., pet	F 679		

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F 679	Continued From page 3 therapy. 2. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance), showed the following: -Admission date of 04/24/24; -Diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures), diabetes, and peripheral vascular disease (a condition where the blood vessels outside the heart and brain become narrowed, blocked, or damaged). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/01/25, showed the following: -The resident was cognitively intact; -The resident did not have little interest or pleasure in doing things or feel down, depressed or hopeless; -The resident had social isolation sometimes; -The resident's preferences for customary routine and activities was not completed. Review of the resident's care plan, revised 01/09/25, showed the following: -He/she preferred activities that identified with his/her prior lifestyle, such as flea market shopping, outings with family, bingo, special events, and watching A&E (a television channel); -Encourage resident to become involved with activities. Provide him/her a monthly activity calendar and assist him/her to and from activities. Remind him/her about activities; -Spend one-on-one time with him/her as needed;	F 679		

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F 679	Continued From page 4 -His/her family comes in and visits him/her often. When the resident's kids, grandkids, and great grandkids were here to visit him/her, he/she did not want to go to any group activities. He/she only wanted to visit with his/her grandbabies. Please respect his/her wishes and privacy. -He/she went out frequently with his/her family. His/her family member came in and had supper with him/her or brought his/her food almost every evening. Assist him/her with calling his/her kids or other family members as needed; -He/she liked to attend some group activities. Review showed the facility did not provide documentation related to the resident's activity attendance from 01/01/25 to 02/14/25. Review of the resident's progress notes, dated 01/01/25 through 02/14/25, showed no documentation by the Activity Director (AD). During an interview on 02/07/25, at 1:28 P.M., Certified Nursing Assistant (CNA) B said the following: -The resident complained about not having activities; -The CNA told the charge nurse and Administrator. The Administrator said they would figure something out, but had not done anything about it. During an interview on 02/07/25, at 2:45 P.M., the resident said the following: -The old AD moved to another facility; -The facility had no activities since the old AD left except a church group every now and then; -He/she would go to activities if the facility had	F 679		

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F 679	Continued From page 5 them; -He/she missed participating in activities; -He/she now had nothing to do but watch TV and did not like this; -He/she had no quality of life without activities. During an interview on 02/14/25, at 7:34 A.M., the MDS Coordinator said the following: -The resident participated in activities when the facility had activities; -The resident mentioned they were tired of nothing going on. During an interview on 02/14/25, at 8:45 A.M., the Administrator said he/she had no documentation for the resident's participation in activities since 01/01/25. 3. Review of Resident #2's face sheet showed the following: -Admission date of 07/01/24; -Diagnoses included dementia, anemia (a condition in which the body does not have enough healthy red blood cells or hemoglobin, the protein in red blood cells that carries oxygen) and heart failure. Review of the resident's quarterly MDS, dated 01/01/25, showed the following: -The resident was cognitively intact; -The resident did not have little interest or pleasure in doing things or feel down, depressed or hopeless; -The resident's preferences for customary routine and activities was not completed.	F 679		

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F 679	Continued From page 6 Review of the resident's care plan, revised 12/03/24, showed the following: -He/she was involved in activities most of the time related to increase in socialization. -Adjust activity to accommodate his/her energy level. Involve him/her with those who have shared interests. Provide activities that resembled his/her prior lifestyle. Provide opportunity for his/her expression of individuality. Provide opportunity to express spiritual needs and beliefs as he/she desired. Provide a setting in which activities were preferred. (Staff did not care plan related to specific activities for the resident.) Review of the resident's progress notes, dated 01/01/25 through 02/14/25, showed no documentation by the AD. Review showed the facility did not provide documentation related to the resident's activity attendance since 01/01/25. During an interview on 02/14/25, at 5:07 A.M., Registered Nurse (RN) F said the resident asked him/her the other day to put a movie on and he/she was not able to do this due to not having the equipment to play a movie at this time. During an interview on 02/14/25, at 7:14 A.M., the resident said the following: -The facility did not have an AD; -He/she liked activities, but the facility had not had any recently that he/she was aware of; -The facility did not have Bingo or movies and he/she liked to participate in both of those activities;	F 679		

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F 679	Continued From page 7 -He/she just watched TV now, but he/she thought it would be nice to have something else to do. During an interview on 02/14/25, at 7:34 A.M., the MDS Coordinator said the following: -The resident participated in activities when the facility had activities; -The resident told him/her it was no use coming out of the room since there was nothing going on. During an interview on 02/14/25, at 8:45 A.M., the Administrator said the following: -The resident comes out of his/her room to talk to the staff; -He/she had no documentation of the resident's participation in activities since 01/01/25. 4. During an interview on 02/07/25, at 1:18 P.M., CNA A said the following: -The facility had not had an AD since 01/2025; -The residents had no activities except pet therapy; -When the old AD left, he/she showed staff where the Bingo items were to do with the residents; -The Administrator did not do any activities with the residents and floor staff did not have time to do activities with the residents. During an interview on 02/07/25, at 1:28 P.M., CNA B said the following: -The facility had no AD since the old AD left in 01/2025; -The residents had no activities unless floor staff did them and they did not have the time; -Department heads did not do activities with the	F 679		

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F 679	Continued From page 8 residents; -The residents did not have activities unless an outside church came in the facility. During an interview on 02/14/25, at 4:00 A.M., CNA C said the following: -He/she did not know if the facility had an AD; -Residents had puzzles and books accessible to them. During an interview on 02/14/25, at 4:27 A.M., CNA D said the following: -The facility did not have an AD; -The AD used to do activities with the residents; -Residents complained about being bored. During an interview on 02/14/25, at 7:56 A.M., CNA H said the following: -The facility had no AD and no consistent activities; -Staff did not follow the activities calendar. During an interview on 02/14/25, at 4:57 A.M., Cook E said the following: -The facility did not have an AD, but he/she did not know how long ago the old AD left; -The facility had not done any scheduled activities with the residents since the AD left except pet therapy on Wednesdays. During an interview on 02/14/25, at 8:05 A.M., Licensed Practical Nurse (LPN) I said the following: -The facility had not had an AD since around the	F 679		

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holidays;
-The kitchen staff did paint nails the other day and CNAs try to play ball on the halls;
-He/she did not know the last time the facility had a Bingo game;
-The Administrator and Director of Nursing (DON) were responsible for ensuring activities were completed.

During an interview on 02/14/25, at 5:07 A.M., RN F said the following:

-The facility had not had an AD for 1 to 1.5 months;
-The residents did not have activities like they were before the old AD left;
-Staff had no way to play a movie for the residents since the old AD took the DVD player that belonged to him/her when he/she left;
-He/she did not know who was responsible for completing activities with the residents;
-The Administrator and DON were responsible to ensure the activities were completed.

During an interview on 02/14/25, at 7:34 A.M., the MDS Coordinator said the following:

-The facility had not had an AD for five to six weeks;
-Since the AD left, the facility had Bingo once;
-The residents were beginning to complain about nothing to do;
-The Administrator did not complete any activities with the residents;
-The Administrator was responsible for ensuring activities were provided for the residents.

During an interview on 02/14/25, at 8:22 A.M., the DON said the following:

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F 679	Continued From page 10 -The facility had not had an AD for two to three weeks; -The facility had pet therapy and church on Wednesdays and Sundays; -Some CNAs painted fingernails the other day; -No staff played Bingo with the residents; -It was not appropriate to not have activities scheduled Mondays, Thursdays and Fridays. There should be activities mornings and afternoons daily; -The activity calendar was scarce; -He/she was not aware staff had no DVD player to play movies for residents; -The Administrator was responsible for ensuring activities were completed with residents. During interviews on 02/14/25, at 5:05 A.M. and 8:45 A.M., the Administrator said the following: -The facility had not had an AD for about a month; -Each department was completing an activity every once in awhile, churches came in and hospice did too; -The facility had puzzles for the residents; -The facility had not had Bingo for the last couple weeks; -It was not appropriate to not have any activities scheduled for the residents; -Normally the AD had documentation of residents participation in activities, but he/she did not believe they had any of this documentation since 01/01/25; -He/she was responsible for ensuring activities were completed with the residents and currently activities were not completed as often as he/she would like them to. MO00249151, MO00249180	F 679		

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide care to all pressure ulcers per standards of practice when the facility failed to have a system in place to obtain wound care orders, ensure timely implementation of new wound care orders, to ensure timely physician notification of wounds, and to document and track wounds timely and completely for one resident (Resident #3) who admitted with stage 2 pressure ulcers (a partial thickness skin loss, appearing as a shallow open sore or a blister, where the top layer of skin (epidermis) and potentially the deeper layer (dermis) are damaged, resulting in a red or pink wound bed without exposed muscle or bone; it can also present as an intact or ruptured blister) on his/her buttocks. A sample of 8 residents was reviewed in the facility with a census of 31. Review of the facility's policy titled "Wound Protocol," dated 2018, showed the following:	F 686		

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F 686	Continued From page 12 -Chronic wounds should be dressed using a clean technique unless physician's orders state otherwise; -Wounds should be cleansed with a non-toxic agent; -Select a dressing that keeps the wound bed moist and the periwound skin dry, it should be at least 2" larger than the affected area; -Reevaluate dressing and skin integrity every shift. -Reevaluate the wounds response to the prescribed treatment on a regular basis, and when needed make recommendations for treatment changes and inform the physician of changes in wound status; thoroughly document all wound information such as type, location, stage (if applicable), length, width, depth, drainage, notation of tunneling (wound that extends from the surface of the skin into deeper layers of tissue, forming a narrow channel or tunnel) or undermining (tissue under the wound has eroded, creating a pocket beneath the skin), description of tissue (necrotic, granulating, etc.), state of periwound area, treatment of wound, etc.; notify appropriate personnel of all new pressure ulcers, or if you have any questions; and educate residents families, friends and staff on interventions (such as weight shifting in bed or chair) to prevent skin breakdown. Review of the facility's "Nursing Admission Checklist," undated, showed nurse to complete initial skin assessment, use the weekly skin assessment observation, update the wound management tab, and obtain any treatment orders if necessary. 1. Review of Resident #3's face sheet (a	F 686		

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F 686	Continued From page 13 document that gives a resident's information at a quick glance) showed the following: -Admission date of 01/17/25; -Diagnoses included fractured rib, altered mental status, and diabetes. Review of the resident's 5-day, Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), showed the following: -The resident had severe cognitive impairment; -The resident was dependent for all Activities of Daily Living (ADL - dressing, eating, bathing, etc.) and bed mobility; -The resident had a stage 1 (the earliest stage of a pressure sore, characterized by a localized area of non-blanchable redness on intact skin, usually over a bony prominence, which may appear red, blue, or purplish and feel warm to the touch, but without any open wounds or skin breakdown) or greater, a scar over bony prominence, or a non-removable dressing/device. -The resident was at risk for developing pressure ulcers. -The resident had one or more unhealed pressure ulcer(s) at Stage 1 or higher. -The resident had one Stage 2 pressure ulcer that was present upon admission. -The resident had a pressure reducing device for chair and bed, pressure ulcer care, application of nonsurgical dressings (with or without topical medications) other than feet, and application of ointments. Review of the resident's baseline care plan, dated 01/17/25, showed the following:	F 686		

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	265455	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLARD CARE CENTER	**400 WEST WALNUT LANE WILLARD, MO 65781**

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F 686	Continued From page 14 -Staff to monitor medications, condition, and report changes to Director of Nursing (DON)/physician as applicable and lab values and report to physician. -Follow skin/wound treatment orders. Review of the resident's initial and weekly wound documentation, dated 01/18/25, showed the following: -The resident had pressure sore on bilateral buttocks that was present upon admission; -Current measurement showed "see wound management"; -The pressure ulcer was stage 2 and did not show tunneling, undermining, or sinus tract; -The pressure ulcer had granulation tissue (new, pink or red, fleshy tissue that forms over a healing wound) that was pink or red tissue with shiny, moist, granular appearance; -The pressure ulcer had no exudate (fluid that drains from a pressure ulcer as part of the healing process) and no odor; -The surrounding tissue/periwound area had erythema (redness of the skin); -Interventions included pressure reducing device for bed, turning and repositioning program, pressure ulcer care, and application of nonsurgical dressings (with or without topical medications) other than the feet; -Staff took measures including cleansing the wound and applying a mepilex (foam dressing for wound care) dressing; Continue treatment with no change, the physician was notified, and plan of care initiated. Review of the resident's January 2025 Physician's Order Sheet (POS), dated 01/2025, showed the following:	F 686		

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F 686	Continued From page 15 -An order, dated 01/20/25, for the wound care provider to eval and treat; -Staff did not document obtaining order for treatment of the the stage 2 pressure ulcer on the resident's bilateral buttocks. Review of the resident's January 2025 Medication Administration Record (MAR) showed staff did not document treatments completed to the resident's stage 2 pressure ulcer. Review of the resident's wound management showed staff did not document measurements of the resident's stage 2 pressure ulcer. Review of the resident's nurses' progress notes, dated 01/17/25 through 01/23/25, showed the following: -On 01/17/25, at 6:27 P.M., the resident arrived to the facility via emergency medical services (EMS). He/she had multiple bruises and two small open areas to his/her bottom. His/her bilateral heels were firm and intact; -On 01/18/25, at 5:17 A.M., bilateral buttocks pressure wounds stage 2 noted. Staff cleansed and mepilex dressings applied until further orders are received. These were present on admission. Excoriated skin in groin folds cleansed and moisture barrier cream applied; -On 01/18/25, at 10:42 P.M., resident was taken to shower room and given good pericare with warm, soapy water. Groin area treated with zinc moisture barrier paste and bilateral buttock wounds treated with TAB ointment (an antibiotic ointment). Staff noted facility had no calcium alginate (a wound dressing) that could be found and added to supply request form. New dressings	F 686		

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F 686	Continued From page 16 applied to bilateral buttocks and arm wounds cleansed and redressed; -On 01/20/25, at 3:12 P.M., (recorded as a late entry on 01/22/25 at 3:12 P.M.) the resident had two open areas to his/her bottom. Referral to wound care provider obtained and consent signed; -On 01/20/25, at 5:00 P.M., through 01/23/25, at 2:13 A.M., showed staff did not document regarding the stage 2 pressure ulcers on the resident's buttocks nor any treatment for the stage 2 pressure ulcers. (Staff did not document physician notification to request orders, or follow-up on an orders request.) During an interview on 02/14/25, at 7:09 A.M., Certified Nursing Assistant (CNA) B said the resident had open areas on his buttocks and the nurses did treatment on the wounds from what he/she remembered. During interviews on 02/07/25, at 1:28 P.M., and 02/14/25, at 7:09 A.M., CNA B said if he/she noticed a new area on a residents skin, he/she reported this to the charge nurse and the nurse assessed the resident. During an interview on 02/14/25, at 4:00 A.M., CNA C said the following: -If he/she noticed a new area on a residents skin, he/she told the charge nurse; -The charge nurse assessed the resident and started a treatment if needed; -He/she believed the charge nurse called the physician to get physician's orders for wound care if the resident did not have them.	F 686		

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F 686	Continued From page 17 During an interview on 02/14/25, at 4:27 A.M., CNA D said the following: -If he/she noticed a new reddened area on a resident, he/she told the charge nurse; -The charge nurse assessed the resident and started a treatment; -He/she believed the nurse got an order for treatment of pressure ulcers from the physician. During an interview on 02/14/25, at 7:56 A.M., CNA H said the resident had wounds and he/she believed the wounds were treated. If he/she noticed a new area on a residents skin, he/she notified the charge nurse immediately, cleaned the area and applied cream if needed. The charge nurse assessed the resident. During an interview on 02/14/25, at 7:00 A.M., Certified Medication Technician (CMT) G said the following: -If he/she noticed a new area on a resident's skin, he/she reported this to the charge nurse; -The charge nurse assessed the resident and notified the physician to obtain physician's orders. During an interview on 02/14/25, at 8:05 A.M., Licensed Practical Nurse (LPN) I said the following: -The resident had wounds on his/her buttocks, but no wound care orders for those wounds; -The resident should have had orders for treatment of these wounds; -Nurses should have completed treatments on the resident's wounds. -If the aides noticed a new area on a resident's skin, they notified the charge nurse immediately;	F 686		

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F 686	Continued From page 18 -He/she assessed and measured the wound and notified the physician to obtain wound care orders; -If a resident admitted with stage 2 pressure ulcers and did not have orders, the charge nurse notified the physician to obtain treatment orders; -The charge nurse was responsible for obtaining wound care orders from a residents physician. During an interview on 02/14/25, at 5:07 A.M., Registered Nurse (RN) F said the following: -The resident admitted with two open areas on his/her buttocks; -The resident had an order for wound care provider to evaluate and treat, but did not have any treatment orders for a treatment of the wounds on the resident's buttocks; -The resident should have had physician's orders for a treatment of his/her buttocks; -He/she saw a note written on 01/18/25 the wound was cleansed and mepilex applied until further instructions; -He/she did not see any physician's orders entered for treatment of the pressure ulcer; -If the aides noticed a new area on a resident's skin, they should notify the charge nurse immediately; -The charge nurse assessed the resident and, if the area needed a treatment, contacted the physician to get treatment orders; -If a resident was admitted with a stage 2 pressure ulcer and did not have treatment orders, he/she called the physician and received treatment orders; -He/she knew a resident had wound treatment orders by looking at the progress notes, through report or looking at the MAR; -The charge nurse was responsible for obtaining	F 686		

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F 686	Continued From page 19 physician's orders for treatment of a pressure ulcer from the resident's physician. During an interview on 02/14/25, at 7:34 A.M., the MDS Coordinator said the following: -The resident had open area on his/her buttocks that were stage 2; -The charge nurse did not document anything in the wound management tab; -The resident had no orders for wound care of the stage 2 pressure ulcers on his/her buttocks; -The resident had an order for wound care provider, but they did not get to see the resident before he/she declined; -The resident should have orders for wound care on his/her stage 2 pressure ulcer on his/her buttocks; -If a resident was admitted with a pressure ulcer, the charge nurse should assess the wound, measure the wound, check for physician's orders and clarify them if needed and ensure the resident had any special equipment if needed; -If the resident did not have any wound care orders, the charge nurse called the physician to obtain the orders; -The charge nurse and DON were responsible for ensuring a resident had wound care orders. During an interview on 02/14/25, at 8:22 A.M., the DON said the following: -The resident admitted with open area on his/her buttocks; -The resident had an order for wound care provider to evaluate and treat, but no treatment orders for the pressure ulcers; -The charge nurse should have obtained treatment orders from the resident's physician;	F 686		

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F 686	Continued From page 20 -He/she could not say if treatment was done due to the resident had not orders for treatment. -If a resident was admitted with pressure ulcers, the charge nurse referred to wound care provider and until they saw the resident, followed the orders from the hospital or obtained treatment orders from the resident's physician; -He/she was responsible for ensuring the charge nurses obtained treatment orders for pressure ulcers. During an interview on 02/14/25, at 8:45 A.M., the Administrator said the following: -The nurse should have obtained treatment orders for the resident's pressure ulcers; -He/she did not know if the resident's pressure ulcers were treated, but nurse's should have completed them; -The resident did not have wound care orders for his/her pressure ulcers on his/her buttocks but the nurse's should have obtained orders from the resident's physician. -If a resident admitted with a pressure ulcer, the charge nurse ensured the facility had the supplies on hand if they knew about it before the resident admitted; -The charge nurse assessed the pressure ulcer, obtained orders for treatment from the resident's physician and obtain orders for wound care plus or an outside wound care clinic if needed; -If the charge nurse obtained an order for wound care plus, they should still obtain orders for treatment and complete the treatments until wound care plus could see the resident; -The charge nurse was responsible for obtaining wound care orders and completing the treatments and the DON was responsible for ensuring this was completed.	F 686		

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F 686	Continued From page 21 MO00249151	F 686		

Missouri Department of Health and Senior Services

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A4083	19 CSR 30-85.042(74) Pressure Sore Prevention/Treatment Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F686. MO00249151	A4083		
A4101	19 CSR 30-85.042(92) Activity Program The facility shall designate an employee to be responsible for the activity program. The designated person shall be capable of identifying activity needs of residents, designing and implementing programs to maintain or increase, or both, the resident's capability in activities of daily living. Facilities shall provide activity programs on a regular basis. Each resident shall have a planned activity program which includes individualized activities, group activities, and activities outside the facility as appropriate to his/her needs and interests. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F679. *The higher classification merited due to the extent of the violation and violation's impact on the residents. MO00249151, MO00249180	A4101		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 3-14-25

PLAN OF CORRECTION

Provider/Supplier Name:	Willard Care Center
Street Address, City, Zip:	400 W Walnut LN, Willard MO 65781
Date of Survey:	02/14/2025

	This plan of correction is submitted as required under State and Federal law. The submission of this does not constitute an admission on the part of as to the accuracy of the surveyor's findings or the conclusion drawn there from. The plan of correction does not constitute an admission on the part of the facility that the findings or that the scope and severity regarding any of the deficiencies cited are correctly applied. This plan should be considered as the facility's letter of credible allegation. Compliance and corrections were or will be considered completed on 3/31/25	
.F-679	The facility will continue to provide an ongoing program of activities designed to meet the needs of interests, and physical, mental, and psychosocial well-being for residents. The Facility will continue to care plan residents specific interests in activities. 1. Resident #1, all current and future admitted residents will have activities provided of interests. 2. Resident #2's care plan was updated on 3/11/25 to address activities of interests. All current and future admitted residents will have care plans to show activities of interests. 3. The Activity Director will document the resident's activity attendance. 4. The Activity Director will make a progress note in resident's electronic medical on admission and at least quarterly regarding activities. 5. The Facility hired an Activity Director. 6. The Administrator/Designee in-serviced the Activity Director on the activity program and responsibilities of an activity director upon hire. 7. The Activity Director will have a calendar of events posted in the facility and each resident will have a calendar of events and times in their rooms. 8. All staff will be in-serviced on assisting residents to activities on or before 3/31/25 per the Administrator/Designee. 9. The Administrator/Designee will review the resident's attendance records and monthly activity calendar at the end of each month to ensure residents are attending and participating in activities. The Activity Calendar will be reviewed for activities and times of activities.	Completed on 3/31/25 and ongoing.

	10. The Activity Director will review the attendance of residents and participation in activities during the QAPI meeting to ensure compliance is being met.	
F-686	The Facility will continue to provide care to all pressure ulcers per standards of practice. 1. Resident #3 is no longer at the facility. 2. All current and future residents with pressure ulcers will be provided care per standards of practice. 3. The DON/Designee will in-service on all nursing staff on proper protocol and standards of practice for pressure ulcers on or before 3/31/25. 4. The Admitting Nurse will perform a head to toe skin assessment and document in resident's electronic medical record under the admission clinical assessment. If any areas of pressure ulcer noted orders will be obtained. The Admitting nurse will complete an initial wound observation with measurements and orders received. 5. The DON/Designee will review all admissions to ensure head to toe assessments are completed. 6. The DON/Designee will review activity report in matrix Mon thru Friday for any new pressure ulcers and ensure orders were received during daily stand up meeting. 7. The DON/Designee will review shower sheets at least 3 times a week for any new open areas to skin. 8. The DON/Designee will review shower sheets daily for any new skin areas. 9. The DON/Designee will review skin assessments weekly times 4 weeks then at least twice a month to ensure skin assessments are completed and any new open skin areas have orders and are being treated. 10. The DON/Designee will complete wound rounds at least weekly for assessment and measurement of wounds are done and documented in matrix in wound mgmt. 11. The DON/Designee will review all residents with pressure areas during weekly resident at risk meeting. 12. All finding will be discussed during QAPI meeting.	Completed on 3/31/25 and ongoing.

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider/Supplier Name:	Willard Care Center
Street Address, City, Zip:	400 Walnut Lane Willard Mo
Date of Survey:	02/14/25

A4083	REFER to F686	3/31/25
A4101	REFER to F679	3/31/25

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

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	265455	A. BUILDING _____ B. WING _____	R-C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLARD CARE CENTER	400 WEST WALNUT LANE WILLARD, MO 65781

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegation of possible abuse were were reported to the state survey agency (Department of Health and Senior Services-DHSS) within the required time frame when staff did not report an allegations of possible abuse involving two residents (Resident	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 609	Continued From page 1 #1 and Resident #2). The facility had a census of 39. Review of the facility's Abuse and Neglect policy titled, "Reporting," undated, showed the following: -It is the policy of the facility that each resident will be free from abuse: -Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property, exploitation, corporal punishment, or involuntary seclusion. The resident will also be free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties; -It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The term abuse (abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation) will be used throughout this policy unless specifically indicated;	F 609		

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WILLARD CARE CENTER	**400 WEST WALNUT LANE WILLARD, MO 65781**

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F 609	Continued From page 2 -An owner, licensee, Administrator, Licensed Nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator; -The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements; -All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown sources, and misappropriation of resident property by facility employees, contract employees, volunteers, contract services, consultants, physicians, visitors, family members, or other individuals will be reported immediately but no later than the following timeframes. If abuse is alleged or the allegation results in serious bodily injury, the allegation must be reported within two hours after the allegation was made. If the allegation does not allege abuse or result in serious bodily injury, the report must be made within 24 hours after the allegation was made; -All employees of the facility are mandated reporters; -The facility will ensure that all reports are made within two hours (abuse or serious bodily injury) or 24 hours (non-abuse). The twp-hour timeframe must be met even during the night shift or during the weekend. 1. Review of Resident #1's face sheet showed the following: -Admission date of 02/26/25; -Diagnoses included of chronic obstructive pulmonary disease (COPD - blocks airflow making if difficult to breathe), dementia, anxiety,	F 609		

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F 609	Continued From page 3 depression, Parkinson's disease (an age-related degenerative brain condition, meaning it causes parts of the brain to deteriorate. It ' s best known for causing slowed movements, tremors, balance problems), psychosis, alcohol abuse, marijuana abuse, restlessness, and agitation. Review of the resident's admission Minimum Data Set (MDS - a federally-mandated comprehensive assessment tool completed by facility staff), dated 03/07/25, showed the following: -Clear speech; -Exhibited moderate cognitive impairment; -Experienced disorganized thinking (behavior fluctuates comes and goes, changes in severity); -Experienced delusions (misconceptions or beliefs that are firmly held, contrary to reality); -Exhibited verbal behaviors directed toward others (threatening, screaming, cursing) on one to three days of review period; -Exhibited physical behaviors not directed toward others on one to three days of review period; -Overall presence of behavioral symptoms; -Behaviors put the resident at a significant risk of physical illness or injury; -Behaviors had no impact on others; -Rejected cares on one to three days of review period; -Exhibited wandering on one to three days of review period (did not significantly intrude on privacy of activities of others); -Used walker for mobility device; -Able to independently go from lying to sitting, from sitting to standing, and transfer from chair to bed independently; -Independent with ambulation, once standing able to ambulate at least 150 feet.	F 609		

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F 609	Continued From page 4 Review of the resident's care plan, dated 03/18/25, showed the following: -Resident may have socially inappropriate/disruptive behaviors at times, especially at night secondary to diagnosis; -Staff to administer medications, monitor and record side effects, and report any adverse side effects; -Allow the resident to have control over situations, if possible; -Avoid over-stimulation, do not try to redirect his/her delusion; -Do not engage the resident in sensitive topics that may trigger behaviors; -Resident occasionally wanders into other resident rooms. Staff to redirect the resident as quickly as possible and orient the resident to his/her current room; -Maintain a calm environment and approach with the resident; -Observe and report socially inappropriate/disruptive behaviors when around others; -Staff to remove the resident from other resident rooms and unsafe situations; -Set expectations and limits for the resident; -When the resident begins to become socially inappropriate/disruptive, provide comfort measures or basic needs (such as pain, hunger, toileting, too hot/cold food, etcetera). Review of the resident's progress note dated 04/11/25, at 5:03 A.M., showed staff documented the following: -At approximately 1:30 A.M., the nurse notified the on-call physician due to resident's behavior issues. the resident in the hallway with no pants urinating on the carpet. Certified nurse assistants (CNAs) and registered nurse (RN) were working	F 609		

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with another resident at the time. The resident was redirected to his/her room and tucked back into bed. He/she was noted to be entering the room next door, turning on the lights and yelling at the resident to "Get out of the bed!" He/she was again redirected and was soon found on the bed next to her (he/she was on the resident's bed numerous times) and putting a tied gown around his/her roommate's (Resident #2) head and neck. Staff gave the resident a haldol injection and moved the resident to a vacant room. The resident bit a CNA during this process. The nurse contacted the resident's physician, the Director of Nursing (DON) and emergency medical services (EMS) and EMS transported the resident to the hospital.

Review of resident and facility records showed staff did not document reporting the allegation of possible abuse to DHSS.

Review of DHSS records showed staff did not report the allegation of possible abuse.

Review of the resident's progress note dated 04/12/25, at 8:49 A.M., showed staff documented the following:
-This shift the resident tried biting and hitting staff and screamed at various residents, chased them down the hallway and cursed at them for no reason. The resident continually tried to eat food off other resident's dirty plates as they are being prepared to be returned to the kitchen, takes food and drinks from trays that are in the process of being passed out to other residents. This is happening during shift change, report, the finishing of dinner and is despite constant redirection. He/she entered another resident's room numerous times and handled that resident's

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belongings. The resident touched the other resident, no inappropriate touching, but was unwelcome by the other resident. The resident went into several other resident rooms and tried to use other resident restrooms. The resident rummaged through other resident's belongings and yelled. He/she cursed at other residents and staff.

Review of resident and facility records showed staff did not document reporting the allegation of possible abuse to DHSS.

Review of DHSS records showed staff did not report the allegation of possible abuse.

2. Review of Resident #2's face sheet showed:
-Admission date of 03/26/25;
-Diagnoses included dementia, recent urinary tract infection, and pneumonia.

Review of the resident's admission MDS, dated 03/28/25, showed the following:
-Resident admitted from the hospital on 03/26/25;
-Resident had unclear speech;
-Severely impaired cognitive skills for daily decision making;
-Short-term and long-term memory problem;
-No behavioral symptoms;
-No rejection of care;
-Dependent on staff for dressing and mobility;
-Required a wheelchair for a mobility device.

Review of the resident's April 2025 progress notes showed no entries related to encounters or interactions with his/her roommate (Resident #1).

3. During an interview on 04/30/25, at 2:53 P.M., the MDS Coordinator/Care Plan Coordinator said

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the following:
-Resident #1 and Resident #2 were roommates;
-Staff reported Resident #1 was pulling the privacy curtain open and closed and telling staff he/she needed to care for Resident #1;
-Resident #1 mistakenly thought Resident #2 was his/her child and would call out to Resident #2 using Resident #1's child's name;
-Staff moved Resident #1 to another room temporarily due to Resident #1 keeping Resident #2 awake;
-He/she was not aware of any physical contact or abuse between Resident #1 and Resident #2;
-He/she was not aware of the progress note about Resident #1 placing a gown on the resident's head/neck;
-If Resident #1 placed a gown around Resident #2's head and neck, the nurse should have reported to the DON or Administrator and the facility should have called the incident to DHSS as an allegation of possible physical/verbal altercation;
-Staff have reported in morning meeting that Resident #1 yelled and cursed at other residents;
-The facility should call in all allegations of resident abuse to the DHSS hotline within two hours.

During an interview on 05/01/25, at 10:20 A.M., Nurse Assistant (NA) A said if a resident yelled or cursed at, or struck another resident, he/she would move the aggressive resident away from the other residents and immediately notify the charge nurse of the situation.

During an interview on 05/01/25, at 10:28 A.M., RN B said the following:
-On 04/11/25, during the night shift, Resident #1 had yelled, "Shut up, shut up, shut up," while

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standing in the room with Resident #2;
-Later that same night, the RN and a NA, heard Resident #1 yelling and entered the room;
-Upon entering the room, Resident #2 was lying on his/her own bed on his/her back and Resident #1 was on top of Resident #2, straddling him/her;
-Resident #1 had removed his/her hospital gown and wore only an incontinent brief;
-Resident #1 was pressing the tied neck string of his/her hospital gown using both hands against the front of Resident #2's neck;
-Resident #2 was dressed in pajamas and under covers;
-Staff immediately intervened and removed Resident #1 from Resident #2's bed and assisted Resident #1 to another room;
-The RN said he/she contacted the DON and told him/her about the incident, but could not recall exactly what details he/she relayed during the phone conversation;
-The nurse then contacted the physician who gave an order to send Resident #1 to the hospital for evaluation;
-The RN did not feel this incident was an example of resident to resident abuse because he/she did not think Resident #1 was trying to injure Resident #2, but instead was trying to get Resident #2 dressed;
-If he/she observed the same scenario with residents that did not have dementia, he/she said that would be an allegation of resident to resident abuse and should be reported;
-He/she did not hotline the incident to DHSS because he/she did not believe abuse, but did report the incident to the DON.

During an interview on 05/01/25, at 11:25 A.M., Nurse Assistant (NA) C said the following:
-If he/she observed resident to resident abuse or

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any type of abuse, he/she would immediately intervene and removed the resident from the situation;
-He/she would then immediately report any allegation of abuse to his/her charge nurse;
-Resident #1 had a history of becoming agitated in the evening;
-Resident yelled and cursed at other residents at times, particularly if the other resident was in his/her way of moving forward;
-At times, Resident #1 wandered into other resident rooms;
-Staff intervene and redirect Resident #1 when he/she becomes agitated;
-The NA notified his/her nurse of the resident's agitation, yelling, and cursing.

During an interview on 05/03/25, at 6:13 A.M., Certified Nurse Assistant (CNA) G said the following:
-He/she worked on the night shift on 04/11/25;
-Resident #1 thought his/her roommate, Resident #2, was his/her child;
-The CNA had been in the residents' room several times and each time Resident #1 appeared more aggravated and was yelling out his/her child's name to the roommate, Resident #2;
-Resident #2 was, "chattering," not making any sense just saying random words, per his/her usual;
-He/she and the other staff working heard a noise and entered the room of Resident #1 and Resident #2;
-Resident #1 was sitting on top of Resident #2 on Resident #2's bed, he/she was straddling Resident #2;
-Resident #1 was yelling the name of his/her child over and over;

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-Resident #1 had the bottom edge of his/her hospital gown draped over Resident #2's head and face;
-Staff immediately intervened and assisted Resident #1 off of Resident #2's bed and into another room;
-The nurse on duty, RN B observed the entire situation;
-He/she thought RN B notified the DON of the situation:
-RN B sent the resident out to the hospital for evaluation;
-If he/she observed resident to resident abuse, he/she would immediately intervene and attempt to stop the abuse and report to the charge nurse;
-The facility was responsible for reporting all allegations of abuse to DHSS within two days.

During an interview on 05/01/25, at 11:29 A.M., Certified Medication Technician (CMT) D said if he/she observed abuse, he/she would immediately report to the charge nurse.

During an interview on 05/01/25, at 11:30 A.M., Licensed Practical Nurse (LPN) E said the following:
-If he/she were notified of an allegation of abuse, he/she would assess the situation, removed the alleged perpetrator of the abuse, notify the Administrator, DON, or designated RN on call immediately;
-He/she would notify the residents families and their physician;
-All allegations of abuse should be reported to DHSS within 2 hours;
-The resident was verbally abusive to others, residents and staff when he/she yelled and cursed at others;
-The nurse reported to the resident's behaviors to

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the DON in the past;
-He/she had never observed the resident being physically abusive to any resident;
-He/she was not aware the resident got in bed with another resident;
-If the nurse was aware of Resident #1 getting into bed with Resident #2 or of the interaction, he/she would have intervened and notified the DON.

During an interview on 05/01/25, at 12:13 P.M., the DON said the following:
-He/she received a phone call from the charge nurse on duty at the facility on 04/11/25 at approximately 1:11 A.M.;
-The DON did not recall exactly what the charge nurse reported about the incident between Resident #1 and Resident #2;
-The nurse did tell the DON that Resident #1 was pressing anything against the front of Resident #2's neck, if the DON were aware of that, he/she would have immediately came to the facility, notified the Administrator, and hotlined the incident to state (DHSS);
-The DON said he/he would have called the hotline about the issue because it would have been an allegation of potential resident to resident physical abuse;
-The DON said no one told him/her Resident #1 was holding a hospital gown against Resident #2's neck.

During an interview on 05/01/25, at 12:52 P.M., the Administrator said the following:
-Regarding the 04/11/25 incident between Resident #1 and Resident #2, staff told the Administrator Resident #1 was attempting to dress Resident #2;
-Resident #1 thought Resident #2 was his/her

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F 609	Continued From page 12 child at times and wanted Resident #2 to get up out of bed; -Staff did get a physician's order and send Resident #1 out to the hospital for an evaluation; -The Administrator said, if he/she was aware of the incident between Resident #1 and Resident #2 on 04/11/25, he/she would have hotlined the incident to DHSS as an allegation of resident to resident physical abuse within two hours of the time of the incident; -All allegations of abuse should be reported to the DON or myself immediately and reported to DHSS within two hours.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of possible abuse	F 610		

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were fully and timely investigated when staff did not complete investigations of allegations of possible resident to resident abuse involving two residents (Resident #1 and Resident #2). The facility census was 39.

Review of the facility abuse policy titled, "Investigation," undated, showed the following:
-It is the policy of the facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated;
-The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. When an incident or suspected incident of abuse is reported, the Administrator or Designee will investigate the incident with the assistance of appropriate personnel.
-The investigation will include who was involved; residents' statements (for non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings); resident's roommate statements (if applicable); interviews obtained from three to four residents who received care from the alleged staff; interviews obtained from three to four different department staff, (if applicable); involved staff and witness statements of events; a description of the resident's behavior and environment at the time of the incident; injuries present including a resident assessment;

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F 610	Continued From page 14 observation of resident and staff behaviors during the investigation; and environmental considerations. All staff must cooperate during the investigation to assure the resident is fully protected. 1. Review of Resident #1's face sheet showed the following: -Admission date of 02/26/25; -Diagnoses included of chronic obstructive pulmonary disease (COPD - blocks airflow making if difficult to breathe), dementia, anxiety, depression, Parkinson's disease (an age-related degenerative brain condition, meaning it causes parts of the brain to deteriorate. It ' s best known for causing slowed movements, tremors, balance problems), psychosis, alcohol abuse, marijuana abuse, restlessness, and agitation. Review of the resident's admission Minimum Data Set (MDS - a federally-mandated comprehensive assessment tool completed by facility staff), dated 03/07/25, showed the following: -Clear speech; -Exhibited moderate cognitive impairment; -Experienced disorganized thinking (behavior fluctuates comes and goes, changes in severity); -Experienced delusions (misconceptions or beliefs that are firmly held, contrary to reality); -Exhibited verbal behaviors directed toward others (threatening, screaming, cursing) on one to three days of review period; -Exhibited physical behaviors not directed toward others on one to three days of review period; -Overall presence of behavioral symptoms; -Behaviors put the resident at a significant risk of physical illness or injury; -Behaviors had no impact on others;	F 610		

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F 610	Continued From page 15 -Rejected cares on one to three days of review period; -Exhibited wandering on one to three days of review period (did not significantly intrude on privacy of activities of others); -Used walker for mobility device; -Able to independently go from lying to sitting, from sitting to standing, and transfer from chair to bed independently; -Independent with ambulation, once standing able to ambulate at least 150 feet. Review of the resident's care plan, dated 03/18/25, showed the following: -Resident may have socially inappropriate/disruptive behaviors at times, especially at night secondary to diagnosis; -Staff to administer medications, monitor and record side effects, and report any adverse side effects; -Allow the resident to have control over situations, if possible; -Avoid over-stimulation, do not try to redirect his/her delusion; -Do not engage the resident in sensitive topics that may trigger behaviors; -Resident occasionally wanders into other resident rooms. Staff to redirect the resident as quickly as possible and orient the resident to his/her current room; -Maintain a calm environment and approach with the resident; -Observe and report socially inappropriate/disruptive behaviors when around others; -Staff to remove the resident from other resident rooms and unsafe situations; -Set expectations and limits for the resident; -When the resident begins to become socially	F 610		

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	265455	A. BUILDING _____ B. WING _____	R-C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 16 inappropriate/disruptive, provide comfort measures or basic needs (such as pain, hunger, toileting, too hot/cold food, etcetera). Review of the resident's progress note dated 04/11/25, at 5:03 A.M., showed staff documented the following: -At approximately 1:30 A.M., the nurse notified the on-call physician due to resident's behavior issues. the resident in the hallway with no pants urinating on the carpet. Certified nurse assistants (CNAs) and registered nurse (RN) were working with another resident at the time. The resident was redirected to his/her room and tucked back into bed. He/she was noted to be entering the room next door, turning on the lights and yelling at the resident to "Get out of the bed!" He/she was again redirected and was soon found on the bed next to her (he/she was on the resident's bed numerous times) and putting a tied gown around his/her roommate's (Resident #2) head and neck. Staff gave the resident a haldol injection and moved the resident to a vacant room. The resident bit a CNA during this process. The nurse contacted the resident's physician, the Director of Nursing (DON) and emergency medical services (EMS) and EMS transported the resident to the hospital. Review of the resident and facility records showed staff did not document an investigation completed of the allegation of possible abuse to DHSS. Review of DHSS records showed staff did not provide an investigation of the allegation of possible abuse. Review of the resident's progress note dated	F 610		

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F 610	Continued From page 17 04/12/25, at 8:49 A.M., showed staff documented the following: -This shift the resident tried biting and hitting staff and screamed at various residents, chased them down the hallway and cursed at them for no reason. The resident continually tried to eat food off other resident's dirty plates as they are being prepared to be returned to the kitchen, takes food and drinks from trays that are in the process of being passed out to other residents. This is happening during shift change, report, the finishing of dinner and is despite constant redirection. He/she entered another resident's room numerous times and handled that resident's belongings. The resident touched the other resident, no inappropriate touching, but was unwelcome by the other resident. The resident went into several other resident rooms and tried to use other resident restrooms. The resident rummaged through other resident's belongings and yelled. He/she cursed at other residents and staff. Review of resident and facility records showed staff did not document investigation of the allegation of possible abuse to DHSS. Review of DHSS records showed staff did not provide an investigation of the allegation of possible abuse. 2. Review of Resident #2's face sheet showed: -Admission date of 03/26/25; -Diagnoses included dementia, recent urinary tract infection, and pneumonia. Review of the resident's admission MDS, dated 03/28/25, showed the following: -Resident admitted from the hospital on 03/26/25;	F 610		

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F 610	Continued From page 18 -Resident had unclear speech; -Severely impaired cognitive skills for daily decision making; -Short-term and long-term memory problem; -No behavioral symptoms; -No rejection of care; -Dependent on staff for dressing and mobility; -Required a wheelchair for a mobility device. Review of the resident's April 2025 progress notes showed no entries related to encounters or interactions with his/her roommate (Resident #1). 3. During an interview on 05/01/25, at 10:20 A.M., Nurse Assistant (NA) A said if a resident yelled or cursed at, or struck another resident, he/she would move the aggressive resident away from the other residents and immediately notify the charge nurse of the situation. During an interview on 05/01/25, at 11:25 A.M., Nurse Assistant (NA) C said the following: -If he/she observed resident to resident abuse or any type of abuse, he/she would immediately intervene and removed the resident from the situation; -He/she would then immediately report any allegation of abuse to his/her charge nurse; -Resident #1 had a history of becoming agitated in the evening; -Resident yelled and cursed at other residents at times, particularly if the other resident was in his/her way of moving forward; -At times, Resident #1 wandered into other resident rooms; -Staff intervene and redirect Resident #1 when he/she becomes agitated; -The NA notified his/her nurse of the resident's agitation, yelling, and cursing.	F 610		

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F 610	Continued From page 19 During an interview on 05/03/25, at 6:13 A.M., Certified Nurse Assistant (CNA) G said the following: -He/she worked on the night shift on 04/11/25; -Resident #1 thought his/her roommate, Resident #2, was his/her child; -The CNA had been in the residents' room several times and each time Resident #1 appeared more aggravated and was yelling out his/her child's name to the roommate, Resident #2; -Resident #2 was, "Chattering," not making any sense just saying random words, per his/her usual; -He/she and the other staff working heard a noise and entered the room of Resident #1 and Resident #2; -Resident #1 was sitting on top of Resident #2 on Resident #2's bed, he/she was straddling Resident #2; -Resident #1 was yelling the name of his/her child over and over; -Resident #1 had the bottom edge of his/her hospital gown draped over Resident #2's head and face; -The CNA said both Resident's were clothed, and he/she did not think Resident #1 was holding the gown against Resident #2's neck/face; -Staff immediately intervened and assisted Resident #1 off of Resident #2's bed and into another room; -RN B sent the resident out to the hospital for evaluation; -If he/she observed resident to resident abuse, he/she would immediately intervene and attempt to stop the abuse and report to the charge nurse. During an interview on 05/01/25, at 11:29 A.M.,	F 610		

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F 610	Continued From page 20 Certified Medication Technician (CMT) D said if he/she observed abuse, he/she would immediately report to the charge nurse. During an interview on 05/01/25, at 11:30 A.M., Licensed Practical Nurse (LPN) E said the following: -If he/she were notified of an allegation of abuse, he/she would assess the situation, removed the alleged perpetrator of the abuse, notify the Administrator, Director of Nursing, or designated RN on call immediately; -He/she would notify the residents families and their physician; -The resident was verbally abusive to others, residents and staff when he/she yelled and cursed at others; -The nurse reported to the resident's behaviors to the DON in the past; -If the nurse was aware of Resident #1 getting into bed with Resident #2 or of the interaction, he/she would have intervened and notified the DON. During an interview on 05/01/25, at 10:28 A.M., RN B said the following: -On 04/11/25 during the night shift, Resident #1 had yelled, "Shut up, shut up, shut up," while standing in the room with Resident #2; -Later that same night, the RN and a nurse assistant, heard Resident #1 yelling and entered the room; -Upon entering the room, Resident #2 was lying on his/her own bed on his/her back and Resident #1 was on top of Resident #2, straddling him/her; -Resident #1 had removed his/her hospital gown and wore only an incontinent brief; -Resident #1 was pressing the tied neck string of his/her hospital gown using both hands against	F 610		

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F 610	Continued From page 21 the front of Resident #2's neck; -Staff immediately intervened and removed Resident #1 from Resident #2's bed and assisted Resident #1 to another room; -The RN said he/she contacted the DON and told him/her about the incident, but could not recall exactly what details he/she relayed during the phone conversation; -The nurse then contacted the physician who gave an order to send Resident #1 to the hospital for evaluation; -The nurse did not feel this incident was an example of resident to resident abuse because he/she did not think Resident #1 was trying to injure Resident #2, but instead was trying to get Resident #2 dressed; -If he/she observed the same scenario with residents that did not have dementia, he/she said that would be an allegation of resident to resident abuse and should be reported. During an interview on 04/30/25, at 2:53 P.M., the MDS Coordinator/Care Plan Coordinator said the following: -Resident #1 and Resident #2 were roommates; -Staff reported Resident #1 was pulling the privacy curtain open and closed and telling staff he/she needed to care for Resident #1; -Resident #1 mistakenly thought Resident #2 was his/her child and would call out to Resident #2 using Resident #1's child's name; -Staff moved Resident #1 to another room temporarily due to Resident #1 keeping Resident #2 awake; -He/she was not aware of any physical contact or abuse between Resident #1 and Resident #2; -He/she was not aware of the progress note about Resident #1 placing a gown on the resident's head/neck;	F 610		

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F 610	Continued From page 22 -If Resident #1 placed a gown around Resident #2's head and neck, the nurse should have reported to the DON or Administrator and the facility should have called the incident to DHSS as an allegation of possible physical/verbal altercation; -Staff have reported in morning meeting that Resident #1 yelled and cursed at other residents; -The facility administrator should investigate all allegations of resident abuse and submit to DHSS within five days. During an interview on 05/01/25, at 12:13 P.M., the DON said the following: -He/she received a phone call from the charge nurse on duty at the facility on 04/11/25 at approximately 1:11 A.M.; -The DON did not recall exactly what the charge nurse reported about the incident between Resident #1 and Resident #2; -The nurse did not tell the DON that Resident #1 was pressing anything against the front of Resident #2's neck, if the DON were aware of that, he/she would have immediately came to the facility, notified the Administrator, and hotlined the incident to state (DHSS); -The DON said the Administrator completed abuse investigations within five days and submitted to DHSS; -This allegation was not investigated, to his/her knowledge. During an interview on 05/01/25, at 12:52 P.M., the Administrator said the following: -Regarding the 04/11/25 incident between Resident #1 and Resident #2, staff told the Administrator Resident #1 was attempting to dress Resident #2; -Resident #1 thought Resident #2 was his/her	F 610		

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F 610	Continued From page 23 child at times and wanted Resident #2 to get up out of bed; -Staff did get a physician's order and send Resident #1 out to the hospital for an evaluation; -The Administrator said, if he/she was aware of the incident between Resident #1 and Resident #2 on 04/11/25, he/she would have hotlined the incident to DHSS as an allegation of resident to resident physical abuse within two hours of the time of the incident; -He/she expected the nurse to moved Resident #1 away from other residents and ensure Resident #2 was safe and not injured, call and notify Resident #2's family, physician, and notify the Ombudsman; -For any allegation of resident abuse, he/she would investigate the abuse, to include interviews with staff and residents, and notify DHSS of results of the abuse investigation within five days per the facility policy.	F 610		

PLAN OF CORRECTION

Provider/Supplier Name:	Willard Care Center
Street Address, City, Zip:	400 Walnut Lane Willard Mo 65781
Date of Survey:	5/1/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction ("POC") is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Willard Care Center (the "Facility") as to the accuracy of the surveyors' findings, nor the conclusions drawn therefrom. The facility's submission of this POC does not constitute an admission on the part of the Facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Corrections on 05/12/2025.	
F609	**Reporting of Alleged Violations** In Response to any and all allegations of abuse, neglect, exploitation, or mistreatment the facility does and will continue to ensure reporting will be done immediately or within 2 hours for allegations of abuse or 24 hours if the event does not involve abuse as in misappropriation or resident property. Facility administration reviewed abuse policy and procedures to include a review of F609. Facility administrator education staff on 5/09/2025 about abuse and investigating allegations of abuse and misappropriation by administrator/Designee. Facility staff were educated by Administrator/designee that reporting will be done immediately or within 2 hours of allegations of abuse or 24 hours if the event does not involve abuse as in misappropriation of resident property. Additionally, staff will report all instances of abuse, neglect,	5/12/2025

	misappropriation, etc. to facility administrator or designee immediately. Staff will be educated about reporting abuse, neglect and misappropriation upon hire and at least annually. Resident #1 has been moved to another room. Resident one has medication reviewed and revised. Resident #2 has shown no signs or symptoms of distress noted resident feels safe in environment. All residents have the ability to be effect by the deficiencies. Administrator/Designee will investigate and report all claims within 2 hours of abuse and neglect or 24 hours for misappropriation. DON/administrator interviewed residents for any other allegations of abuse or neglect during the investigation process. Don/Designee will interview at least 5 residents weekly time 4 weeks to ensure there are no allegations of abuse, neglect or misappropriation. IDT will review concerns of abuse, neglect and misappropriation weekly for fallow-up, care planning, and additional actions as appropriate. Alleged incidents are monitored/reviewed daily by DON/Designee, excluding weekends. On Weekends facility staff will report any concerns to DON/Administrator immediately for review and any recommendations for initiation of abuse Prohibition protocol. Any allegations of abuse or neglect will be reviewed and discussed Durning monthly QA meeting with medical director and department heads.	
F610	**Investigation/Prevent/Correct Alleged Violation** The facility has and will continue to thoroughly investigate, prevent abuse, neglect, exploitation, mistreatment, and take appropriate corrective actions of any allegations of abuse, neglect or misappropriation. Administrator/designee will investigate allegations within 24 hours and report to state the investigation within 5 Calander days of investigation. Facility administration reviewed abuse policy and procedures to include a review of F610. Resident #1 has been moved to another room. Resident one has medication reviewed and revised. Resident #2 has shown no signs or symptoms of distress noted	5/12/2025

	resident feels safe in environment. All residents have the ability to be effect by the deficiencies. Facility administrator education staff on 5/09/2025 about abuse and investigating allegations of abuse and misappropriation by administrator/Designee. Facility staff were educated by Administrator/designee that reporting will be done immediately or within 2 hours of allegations of abuse or 24 hours if the event does not involve abuse as in misappropriation of resident property. Additional education on abuse neglect and misappropriation and investigation to all staff will be provided upon hire and at least annually by administrator/designee. Any allegations of abuse or neglect will be reviewed and discussed Durning monthly QA meeting with medical director and department heads.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider/Supplier Name:	Willard Care Center
Street Address, City, Zip:	400 Walnut Lane Willard MO 65781
Date of Survey:	5/1/2025

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A8023	Refer to tag F609	5/12/2025
	Refer to tag F610	5/12/2025

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