STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265373	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Waynesville	700 Birch Lane Waynesville, MO 65583

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to maintain professional standards of care, when staff failed to document wound care and treatments as directed by the physician for two residents (Resident #1 and #2) out of three sampled residents. Staff failed to ensure one Resident's (#3) urine sample was collected and sent to the laboratory, in a timely manner as directed by the resident's physician and delayed medication administration instead of utilizing the emergency kit. The facility census was 76.1. Review of the facility's Physician Orders policy, revised 02/27/25, showed the facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. Physician orders may include medications and treatments. Review of the facility's Treatment Orders policy, revised 06/12/25, showed treatment orders are written per physician orders. 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. 2. Review of Resident #1's admission MDS, dated [DATE], showed staff assessed the resident as mild cognitive impairment, at risk for pressure ulcer, and received surgical wound care. Review of the resident's POS, dated 08/01/25 through 08/31/25, showed a physician order directed staff to administer the following wound treatments to the resident's tailbone: -07/23/25: Calcium alginate with silver, cover with gauze island with boarder, apply once daily and as needed if saturated, soiled, or dislodged, every day shift, stop date 08/11/25;-08/12/25: Cleanse and dry skin around wound, apply xeroform (a petrolatum-based dressing) to wound bed, then fill wound gently with fluffed Dakin's 1/4 strength (topical antiseptic used to clean wounds) moistened gauze, including the undermining, cover with ABD pad (to absorb drainage and protect wounds) and secure with tape, change once daily and as needed if soiled or dislodged, use skin prep (a protective skin-protectant film) under any tape, every day shift, stop date 08/20/25. Review of the resident's TAR, dated 08/01/25 through 08/31/25, did not contain documentation staff provided wound treatment as directed by the physician to the resident's tailbone on 08/09/25 and 08/19/25. Review of the resident's POS, dated 09/01/25 through 09/30/25, showed a physician order directed staff to administer the following wound treatments to the resident's feet and sacrum. -08/22/25: Cleanse sacrum with wound cleanser soaked gauze, apply wound vac per manufacturer's guidelines at 125 millimeter of mercury (mmHG) setting continuous, apply skin prep peri wound for vac drape, fill wound with wound cleanser moistened black sponge, place a second piece of black sponge to entrance to help hold wound open, place second drape and suction, ensure seal is obtained. Change twice per week and as needed for leak that is unable to be resealed, every day shift on Tuesday and Friday, stop date 09/16/25;-09/17/25: Apply skin prep to right lateral first metatarsal joint (on the great toe) deep tissue injury, cover with foam dressing, every day shift every three days.-09/18/25: Moisturizer to be applied bilateral heels/feet daily, every shift for dry skin. Review of the resident's TAR, dated 09/01/25 through 09/30/25, did not contain documentation staff (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided wound care and treatment as directed by the physician to the resident's sacrum on 09/12/25, 09/16/25, to the resident's heels/feet on 09/21/25, 09/23/25, 09/24/25, 09/27/25, and 09/30/25, or to the resident's right great toe on 09/21/25 and 09/30/25. Review of the resident's progress notes, dated 09/01/25 through 09/30/25, showed the record did not contain documentation regarding the missed treatments or that the resident refused the treatments. During an interview on 12/03/25 at 3:40 P.M., LPN B said he/she is aware some of the resident's wound vac treatments were not completed due to either resident refusal/pain, resident out to an appointment, or a disagreement between the facility's medical director and the wound physician regarding the frequency for changing the wound vac, but there should be a progress note to indicate why those treatments were not completed. LPN B said he/she did not know why the nurses did not document they administered the other treatments. 3. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 09/17/25, showed staff assessed the resident as cognitively intact and diagnoses to include Diabetes. Review of the resident's Physician Order Sheet (POS), dated 11/01/25 through 11/24/25, showed a physician order directed staff to administer the following treatments to the resident's right great toe: -Cleanse wound with wound cleanser/normal saline (NS), apply calcium alginate with silver (sterile dressing used to absorb moisture and reduce wound infection), cover with bandage, every day shift for wound care, stop date 11/12/25;-Cleanse wound with wound cleanser/NS, apply Medi honey (used to reduce inflammation and promote wound healing) with bordered gauze, every day shift every two days for wound management, start date 11/12/25. Review of the resident's Treatment Administration Record (TAR), dated 11/01/25 through 11/24/25, did not contain documentation staff provided wound treatments on 11/02/25, 11/04/25, 11/05/25, 11/06/25, 11/12/25, and 11/20/25 as directed by the physician, Review of the resident's progress notes, dated 11/01/25 through 11/24/25, showed the record did not contain documentation regarding the missed treatments. During an interview on 12/03/25 at 3:40 P.M., Licensed Practical Nurse (LPN) B said the nurse is expected to document with a progress note or on the TAR if the resident refused or other reason for not providing a treatment, and he/she does not know why staff did not document the resident's treatments were completed on those days. 4. During an interview on 11/24/25 at 12:38 P.M., the Director of Nursing (DON) said he/she expects the wound nurse or the charge nurse to administer all treatments as directed by the physician and document on the TAR once completed. The DON said if there are missing documentation on the TAR, either the nurse did not sign the TAR or just did not complete the treatment. The DON said the wound nurse runs a 72-hour report on Mondays for any missing treatments for Saturdays and Sundays, conducts another daily audit Tuesdays through Fridays, and follows up with the physician regarding any missed treatments. During an interview on 11/24/25 at 2:05 P.M., LPN A said the facility wound nurse is responsible to provide residents' wound treatments when he/she is at the facility, and in his/her absence, the charge nurse is responsible to administer the treatments and document on the TAR once completed. LPN A said if there are missing documentation/signatures on the TAR, the nurse either forgot to sign the TAR or did not do the treatment. LPN A said if the nurse did not administer a treatment, he/she is expected to either document a reason on the TAR, in a progress note, or both. During an interview on 12/03/25 at 3:40 P.M., LPN B said he/she and the charge nurses are responsible to administer all treatments as directed by the physician and document on the TAR once completed. He/She said there should not be any missing signatures on the TARs, because the charge nurses are expected to double check the TARs for any missing treatments and ensure the treatment is administered before the end of their shift daily. 5. Review of the facility's Laboratory Services Policy, reviewed 09/23/25, showed the facility will ensure laboratory services meet the needs of residents, results are reported promptly (results (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall be relayed with little or no delay to the ordering physician) to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnoses and treatment, and the facility is responsible for the quality and timeliness of services whether services are provided by the facility or outside resource. 6. Review of Resident #3's admission MDS, dated [DATE], showed the facility assessed the resident cognitively intact with diagnoses of chronic kidney disease - stage four, peripheral vascular disease (circulation disorder where blood vessels outside the heart become narrowed, blocked, or weakened), high blood pressure , diabetes, fibromyalgia (widespread pain, fatigue, and other symptoms, such as problems with sleep, thinking, and memory) and schizophrenia (chronic mental health disorder that affects a person's ability to think, feel, and behave, leading to a distorted perception of reality). Review of the resident's POS, dated 09/26/25, showed the physician directed staff to administer Macrobid (antibiotic used to treat and prevent urinary tract infections) two times a day for five days. Review of the resident's Medication Administration Record (MAR), dated 09/26/25 showed staff did not document the resident received Macrobid on 09/26/25. Review of the resident's nurses note, dated 9/19/2025 at 1:49 P.M., showed staff documented the resident had bloody discharge in his/her brief with no foul odor. Staff received an order for a urinalysis due to concerns. Review showed the nurses notes did not contain documentation staff obtained the urine. Review of the resident's nurses note, dated 9/21/25 at 11:24 P.M., showed staff documented the urine specimen was collected, labeled and stored in lab fridge for lab pickup. Review of the resident's nurses note, dated 9/26/25 at 1:19 P.M., showed staff documented they received results of the resident's urinalysis and resident was diagnosed with a urinary tract infection, faxed results and received an order to start resident on Macrobid 100 mg twice a day for five days. Order noted and staff contacted pharmacy. During an interview on 11/24/25 at 12:18 P.M., the DON said the physician ordered for the resident to have a urinalysis on 9/19/25, the collection was delayed and not collected until 9/21/25 and the lab did not receive the urine specimen until 9/22/25. He/She said he/she does not know why the urine specimen was not collected on 9/19/25, he/she expects urine specimens to be collected when the urinalysis is ordered. He/She said final culture for urine analysis is seventy-two hours. He/She the staff was notified of the diagnoses and treatment on 09/26/25 and treatment should not have been delayed because the medication was in the facility's emergency kit. He/She said his/her expectation is to start treatment right away. He/She said he/she does not know why the medication was delayed. Complaint# 2631457 and 2640655

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, facility staff failed to ensure residents remained free of significant medication errors when staff administered Resident #6's medication ezetimibe (treats high cholesterol), simvastatin (manage high cholesterol and reduce the risk of heart attacks and strokes), Vistaril (treats anxiety), or trazodone (treats major depression) to Resident #5. The facility census was 76.1.Review of the facility Administration of Medications, reviewed 09/09/25, showed the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Medication administration is the responsibility of those individuals who through certification and licensure are authorized in their state to administer medication in a skilled nursing facility. Staff who are responsible for medication administration will adhere to the 10 rights of medications administration - Right Resident: use two identifiers. Ask the resident his/her full name and compare it to the name on the medication or treatment administration record (MAR/TAR) and compare the resident's photo to the resident. 2. Review of Resident #5's admission minimum data set (MDS), a federally mandated assessment tool, dated 10/21/25, showed staff assessed the resident as severely cognitively impaired with diagnoses of Parkinsons (progressive brain disorder causing movement issues like tremors, stiffness and slowness). Review of the resident's progress notes, dated 11/5/2025 12:25 A.M., showed staff documented the resident received incorrect medication tonight from Certified Medication Technician (CMT) on shift, gave roommates meds instead. Resident took ezetimibe, simvastatin, Vistaril, or trazodone. Resident attempted to ambulate to restroom, he/she is quite sedated from trazodone. Resident was educated on fall risk and agreed to call for assistance with transfers. Attempted to notify residents family but phone line has been disconnected, number not in service. Physician notified, directed to continue to monitor resident through the night. Review of the resident's physician order sheet (POS), dated November 2025, did not contain an order for ezetimibe, simvastatin, Vistaril, or trazodone.Review of the facility investigation, dated 11/04/25, showed CMT C administered another resident's medication to Resident #5 because he/she administered medications that were prepared by another staff member and there was confusion. CMT C's statement, dated 11/04/25, showed he/she documented I gave a med cup to the wrong resident. I had gotten done passing meds on my hall and went to go help. The nurse had popped the meds into a med cup and handed it to me. There was a miscommunication, and I gave the meds to the wrong resident in the room.During an interview on 11/24/25 at 11:19 A.M., the Director of Nursing (DON) said Resident #5 had a medication error when the resident was given his/her roommates medications. He/She said the physician was notified and the resident was tired but had no other side effects. During an interview on 11/24/25 at 11:49 A.M., the resident said he/she does not know how he/she got the wrong medication or what medication he/she got but said he/she was so tired and had a lot of weird dreams after the error. He/She said staff came to check on him throughout the night.During an interview on 12/09/25 at 4:08 P.M., CMT B said the facility was short a nurse and an agency nurse came in late to help. He/She said he/she finished his/her medication pass and went to help the nurse because he/she was behind. He/She said the nurse gave him/her a pill cup to take to a resident, he/she said he/she was unfamiliar with the residents on that hall and there were two residents in the room and he/she gave the medication to the wrong resident. He/She said he/she told the nurse immediately and the nurse took it from there and called the department heads and the physician. He/She said he/she has not seen the nurse since and was educated by the DON on medication administration. He/She said he/she is aware he/she should never pass medications that he/she did not prepare but he/she tried to help to get the residents their medications on time. Complaint # 2675499