Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265455 | A. Building<br>B. Wing | 11/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Willard Care Center | 400 West Walnut Lane<br>Willard, MO 65781 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed ensure notification to the resident's family/responsible party of changes of condition for all when residents when staff failed to document family/responsible party notification of four residents (Resident #1, #2, #3, and #4) for resident change in health condition, resident falls, and/or new physician orders. The facility had a census of 58.Review of the facility provided Patient [NAME] of Rights as provided by the Long-Term Care Ombudsman (advocate for residents in nursing homes and assisted living facilities who helps protect their rights, health, and quality of life) Program, showed the resident had the right to:-Be fully informed of services available to you;-Participate in planning your care and being informed of all aspects of your care.Review showed the facility did not provide a policy provided related notifications of resident change in condition to responsible party or family members. 1. Review of Resident #1's face sheet showed the following: -admission date of [DATE];-Hospice admission date of [DATE];-Resident had an emergency contact and durable power of attorney (DPOA - legal document allowing someone to make decisions on your behalf) listed with name and phone number;-Diagnoses included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) with agitation, heart failure, and cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain).Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated [DATE], showed the following:-Moderate cognitive impairment;-Partial to moderate assistance required with showering, toileting hygiene;-Supervision required with personal hygiene.Review of the resident's care plan, last updated [DATE], showed the following:-Resident at risk for falls related to generalized weakness, decreased cognition, and disease process;-Staff should notify the resident's doctor and family or guardian of a fall;-Resident did not want cardiopulmonary resuscitation initiated (CPR - emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped);-Staff should notify the resident's family and physician of any changes in condition.Review of the resident's [DATE] Physician Order Sheet (POS) showed an order, dated [DATE], for ceftriaxone (a powerful, broad-spectrum antibiotic used to treat a wide variety of bacterial infections) reconstituted solution, 1 gram injection once per day, for diagnosis of cellulitis;Review of the resident's nursing progress note dated [DATE], at 3:25 A.M., showed resident started antibiotic treatment for cellulitis (common, serious bacterial infection of the skin's deeper layers and underlying tissue, often causing redness, swelling, warmth, pain, and tenderness). He/she was free of side effects or adverse reaction related to this treatment. Review of the resident's [DATE] progress notes showed staff did not document notification the resident's family or responsible party of the new medication order. Review of the resident's [DATE] POS showed the following:-The order, dated [DATE], for ceftriaxone was discontinued [DATE];-An order dated<br><br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | [DATE] and discontinued [DATE], for cefuroxime axetil (semisynthetic, broad-spectrum, antibiotic used to treat a wide variety of bacterial infections) tablet, 250 mg, 1 tablet twice daily for diagnosis of cellulitis.Review of the resident's [DATE] progress notes showed staff did not document notification the resident's family or responsible medication order changes2. Review of Resident #2's face sheet showed the following: -admission date of [DATE];-Hospice admission date of [DATE];-Emergency contact and legal guardian listed with name and number;-Diagnosis included dementia, repeated falls, heart disease, and chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should).Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Partial to moderate assistance required with personal hygiene, showering.Review of the resident's care plan, updated [DATE], showed the following:-Resident preferred no life saving measures;-Staff should communicate with resident family, hospice, and physician if any changes in condition.Review of the resident's nursing progress notes showed the following:-On [DATE], at 12:30 P.M., staff noted while assessing resident during lunchtime this nurse noticed resident had a small bruise to his/her right side of his/her mouth. When asking resident what happened he/she stated, I fell on my trash can yesterday. Certified nurse aide (CNA) reported no falls this shift. No other injuries noted. Neuros (a series of questions and tests used by healthcare providers to assess how well a person's nervous system is working) and range of motion within normal limits. Vital signs stable. Neuros initiated. No complaints of pain or discomfort noted. On call nurse notified. Residents' safety maintained throughout shift. Call light, water and personal items within reach. Continue with current plan of care. (Staff did not document notification or the resident's family or responsible party regarding the bruising and reported fall.)-On [DATE], at 12:30 P.M., staff noted this nurse was notified by the aide in the back that resident reported to him/her that he/she fell last night on the floor and hit his/her head and the male CNA picked him/her up. Upon assessment resident noted to have dime sized bump to right side of his/her forehead above his/her eye. Neuros and range of motion within normal limits. Vital signs stable. Resident was trying to get self out of bed. Neuros initiated. No other injures noted. (Staff did not document notification or the resident's family or responsible party regarding the injury or reported fall.)-On [DATE], at 1:45 P.M., the resident was using the restroom and while the aide was in there with him/her trying to help assist him/her transfer the resident freaked out and slipped and hit his/her head on the bar. No injury noted to head. Neuros intact. Range of motion within normal limits. Vital signs stable. Neuros initiated. Resident safely assisted back into wheelchair. Resident's safety maintained. (Staff did not document notification or the resident's family or responsible party regarding the fall.);-On [DATE], at 6:30 A.M., resident was in the bathroom and tried to get up off the toilet by self and fell and hit his/her head. Resident noted to have dime sized goose egg to middle of forehead. No other injuries noted. Vital signs stable. Neuros and range of motion within normal limits. Neuros initiated. Resident educated to utilize call light in bathroom to ask for help. Resident verbalized understanding. No complaints of pain or discomfort. Resident's safety maintained. (Staff did not document notification or the resident's family or responsible party regarding the fall.)3. Review of Resident #3's face sheet showed the following : -admission date of [DATE];-Emergency contact listed with name and phone number;-Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe),and type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)). Review of the resident's admission MDS, dated [DATE], showed the following:-Moderate cognitive deficit;-Substantial to maximal assistance required for showering, dressing;-Partial to moderate assistance required for personal hygiene.Review of the resident's care plan,<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | updated [DATE], showed the following:-Resident did not want CPR and had services with hospice since admission;-Staff should notify the resident's family, hospice, and physician of any changes in condition.Review of the resident's nursing progress notes dated [DATE], at 12:00 A.M., showed resident was found at the foot of his/her bed at 3:00 P.M. No apparent injury. Assisted into his/her wheelchair and taken to the television room to be observed for safety. His/her oxygen concentrator plugged in and on 5 liters. Attempted to be redirected without understanding of the situation. Oriented to person only. This is not new. He/she is at baseline for him/her. Staff to continue to monitor for safety. (Staff did not document notification or the resident's family or responsible party regarding the fall.)4. Review of Resident #4's face sheet showed the following:-admission date of [DATE];-Emergency contact listed with name and phone number;-Diagnoses included dementia, chronic pain, reduced mobility, and anxiety disorder.Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive deficit;-Partial to moderate assistance with personal hygiene, showering.Review of the resident's care plan, last updated [DATE], showed the following:-Resident at risk for falls related to impaired safety awareness, impaired mobility, general debility, and disease processes;-Staff should notify the resident's family and doctor for falls;-Staff should complete documentation as per facility protocol;-Resident wanted life saving measures;-Staff should notify the resident's family and physician of any changes in condition.Review of the resident's nursing progress notes showed staff documented the following:-On [DATE], at 3:10 P.M., the resident was wandering and went into another resident's room. The other resident hit him/her and knocked him/her to the ground. Staff called both residents to the desk to counsel them. Staff notified the Director of Nursing (DON), and he/she will arrive shortly. There appeared to be no injuries to the resident. Resident was sitting quietly at the desk. (Staff did not document notification or the resident's family or responsible party regarding the altercation.)-On [DATE], at 3:25 P.M., staff noted fall - this nurse was called back to the memory care unit due to the resident being found on the floor. Upon assessment the resident was found in the hallway on the floor on his/her back. Resident did hit the back of his/her head. Resident unable to tell nurse what he/she was trying to do. Resident's shoes were untied. Resident safely assisted up by two staff members. This nurse assisted the resident in tying his/her shoes. Neuros and range of motion within normal limits. Vital signs stable. Physician notified. No new orders received. Neuros initiated. Resident with poor safety awareness. Resident's safety maintained throughout shift. Staff to continue with current plan of care. (Staff did not document notification or the resident's family or responsible party regarding the fall.)5. During an interview on [DATE], at 11:25 A.M., CNA D said if a resident had a change of condition, he/she would report to the nurse. If the nurse did not respond he/she would tell the DON and continue the chain of command if no response. He/she said the nursing staff call the resident's family for change of health.During an interview on [DATE], at 12:00 P.M., CNA E said if a resident had a change from their baseline, he/she would contact the charge nurse. The nurse contacted the families. It was not in the scope of the aide to contact families.During an interview on [DATE], at 11:50 A.M., Certified Medication Tech (CMT) C said if he/she noted a change in resident condition or resident fall, he/she would notify the nurse. He/she said he/she did not make calls to resident families; the nurses call the families and physicians.During an interview on [DATE], at 10:25 A.M., Licensed Practical Nurse (LPN) A said that if a resident had any change of health condition, anything that was outside of their baseline health, he/she would notify the family or emergency contact about the change. He/she said that if the resident was on hospice, the hospice staff generally call the residents family, but he/she would still contact the family for verification and would document who was contacted. During an interview on [DATE], at 10:50<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A.M., LPN B said that when a resident had a change in health condition, falls, or new physician orders the nursing staff should notify the family or responsible party and the nurse should document in the progress note who was contacted. If hospice noted the change in condition, the facility nurse should still contact the resident's contact person and document.During an interview on [DATE], at 12:15 P.M., the MDS Coordinator said staff should notify the charge nurse of any resident change in condition. The nurse should assess and notify the physician and follow any new orders. The nurse should contact the family of any and all changes, even if the resident was their own person or on hospice, the family should be notified. If there was a non-injury 3:00 A.M. fall the family may not be notified until the morning if they requested but this should be documented. Resident #2 had multiple falls, but staff should document family contact with each fall and document the contact. The staff should contact Resident #1's family for all changes including medication changes.During an interview on [DATE], at 11:00 A.M., the DON said she did not find a specific policy related to notification of resident family or responsible party about change in health condition, but it was included in the resident rights. The nursing staff should notify the physician and family of health changes and resident falls. If there are new medication orders the nursing staff should contact the family. The nursing staff should document all contact with family in the progress notes. All families should be contacted regardless of resident cognitive status, unless there were previous plans made with the emergency contact, or the resident did not have an emergency contact. If it was not charted it was not done. Resident #2 had multiple falls, and family should have been contacted after each fall. Resident #1's family should have been contacted about medication changes or new orders. Staff should be documenting contact with resident family members.During an interview on [DATE], at 12:10 P.M., the Administrator said that the facility staff should notify the charge nurse of falls and any change in health condition. Hospice should also notify the facility nurse of change in condition. The nurse should evaluate the resident and let the DON and physician know of change of health. The nurse should notify the family of health condition changes, falls, and new orders including medication orders within the first few hours of the change condition, this is for all residents. The nursing staff should make a progress note that identifies who was notified. Resident # 2 family should be contacted each time that he/she had a fall, and it should be documented they were contacted. Resident #4, the family should be contacted for change in health condition and the information should be documented. Resident #1 family should be notified of medication changes and information documented. Resident #3 family should be notified of change of health and information should be documented.Complaint 2665069 |