

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Four Seasons Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 Highway Tt Sedalia, MO 65301	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42815</p> <p>Based on interview, and record review, facility staff failed to document and update care plans to include the use of a colostomy bag (a bag that collects stool) for one (Resident #2) and new interventions for one resident (Resident #1) with a behavior of inserting foreign objects into his/her colostomy bag and stoma (opening in the body) out of four sampled residents. The facility census was 232.</p> <p>1. Review of the facility's policy titled, Comprehensive Care Plans, dated 6/26/24, showed staff were directed to:</p> <ul style="list-style-type: none"> -Develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment; -The comprehensive care plan will include measurable objectives and timeframe's to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. <p>2. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/19/24, showed staff assessed the resident as cognitively intact and used an ostomy bag.</p> <p>Review of the resident's Physician Order Summary (POS), undated, showed an order for a colostomy bag.</p> <p>Review of the resident's care plan, dated 07/15/24, showed it did not contain direction for staff in regard to the use of a colostomy bag.</p> <p>During an interview on 10/02/24 at 8:24 A.M., the Director of Nursing (DON) said if a resident had a colostomy bag, it should be addressed in the care plan. The DON said he/she did not know if the colostomy bag was addressed in the resident's care plan, but it should be if it was not. He/She said the MDS Coordinator and him/her were responsible to update the care plan.</p> <p>(continued on next page)</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/02/24 at 2:27 P.M., the MDS Coordinator said the resident did have a colostomy bag. He/She said he/she did not know why it was not listed on his/her care plan and it was overlooked by himself/herself and the care plan coordinator. He/She said he/she was able to update the care plans, as well as the DON and other staff.</p> <p>3. Review of Resident #1's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact and uses an colostomy bag.</p> <p>Review of the resident's Physician Order Summary, undated, showed an order for a colostomy bag.</p> <p>Review of the resident's medical record showed staff documented:</p> <ul style="list-style-type: none"> -On 06/23/24, the resident sent to the hospital due to shoving a paperclip in his/her stoma; -On 07/03/24, the resident sent to the hospital due to shoving a fork in his/her colostomy bag; -On 09/10/24, the resident sent to the hospital due to placing foreign objects in his/her stoma; -On 09/17/24, the resident sent to the hospital due to shoving a spoon and fork in his/her stoma; <p>Review of the resident's care plan, dated 08/27/24, showed staff documented the resident used a colostomy bag. Staff documented the resident exhibited behavior's of inserting foreign objects into his/her colostomy bag. Review of the care plan showed staff documented on 02/23/24 resident with the behavior of inserting foreign objects. The care plan did not contain documentation of new interventions since 02/23/24.</p> <p>During an interview on 09/25/26 at 2:16 P.M., Charge Nurse A said the resident had a history of inserting foreign objects into his/her colostomy bag. He/She said he/she did not know if there were interventions after each incident, but he/she said there should be and it should be documented in the care plan.</p> <p>During an interview on 09/25/24 at 2:40 P.M., the DON said the resident had a history of inserting foreign objects in his/her colostomy bag. He/She said staff did not attempt interventions after each incident of inserting foreign objects in his/her colostomy bag. He/She said staff should have attempted interventions and addressed in the care plan.</p> <p>During an interview on 09/25/24 at 2:40 P.M., the administrator said the resident had a history of inserting foreign objects in his/her colostomy bag. She said staff did not attempt interventions after each incident of inserting foreign objects in his/her colostomy bag. She said staff should have attempted interventions and addressed in the care plan.</p> <p>During an interview on 10/02/24 at 2:27 P.M., the MDS Coordinator said he/she did know the resident had a history of inserting foreign objects into his/her colostomy bag. He/She said the DON and administrator were responsible to implement new interventions and would relay the informaiton to the care plan coordinator or himself/herself. He/She said he/she was not told of any new interventions.</p> <p>MO00242343</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>42815</p> <p>Based on interview and record review, the facility staff failed to provide supervision of one resident (Resident #1) who has a history of inserting foreign objects into his/her colostomy bag (a bag that collects stool) and stoma (an opening in the body) which resulted in the resident being transferred to the hospital. The facility census was 232.</p> <p>1. Review of the facility's policy titled, Incidents and Accidents Policy, dated 05/18/24, showed staff were directed to assure appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care.</p> <p>2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/18/24, showed staff assessed the resident as cognitively intact and used a colostomy bag.</p> <p>Review of the resident's Physician Order Summary, undated, showed an order for a colostomy bag.</p> <p>Review of the resident's medical record showed staff documented:</p> <ul style="list-style-type: none"> -On 06/23/24 at 1:34 P.M., the resident sent to the hospital due to shoving a paperclip in his/her stoma; -On 07/03/24 at 12:39 P.M., the resident sent to the hospital due to shoving a fork in his/her colostomy bag; -On 09/10/24 at 10:47 A.M., the resident sent to the hospital due to placing foreign objects in his/her stoma; -On 09/17/24 at 2:55 P.M., the resident sent to the hospital due to shoving a spoon and fork in his/her stoma. <p>Review of the resident's care plan, dated 08/27/24, showed staff documented the resident used a colostomy bag. Staff documented the resident exhibited behavior's of inserting foreign objects into his/her colostomy bag. Review of the care plan showed staff documented on 02/23/24 resident has behavior of inserting foreign objects. The care plan did not contain interventions for the resident inserting foreign objects.</p> <p>Review of the resident's hospital paperwork, dated 09/18/24, showed the resident admitted to the hospital due to insertion of a foreign object in his/her ostomy, which required a procedure to examine the lower part of the colon and rectum to assist with removal of the foreign object surgically.</p> <p>During an interview on 09/25/26 at 2:16 P.M., Charge Nurse A said the resident had a history of inserting foreign objects into his/her colostomy bag. He/She said he/she did not know if there were interventions after each incident, but he/she said there should be and it should be documented in the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/25/24 at 2:40 P.M., the Director of Nursing (DON) said the resident had a history of inserting foreign objects in his/her colostomy bag. He/She said staff did not attempt interventions after each incident of inserting foreign objects in his/her colostomy bag. He/She said staff should have attempted interventions and addressed the interentions in the care plan.</p> <p>During an interview on 10/02/24 at 8:24 A.M., the DON said if staff did attempt interventions after each incident, it could have potentially prevented future incidents of the resident's inserting foreign objects in his/her colostomy bag. He/She said staff did not have interventions in place to monitor the silverware prior to the resident leaving the table after meals.</p> <p>During an interview on 09/25/24 at 2:40 P.M., the administrator said the resident had a history of inserting foreign objects in his/her colostomy bag. He/She said staff did not attempt interventions after each incident of inserting foreign objects in his/her colostomy bag. He/She said staff did not have interventions in place to monitor the silverware prior to the resident leaving the table after meals.</p> <p>MO00242343</p>		