STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265149	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Living Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, facility staff failed to contact one resident's (Resident #1's) responsible party after the resident had a change in condition. The facility census 231. 1. Review of the facility's, Notification of Change policy, dated 05/14/24, showed:-The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification;-The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring Notification include accidents, resulting in injury or potential to require physician intervention.2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff used to assess the care needs of the resident, dated 06/20/25, showed staff assessed the resident as moderately cognitively impairment.Review of the resident's progress notes, dated 06/19/25, showed results were reviewed with the physician for the right humorous and right shoulder x-ray from 06/15/25 and the resident had a humeral fracture.During an interview on 07/11/25 at 9:53 A.M., the resident's guardian said he/she was not notified the resident had sustained a fracture of his/her arm.During an interview on 07/11/25 at 11:43 A.M., Licensed Practical Nurse (LPN) A said staff are directed to contact the resident family or guardian when a resident had a change in condition. During an interview on 07/11/25 at 12:25 P.M., the administrator said staff are directed to contact the resident's guardian if the resident's experienced a change in condition. During an interview on 07/11/25 at 12:26 P.M., the Director of Nursing (DON) said staff are directed to contact the resident's guardian if the resident's experienced a change in condition.Complaint 1516289

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to review and revise the plan of care with changes in the resident's needs for two residents (Resident #1 and #2) out of three sampled residents. The facility census was 231. 1. Review of the facility's policy, MDS 3.0, Care Assessment Summary and Individual Care Plans, dated 11/06/23, showed:-The Plan of Care should address improvements where possible and maintenance and prevention of avoidable declines and all Care Area Triggers;-There are twenty (20) areas that can become triggered areas for concern and must be addressed with individualized interventions on the plan of care for resident;-The policy did not address timeframes for revising a resident's care plan after a change in condition.2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff used to assess the care needs of the resident, dated 06/20/25, showed staff assessed the resident as moderately cognitively impairment and documented one non-injury fall since admission or prior assessment.Review of the resident's care plan, revised 06/12/25, showed the resident was a risk for falls related to confusion, incontinence, and psychoactive drug use. The plan did not contain documentation of a new fall intervention after 06/12/25.Review of the facility's incident report, dated 06/14/25, showed the resident had an unwitnessed fall.3. Review of Resident #2's Part A Discharge MDS, dated [DATE], showed staff assessed the resident as cognitively intact and did not contain documentation of a fall since admission or prior assessment.Review of the resident's care plan, revised 06/27/25, showed the resident is a low risk for falls and is at risk for falls related to psychoactive medications and extrapyramidal symptoms. The plan did not contain document of a new fall intervention after 06/27/25. Review of the facility's incident report, dated 06/28/25, showed staff documented the resident had an unwitnessed fall.Review of the facility's incident report, dated 07/01/25, showed staff documented the resident had an unwitnessed fall.4. During an interview on 07/11/25 at 11:43 A.M., Licensed Practical Nurse (LPN) A said staff are directed to utilize the resident care plans to determine how to properly care for each resident. He/She said the MDS Coordinator was responsible to update the resident care plan after a change in condition.During an interview on 07/11/25 at 12:25 P.M., the administrator said staff are educated to update care plans with a new intervention after a resident sustained a fall. He/She said the risk management team discussed interventions after a resident had a fall. He/She said the Care Plan Coordinator updated the care plan and the Director of Nursing (DON) was responsible to ensure the new interventions were updated in the resident's care plan.During an interview on 07/11/25 at 12:26 P.M., the DON said staff are educated to update care plans with a new intervention after a resident sustained a fall. He/She said the risk management team discussed interventions after a resident had a fall. He/She said the Care Plan Coordinator updated the care plan and he/she was responsible to ensure new interventions were addressed in the care plan, but had been busy with other assignments and unable to review the care plans. Complaint 1516289

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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. (continued on next page)

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, facility staff failed to maintain professional standards of practice when staff failed to ensure prescribed medications were available and administered after admission from 07/18/25 to 07/21/25 to one resident (Resident #3) out of two sampled residents and failed to notify the physician to obtain further orders. The facility's census was 230.1. Review of the facility's policy titled, Medication Administration, dated 06/26/24, showed medications are administered by a licensed nurse, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. 2. Review of the facility's policy titled, Transcription of Orders/Following Physician's Orders, dated 05/18/24, showed: -The Licensed/Registered Nurse will check the emergency kit to verify if the medication is present in the facility to begin immediately. If the medication is not available, the facility may contact the backup pharmacy to deliver the medication sooner. If the medication is unable to be started within 24 hours of the order, the prescribing physician will be notified, and further orders will be obtained;-If the medication is unavailable, the Licensed Nurse will contact the pharmacy and have the medication delivered. If the resident is not going to receive their scheduled medication per Physician's Order, the Licensed Nurse will contact the Director of Nursing (DON), the administrator, physician, and legal guardian, if applicable. The Resident Care Coordinator (RCC)/Unit Manager/Designated Nurse will then follow any further order that may be provided by the physician;-The facility may utilize a stat or emergency medication kit or back up pharmacy to deliver the medication to the resident before the primary pharmacy is able to deliver. 3. Review of Resident #3's Electronic Medical Record (EMR), on 07/23/25, showed the resident admitted to the facility on [DATE], with primary diagnosis of Schizoaffective Disorder (a chronic mental health condition that includes symptoms of hallucinations, delusions, and mood disorders). Review of the resident's Physician Order Sheet (POS), dated 07/18/25 through 07/23/25, showed: -Amiloride (used to treat high blood pressure/edema without losing potassium) HCl 5 milligrams (mg), give two tablets by mouth twice daily (BID);-Cobenfy Oral Capsule (used to treat schizophrenia) 125-30 mg, give one capsule by mouth three times daily (TID);-Gabapentin Capsule (commonly used to treat psychiatric disorders) 300 mg, give one capsule by mouth TID for mood stabilizer; -Lithium Carbonate ER (used to control mood, behaviors and thoughts) 300 mg, give one tablet by mouth at bedtime, give with Lithium 450 mg;-Lithium Carbonate ER 450 mg, give one tablet by mouth at bedtime, give with Lithium 300 mg;-Lorazepam (used to treat anxiety disorders) 0.5 mg, give one tablet by mouth TID;-Ondansetron (used to prevent nausea and vomiting) 4 mg disintegrating tablet, give one tablet by mouth BID;-Pantoprazole Sodium (used to treat heartburn) 40 mg, give one tablet by mouth daily;-Senna (used to treat constipation) 8.6 mg, give two tablets by mouth in the mornings;-Multivitamin-Minerals, give one tablet by mouth in the mornings for supplement. Review of the resident's Medication Administration Record (MAR), dated 07/18/25, showed staff documented awaiting medication for Gabapentin, Lorazepam, and Lithium Carbonate, at 8:00 P.M.; Review of the resident's MAR, dated 07/19/25, showed staff documented awaiting medication for: -Pantoprazole Sodium, at 5:00 A.M. ;-Multivitamin-Minerals, at 6:00 A.M.;-Amiloride, at 6:00 A.M. and 2:00 P.M;-Cobenfy, at 6:00 A.M. and 2:00 P.M;-Ondansetron, at 6:00 A.M. and 2:00 P.M.;-Gabapentin, at 7:00 A.M., 11:00 A.M. and 8:00 P.M. ;-Lorazepam, at 7:00 A.M., 11:00 A.M. and 8:00 P.M.;-Lithium Carbonate, at 8:00 P.M.; Review of the resident's MAR, dated 07/20/25, showed staff documented awaiting medication for: -Pantoprazole Sodium, at 5:00 A.M.;-Amiloride, at 6:00 A.M. and 2:00 P.M;-Cobenfy, at 6:00 A.M. and 2:00 P.M;-Ondansetron, at 6:00 A.M. and 2:00 P.M.;-Gabapentin, at 7:00 A.M., 11:00 A.M. and 8:00 P.M.;-Lithium Carbonate, at 8:00 P. M. Review of the resident's MAR, dated 07/21/25, showed staff documented awaiting medication for: -Senna, at 6:00 A.M.;-Multivitamin-Minerals, at 6:00 A.M.;-Amiloride, at 6:00 A.M. and 2:00 P.M;-Cobenfy, at 6:00 A.M. and 2:00 P.M;-Ondansetron, at 6:00 A.M. and 2:00 P.M.;-Gabapentin, at 7:00 A.M. and 11:00 A.M. ;-Lorazepam, at 7:00 A.M. and 11:00 A.M. Review of the resident's EMR, dated 07/18/25 through 07/22/25 did not contain documentation staff contacted the physician or the pharmacy when the resident did not receive his/her medications, and did not contain documentation staff utilized the facility's general (stock) and stat medication supply to administer the resident's medications. During an interview on 07/23/25 at 1:25 P.M. , RCC/Licensed Practical Nurse (LPN) D said if the pharmacy had not yet delivered the resident's medications, staff should try to administer available medications from the facility's general stock and stat medication supply and notify the physician of any medications that were not administered. He/She said