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	12/08/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to ensure the doors on the Tiger Medical Unit, a secured unit, were monitored during a fire alarm test which resulted in one resident (Resident #27) eloping from the facility at approximate 3:00 P.M. In addition, staff failed to complete hourly face checks for the resident, did not check on the resident after he/she missed dinner and smoke breaks, and did not notice the resident was missing until 9:00 P.M. Facility staff further failed to properly complete a thorough head count to ensure all residents were in the facility after the fire drill when staff were made aware two residents (Resident #116 and #112) had left the facility when the unit doors were left unattended and unlocked. Facility staff failed to properly store and lock medications to ensure resident safety for six residents (Resident #163, #211, #233, #74, #86, and #39) of a sample of 45 residents. The facility census was 231.The administrator was notified on 12/5/25 at 6:06 P.M., of an Immediate Jeopardy (IJ) which began on 12/4/25. The IJ was removed on 12/5/25, as confirmed by surveyor onsite verification. Review of the facility's Elopement policy, dated 06/12/24, showed residents who are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The facility is equipped with door locks/alarms. Alarms are not a replacement for necessary supervision. Review of the facility's Fire Drill Policy, dated 12/27/24, showed the policy did not contain staffing assignments during drills for secured units. Further review showed the policy did not address monitoring of doors during fire alarm drills or emergencies. 1.Review of Resident #27's Medicare 5-Day Minimum Data Set (MDS), dated [DATE], showed staff assessed the resident had verbal behaviors towards others, and required supervision or touch assistance with eating, walking, transfers, personal hygiene, and bathing. Diagnoses of Anxiety Disorder, Schizophrenia (a serious brain disorder causing abnormal reality interpretation, with symptoms like hallucinations (hearing voices), delusions (false beliefs), disorganized speech, and impaired thinking), Schizo-affective Disorder (Bipolar Type) (a serious mental illness blending symptoms of schizophrenia (psychosis like hallucinations/delusions) with bipolar disorder (manic highs and depressive lows), where psychotic symptoms occur alongside or even without significant mood episodes), Asthma, and Chronic Obstructive Pulmonary Disease (COPD). Review of the resident's care plan, dated 07/23/25, showed staff documented the resident had explosive anger, extreme emotional swings, fear of being left alone, impulsive, had self-destructive behaviors, concerns for self-harm, and skilled nursing to complete face checks. Review of the resident's Elopement Assessment, dated 11/14/25, showed the resident scored a zero, not at risk for elopement. Review of the facility's surveillance video showed on 12/4/25 at 2:53 P.M., staff for the Tiger Medical Unit could not be observed in the hallway or at the fire exit, during the fire drill. Resident #27 exited his/her room and walked straight out the fire exit door by the Business Office. At 2:53:44 P.M., the exterior camera footage showed the resident crossed the back parking lot of the facility and entered the woods behind the facility.Review of Resident #116's care plan, dated 10/23/25, showed staff documented the resident has a history of behavioral challenges that require protective oversight in a secure setting; is at risk of elopement; and expresses a desire to leave facility. Eloped from his/her personal window on 10/23/25 at 12:24 P.M. Monitor resident's location frequently and initiate face-checks if/when necessary. Review of Resident #116's Quarterly Elopement Assessment, dated 11/5/25, showed staff assessed the resident as a high risk for elopement. Review of Resident 112's Quarterly Elopement Assessment, dated 10/16/25 showed staff assessed the resident as not a risk for elopement. Review of Resident #112's care plan, dated 11/3/25, showed staff documented staff should provide protective oversight and assist where needed. Observation on 12/4/25 at 3:00 P.M., showed Dietary Aide (DA) B yelled out the back dining room door Get back in here. Observation showed Resident #116 held open the exit door attached to the enclosed fence on Tiger Lane and Resident #112 outside the door and fence. Review of Resident #27's hourly face checks, dated 12/04/25, showed face checks were completed at the following times: 00:43 AM, 02:33 AM, 03:32 AM, 04:43 AM, 05:04 AM, and 19:50 (7:50 PM). Six hourly face checks were completed out of a possible 24 checks. One hourly check was documented as competed after the resident eloped from the facility. Review of the resident's Medication Administration Record (MAR), dated December 2025, showed the following for 12/04/25:- Melatonin Oral Tablet 10 milligrams (mg), Give 10 mg by mouth at bedtime related to insomnia

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. (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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed train their staff on how to adequately care for residents behavioral health needs and two residents, with behavioral health needs, were involved in a resident to resident altercation (Resident #22 and #44) and failed to educate staff on resident specific behaviors and interventions for seven residents (Resident #170, #19, #27, #116, #129, #163, and #211) of 35 sampled residents on two units, the women's behavioral health unit and Tiger Lane. The facility census was 231. 1. Review of the facility's Behavioral Health Services Policy, revised 10/31/24, showed it is the policy of the facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders. The facility will consider the acuity of the resident population. All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the staff member and resident needs identified through the facility assessment. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. The facility will ensure that a resident who, upon admission was not assessed or diagnosed with a mental or psychosocial adjustment difficulty or a documented history of trauma and/or PTSD does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors while residing in the facility. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and support based upon residents' individual needs, include, but are not limited to:-Depression: It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community; -Anxiety and Anxiety Disorders: There are many types of anxiety disorders, each with different symptoms. The most common types of anxiety disorders include Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Phobias and Post-Traumatic Stress Disorder; -Schizophrenia: Is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40;-Bipolar Disorder: Is a mental disorder that causes dramatic shifts in a person's mood or energy and may affect the ability to think clearly.Assessment /Care Planning: The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff will: obtain history from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health; monitor the resident closely for expressions or indications of distress; evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable; assess and develop a person-centered care plan for concerns identified in the resident's assessment; share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnosis; accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record. -Mental Disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities;-SUD is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home;-Non-Pharmacological Intervention refers to approaches to care that do not involve