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	04/03/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, facility staff failed to report an allegation of sexual abuse for one resident's (Resident #4) within the required two hours to the state agency Department of Health and Senior Services (DHSS). The facility census was 228. 1. Review of the facility's Abuse and Neglect Policy, dated 06/12/24, showed it is the policy of this facility to report all allegations of abuse and are reported immediately to the administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames. The facility must ensure that all the alleged violations involving abuse or sexual assault are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse to the State Survey Agency. 2. Review of Resident #4 quarterly Minimum Data Set (MDS), dated [DATE], a federally mandated assessment tool, showed staff assessed the resident as cognitively intact and admitted on [DATE]. Review of the resident's progress notes, dated 04/02/2026, showed staff documented the resident reported he/she was raped in his/her sleep and wanted to be sent to the hospital to obtain a rape kit. During an interview on 04/03/26 at 1:46 P.M., Licensed Practical Nurse (LPN) A said the resident had reported to staff he/she was raped by someone then later said it was his/her family member. He/She said he/she reported the allegation to the administrator around 5:00 A.M He/She said he/she was told the administrator reported the allegation to DHSS.During an interview on 04/03/26 at 2:20 P.M., the administrator said he/she received a call around 5:30 A.M. regarding the allegation of sexual abuse. He/She said he/she did not file a complaint with DHSS because he/she investigated the allegation of sexual abuse and determined within two hours, the allegation of sexual abuse did not occur. 2972664

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, facility staff failed to document a complete and accurate Minimum Data Set (MDS) assessment (a federally mandated assessment) when they did not accurately code a psychiatric/mood disorder diagnosis for three residents (Resident #1, Resident #2 and Resident #3) out of four sampled residents. Facility census was 232.1. Review of the facility's MDS 3.0, Care Assessment Summary and Individualized Care Plans policy, dated 11/06/23, showed to understand the changes presented by Centers of Medicare and Medicaid Services (CMS) for the MDS 3.0 to define the intent of each section of the MDS 3.0 and to ensure that MDS 3.0 sections are completed accurately and in a timely manner by the assigned responsible parties. 2. Review of the resident's diagnosis report, dated 04/30/23, showed staff documented a diagnosis of bipolar disorder.Review of Resident #1's quarterly MDS, dated [DATE], staff assessed the resident as cognitively intact. The assessment did not contain documentation that the resident had a diagnosis of a bipolar disorder.Review of the resident's care plan, dated 3/31/26, showed staff documented the resident had a diagnosis of bipolar and schizophrenia, and exhibited behaviors of hallucinations and delusions. 3. Review of the resident's diagnosis report, dated 06/04/25, showed staff documented a diagnosis of PTSD.Review of Resident #2's quarterly MDS, dated [DATE], staff assessed the resident as cognitively intact. The assessment did not contain documentation that the resident had a diagnosis of Post Traumatic Stress Disorder (PTSD).Review of the resident's care plan, dated 03/28/26, showed staff documented the resident did have a diagnosis of PTSD with interventions in place, but did not contain direction for staff related to PTSD triggers. 4. Review of the resident's diagnosis report, dated 10/15/25, showed a diagnosis of PTSD.Review of Resident #5 quarterly MDS, dated [DATE], staff assessed the resident as cognitively intact. The assessment did not contain documentation that the resident had a diagnosis of PTSD.Review of the resident's care plan, dated 01/15/26, showed staff documented the residents had a history of PTSD.5. During an interview on 04/14/26 at 1:38 P.M., the MDS Coordinator said if a resident had an active diagnosis and was being treated for PTSD or a bipolar disorder, it should be documented on the MDS. He/She said he/she did not know if Resident #2 and Resident #5 had a diagnosis of PTSD or if Resident #1 had a diagnosis of bipolar disorder, since the facility had a large population. 2967099, 2967098, 2967147

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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 interview and record review, facility staff failed to update one resident's (Resident #2) plan of care who experienced suicidal ideation and had a history of self-harm, and facility staff failed to update three resident's (Resident #1, Resident #3 and Resident #5) plan of care after they exhibited increased behaviors. The facility census was 232. 1. Review of the facility's policy, MDS 3.0, Care Assessment Summary and Individualized Care Plans, dated 01/06/23, showed it did not contain direction for staff regarding updating the resident's plan of care with new interventions after a new or increased behavior.2. Review of Resident #1's progress notes, dated 01/27/2026, showed staff documented the resident was an aggressor in a resident-to-resident altercation and reported the holy spirit had taken over his/her body and he/she did not need medication.Review of the resident's quarterly Minimum Data Set (MDS), dated [DATE], a federally mandated assessment tool, showed staff assessed the resident as cognitively intact, and without hallucinations and delusion.Review of the resident's care plan, dated 3/31/26, showed staff did not document new intervention after the altercation on 01/26/26.3. Review of Resident #2's quarterly MDS, dated [DATE], staff assessed the resident as cognitively intact with a diagnosis of depression. The assessment did not contain documentation of the resident having thoughts that he/she would be better off dead, or of hurting self in some way.Review of the resident's care plan, dated 03/28/26, showed staff documented the resident at low risk for suicide. The care plan did not provide guidance for staff in regard to interventions when resident exhibited suicidal ideations, makes self-harm statements, or self-harm attempts.Review of the residents' progress notes showed staff documented:-02/11/2026 the resident expressed to staff that he/she was manic and felt he/she wanted to hurt himself/herself on 02/10/26. -03/09/26, the resident was found with a shoestring around his/her neck.-03/28/26, the resident was transferred to the hospital after staff found the resident with a charger cord tied tightly around his/her neck. 4. Review of Resident #3's progress notes, dated 02/19/26, showed staff documented the resident pushed another resident causing both residents to tumble to the floor and exchanged one punch.Review of the residents quarterly MDS, dated [DATE], staff assessed the resident as cognitively intact and did not exhibit physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually).Review of the resident's care plan, dated 3/19/26, showed staff did not document new intervention after the altercation on 02/19/26, and did not contain guidance for staff in regard to interventions when resident exhibited behaviors.5. Review of Resident #5 quarterly MDS, dated [DATE], staff assessed the resident as cognitively intact, and without physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), and verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others).Review of the resident's care plan, dated 01/15/26, showed staff did not document new intervention after the altercation on 02/06/26 or 03/21/26, and did not contain guidance for staff in regard to interventions when resident exhibited behaviors.Review of the resident's progress notes showed staff documented on 02/06/2026 a call was placed to the guardian because resident had increased behaviors, lashed out towards staff by grabbing a cigarette box and then had a verbal altercation with another resident. 6. During an interview on 4/03/26 at 1:46 P.M., Licensed Practical Nurse (LPN) A said the care plan should be updated with new interventions after a statement of self-harm or behaviors of self-harm or incidents of physical aggression. He/She said there are a lot of resident's with behaviors, and he/she said there could be more information and education for staff to prevent behaviors.During an interview on 04/03/25 at 2:20 P.M., the administrator said he/she would consider new or increased behaviors, including being physically aggressive and causing injury, or statement or behaviors of self-harm to be a significant change. He/She said the MDS Coordinator was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for completing a significant change assessment. He/She said the care plan should be updated with new interventions after a new behavior of self-harm or aggression towards other. He/She said nurses would be responsible to update the care plan.During an interview on 04/08/26 at 3:11 P.M., the MDS Coordinator said he/she was responsible for completing the significant change and comprehensive assessment. He/She would consider a new statement of self-harm, or an action of self-harm, or new aggressive behaviors a significant change in condition unless it was documented on the Preadmission Screening and Resident Review (PASAAR). He/She said he/she did not know if the behaviors were on Resident #1, Resident #2, Resident's #3's or Resident #4's PASAAR, since he/she had hundreds of residents to keep up with.2967099, 2967098, 2967147