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	06/12/2026

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free of significant medication errors when Registered Nurse (RN) A did not verify admission physician's orders, which resulted in staff not administering diabetic medications and resident hospitalization with Diabetic ketoacidosis (DKA) (a life-threatening complication of diabetes that occurs when the body lacks enough insulin to use blood sugar). The facility census was 224.The administrator was notified on 06/12/26 of Past Non-Compliance which occurred on 06/08/26. The Director of Nursing (DON) investigated, notified the residents' responsible party, counseled RN A, and in-serviced staff regarding medication administration, transcribing physician's orders, medication reconciliation, and the admission process. Staff corrected the deficient practice on 06/08/26. Review of the facility's Medication Reconciliation Policy, dated 05/14/24, showed the facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free from any significant medication errors, and that the facility's medication error rate is less than five percent (%). Review of the facility's admission Process, Assignment of Primary Diagnosis Policy, dated 12/01/22, showed:-If the decision is made to admit the resident, then the admissions coordinator will obtain all pertinent information to ensure that the resident's needs can be met including current drug regimen, diet orders, laboratory orders and any special need items. -The DON/ADON (Assistant Director of Nursing)/RN designee will input the resident's information onto the Resident Diagnosis Sheet;-A Licensed/Registered Nurse will ensure that all admission paperwork including physician orders, medications, diet orders, laboratory orders are followed;-The RN will need to complete a Chart Audit within 24 hours of Admission. Review of the facility's Transcription/Orders/Following Physician's Orders Policy, dated 05/18/24, showed:-Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in resident's electronic medical records in orders section;-The Licensed Nurse will review electronic Medication Administration Records (MARs) and electronic Treatment Administration Records (TARs) on a routine basis to monitor for medications that were not administered to the resident due to unavailability, refusal, omission, etcetera;-The Nurse or Certified Medication Technician (CMT) in charge of medication administration must review all their designated MARSs and TARs prior to the end of their shift to ensure that all medications/treatments scheduled to be given on their shifts were administered according to the physician's order and that all necessary interventions were taken in the event of an omission. 2. Review of Resident #1's Face Sheet from the transferring facility, dated 05/20/26, showed the resident with diagnoses of Type I Diabetes Mellitus (a chronic metabolic disorder characterized by persistently high glucose (blood sugar) levels with Hyperglycemia (high blood sugar). Review of the resident's transferring facility's Physician's Orders, dated 05/20/26, showed Insulin Glargine (a long-acting insulin) 100 units/milliliter (U/ml) 20 units subcutaneously (under the skin) one time a day, Insulin Glargine 100 U/ml 30 units subcutaneously at bedtime, Insulin Lispro (a rapid-acting insulin) 100 U/ml four units subcutaneously with meals, Insulin Lispro 100 U/ml inject with meals as sliding scale for blood glucose levels as follows: -0-150-Do not administer;-151-200-two units;-201-250-four units;-251-300-six units-301-350-eight units-351-400-ten (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 0760 Level of Harm - Actual harm Residents Affected - Few	units-401-450-12 units-451-500- 14 units-501-550- 16 units and notify physician. Review of the resident's medical record did not contain admission paperwork to include diagnoses, face sheet. Review of the resident's Physician Order Sheet, for June 2026, showed no documentation of medication orders or diabetic medication orders. Review of the resident's MAR, dated June 2026, showed the MAR did not document any orders or that they administered the resident's insulin from 06/06/26 through 06/08/26. Review of the resident's nurse's notes, dated 06/06/26 through 06/08/26, showed the resident admitted to the facility on [DATE]. Review showed the nurses notes did not contain documentation of diagnoses, physician's orders, or documentation staff contacted the physician to clarify or to obtain physician orders for the resident upon admission. During an interview on 06/30/26 at 9:47 A.M., Licensed Practical Nurse B said he/she was not on duty on the weekend of 06/05/26 through 06/07/26. The first interaction he/she had with the resident was on the morning of 06/08/26, so he/she did not know the resident's baseline. When he/she checked on the resident at approximately 8:00 A.M. on 06/08/26, the resident was covered in coffee ground emesis and had loose stool. He/She thought the resident may have an impaction or gastrointestinal (GI) bleed, so he/she sent the resident to the Emergency Department (ED). He/She said there were no physician's orders or diagnoses in the resident's chart, and no documentation the resident was diabetic. Review of the resident's nurse note, dated 06/09/26, showed the DON documented the resident admitted on [DATE] from another facility, and upon admission the RCC (Resident Care Coordinator) entered orders for the resident based on old referral orders instead of his/her current new admission orders brought in with the resident. The RCC did not verify that the orders on the old referral were the correct orders with the physician. Weekend RN (Registered Nurse) did not complete 24-hour RN chart audit. The resident voiced concerns related to medication throughout the weekend. No one addressed his/her concerns. Sent to hospital 06/08/26, admitted for Diabetic Keto-acidosis (DKA). Review of the resident's hospital records, dated 06/08/26, showed hospital staff documented the resident admitted with Diabetic Ketoacidosis with a blood glucose level over 600 (normal levels are 74 to 106). During an interview on 06/15/26 at 2:00 P.M., RN A/Admissions Coordinator said he/she needed to complete five admissions on 06/05/26. The DON sent him/her the referral packet for the resident and he/she was overwhelmed. He/She did not enter insulin orders for the resident or call the physician to verify orders and did not administer medications to the resident before he/she went off duty. He/She did not know if the resident was feeling ill,. He/She should have verified to ensure medication orders were correct. During an interview on 06/18/26 at 2:23 P.M., the DON said he/she was not on duty when RN A admitted the resident to the facility. He/She was on his/her way to the facility on [DATE], when staff notified him/her the resident was having coffee consistent emesis and staff were sending the resident to the hospital. He/She said when hospital staff called the facility to question facility staff regarding the resident's insulin and blood glucose levels, he/she looked at the resident's admission and medical chart and discovered staff had not transcribed the resident's current physician's orders into his/her medical record. He/She said when the facility admits a new resident, either the RCC or the floor nurse will enter admission orders in the resident's electronic medial chart, and the RN on duty should review the information within 24 hours to ensure accurate information. He/She would consider the failure to administer the resident's medication a significant medication error with the potential to cause harm. During an interview on 7/1/26 at 9:15 A.M., the physician said the resident was a brittle type I diabetic who received Lantus and Lispro insulin. The resident had a history of DKA if insulin was not given. The physician said the facility should have had those orders as they had been requested and if not, they should have reached out to clarify the residents' orders. The physician said he/she never got a call from the facility to confirm the details of the residents' orders. The physician said he/she would expect a facility to notify the physician to go over all orders prior to admitting them to assure residents receive significant medications such as insulin. #3040985