STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265396	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Care Center	1106 South Oak California, MO 65018

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 for three residents (Resident #3, #13, and #21) out of 14 sampled residents. The facility census was 32. 1. Review of the facility's Care Plan Comprehensive policy, undated, showed an assessment of each resident is an ongoing process and the care plan's revised as changes occur in the resident's condition. The interdisciplinary care plan team is responsible to review and update care plans when a significant change in the resident's condition occurs. 2. Review of Resident #3's comprehensive admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/07/26, showed staff assessed the resident as cognitive, no behavioral symptoms and did not reject care, with a diagnosis of stroke with upper extremity impairment on one side and lower extremity impairment on both sides, high risk for falls. Review of the resident's care plan, dated 11/12/25, showed it did not address interventions for the resident's prosthesis on both lower extremities and did not address the need for residents' improper fit of denture use. Review of resident's nurse note, dated 04/30/26, showed staff documented the resident in therapy to assist with proper placement and use of prosthetics. During an interview on 05/07/26 at 12:26 P.M., the resident said his/her dentures do not fit as they should since his two strokes. Without his/her teeth, heshe feels ugly about him/herself. The resident said he/she suffers from depression and without his/her teeth makes it worse. During an interview on 05/07/26 at 12:55 P.M., the Care Plan Coordinator said anything abnormal should be care planned, such as adaptive equipment the use of dentures. He/She said it is important to have these things in the care plan, so staff know how to take care of the residents. The care plan coordinator said he/she did not know these things were not on the care plan. During an interview on 05/07/26 at 1:35 P.M., the Director of Nursing (DON) said staff use I Care plan which and any abnormal thing about the resident. The care plan is used so the nurse or aide knows how to care for the resident. The DON said the MDS and care plan should match. If a resident has dentures, it should also be on the care plan. During an interview on 05/07/26 at 2:05 P.M., the administrator said she would expect dentures to be care planned. If a resident has had a stroke and has limitations it should also be on the care plan. It is the care plan coordinator's responsibility to update and add to the care plan and was not aware those (continued on next page)

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 - Some	things were not on the care plan. 3. Review of Resident #13's MDS, dated [DATE], showed staff assessed the resident as cognitive, debility, related to cardiorespiratory conditions; heart failure, anemia, coronary artery disease. Review of the resident's nurse note, dated 02/27/26, showed the resident received an Implantable Cardioverter-Defibrillator (ICD), a small, battery-powered device surgically placed in your chest that continuously monitors your heart rate and automatically delivers electrical pulses or shocks to correct life-threatening, dangerously abnormal heart rhythms (arrhythmias) and prevent sudden cardiac arrest. Review of the resident's Cardiology Note, dated 03/26/26, showed the resident received a dual chamber ICD on 02/27/26 and an order to report a weight gain of two to three pounds in 24 hours and five pounds in a week. Review of the resident's care plan, updated on 04/15/26, showed the care plan did not address staff to report the daily and weekly weight monitoring and did not update the care plan within 14 days when the resident received an ICD. During an interview on 05/07/26 at 12:55 P.M., the Care Plan Coordinator said anything abnormal should be care planned, such as a pacemaker. The care plan coordinator said he/she did not know these things were not on the care plan. During an interview on 05/07/26 at 1:35 P.M., the DON said staff use I Care plan which documents social history, and any abnormal thing about the resident so the nurse or aide knows how to care for the resident. The DON said the MDS and care plan should match. If a resident a pacemaker it should also be on the care plan. During an interview on 05/07/26 at 2:05 P.M., the administrator said she would expect a pacemaker to be care planned. It is the care plan coordinator's responsibility to update and add to the care plan and was not aware those things were not on the care plan. 4. Review of Resident #21's Quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, did not have behavioral symptoms and did not reject care, with a diagnosis of hemiplegia or hemiparesis (neurological conditions causing one-side body weakness or paralysis) with upper and lower extremity impairment on one side. Review of the resident's care plan, last updated 02/25/26, showed staff did not contain interventions for the resident's contracture. Observation on 05/05/26 at 12:30 P.M., showed the resident in his/her wheelchair with left hand contracted without interventions in place. Observation on 05/06/26 at 3:00 P.M., showed the resident in his/her wheelchair with left hand contracted without interventions place. Observation on 05/07/26 at 12:00 P.M., showed the resident in his/her wheelchair with left hand contracted without interventions place. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/07/26 at 12:55 P.M., the Care Plan Coordinator said anything abnormal should be care planned, such as adaptive equipment and their transfer needs, He/She said weaknesses or contractures should be on the care plan. He/She said it is important to have these things on the care plan, so staff know how to take care of the residents. The care plan coordinator said he/she did not know these things were not on the care plan. During an interview on 05/07/26 at 1:35 P.M., the DON said contractures should be on the care plan so the nurse or aide know how to care for the resident. The DON said the MDS and care plan should match. During an interview on 05/07/26 at 2:05 P.M., the administrator said if a resident has limitations, it should be on the care plan. It is the care plan coordinator's responsibility to update and add to the care plan and he/she was not aware those things were not on the care plan.

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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. Based on interviews and record review, facility staff failed to maintain professional standards of practice when staff failed to transcribe a treatment order for daily weights for one resident (Resident #13) with congestive heart failure (CHF). The facility census was 32.1. Review of the facility's Physician Orders policy, undated, showed current orders are maintained in each resident record to avoid confusion and errors. 2. Review of Resident #13's admission Minimum Data Set (MDS), a federally mandated assessment tool, 04/16/26, showed staff assessed the resident as:-Cognitively intact;-Debility, related to cardiorespiratory conditions; heart failure, anemia, coronary artery disease. Review of the resident's Cardiology visit note, dated 03/26/26, showed an order to report a weight gain of two to three pounds in 24 hours and five pounds in a week. Review of the resident's Physician Order Sheet (POS), dated 03/31/26, showed the POS did not contain the order for daily weights or to report a weight gain of two to three pounds in 24 hours and five pounds in a week. Review of the resident's POS, dated 04/30/26, showed the POS did not contain the order for daily weights or to report a weight gain of two to three pounds in 24 hours and five pounds in a week. During an interview on 05/12/26 at 8:15 A.M., the resident's Cardiology Nurse Practitioner said he/she expects the facility to record the resident's weight as ordered. He/She said if the facility did not understand the order, he/she expects the facility to communicate for clarification of the order. He/She said if the facility does not record the resident's weights as ordered, the resident can become fluid overloaded. He/She said he/she does not have any communication or records of resident's weights. During an interview on 05/07/26 at 10:15 A.M., Licensed Practical Nurse (LPN A) said when a resident returns from the doctor's office with new orders, the charge nurse is responsible to review the orders, notify the physician to ensure an order is changed. The LPN said the charge nurse is responsible to transcribe the order as followed. The LPN said the order to complete daily weights, and weekly weights should be followed. The charge nurse is responsible for making sure they are transcribed but not to follow up. During an interview on 05/07/26 at 1:35 P.M., the Director of Nursing (DON) said the charge nurse is responsible for transcribing new orders. The DON said he/she's never seen an order like that and assumed the resident was responsible to monitor his/her weights. The DON said he/she is responsible for ensuring orders are followed per the physician. During an interview on 05/07/26 at 2:07 P.M., the administrator said the error in order should be identified. He/She said there should be clarification of an order if misunderstood. The resident is not responsible for his/her weights, we are responsible for ensuring orders are followed. He/She said the charge nurse on duty should follow up with the order, any clarifications and communicate with the physician.