STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265455	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willard Care Center	400 West Walnut Lane Willard, MO 65781

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 - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265455	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willard Care Center	400 West Walnut Lane Willard, MO 65781

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed ensure notification to the resident's family/responsible party of changes of condition for all when residents when staff failed to document family/responsible party notification of four residents (Resident #1, #2, #3, and #4) for resident change in health condition, resident falls, and/or new physician orders. The facility had a census of 58.Review of the facility provided Patient [NAME] of Rights as provided by the Long-Term Care Ombudsman (advocate for residents in nursing homes and assisted living facilities who helps protect their rights, health, and quality of life) Program, showed the resident had the right to:-Be fully informed of services available to you;-Participate in planning your care and being informed of all aspects of your care.Review showed the facility did not provide a policy provided related notifications of resident change in condition to responsible party or family members. 1. Review of Resident #1's face sheet showed the following: -admission date of [DATE];-Hospice admission date of [DATE];-Resident had an emergency contact and durable power of attorney (DPOA - legal document allowing someone to make decisions on your behalf) listed with name and phone number;-Diagnoses included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) with agitation, heart failure, and cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain). Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated [DATE], showed the following:-Moderate cognitive impairment;-Partial to moderate assistance required with showering, toileting hygiene;-Supervision required with personal hygiene.Review of the resident's care plan, last updated [DATE], showed the following:-Resident at risk for falls related to generalized weakness, decreased cognition, and disease process;-Staff should notify the resident's doctor and family or guardian of a fall;-Resident did not want cardiopulmonary resuscitation initiated (CPR - emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped);-Staff should notify the resident's family and physician of any changes in condition.Review of the resident's [DATE] Physician Order Sheet (POS) showed an order, dated [DATE], for ceftriaxone (a powerful, broad-spectrum antibiotic used to treat a wide variety of bacterial infections) reconstituted solution, 1 gram injection once per day, for diagnosis of cellulitis;Review of the resident's nursing progress note dated [DATE], at 3:25 A.M., showed resident started antibiotic treatment for cellulitis (common, serious bacterial infection of the skin's deeper layers and underlying tissue, often causing redness, swelling, warmth, pain, and tenderness). He/she was free of side effects or adverse reaction related to this treatment. Review of the resident's [DATE] progress notes showed staff did not document notification the resident's family or responsible party of the new medication order. Review of the resident's [DATE] POS showed the following:-The order, dated [DATE], for ceftriaxone was discontinued [DATE];-An order dated [DATE] and discontinued [DATE], for cefuroxime axetil (semisynthetic, broad-spectrum, antibiotic used to treat a wide variety of bacterial infections) tablet, 250 mg, 1 tablet twice daily for diagnosis of cellulitis.Review of the resident's [DATE] progress notes showed staff did not document notification the resident's family or responsible medication order changes2. Review of Resident #2's face sheet showed the following: -admission date of [DATE];-Hospice admission date of [DATE];-Emergency contact and legal guardian listed with name and number;-Diagnosis included dementia, repeated falls, heart disease, and chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should).Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Partial to moderate assistance required with personal hygiene, showering.Review of the resident's care plan, updated [DATE], showed the following:-Resident preferred no life saving measures;-Staff should communicate with resident family, hospice, and physician if any changes in condition.Review of the resident's nursing progress notes showed the following:-On [DATE], at 12:30 P.M., staff noted while assessing resident during lunchtime this nurse noticed resident had a small bruise to his/her right side of his/her mouth. When asking resident what happened he/she stated, I fell on my trash can yesterday. Certified nurse aide (CNA) reported no falls this shift. No other injuries noted. Neuros (a series of questions and tests used by healthcare providers to assess how well a person's nervous system is working) and range of motion within normal limits. Vital signs stable. Neuros initiated. No complaints of pain or discomfort noted. On call nurse notified. Residents' safety maintained throughout shift. Call light, water and personal items within reach. Continue with current plan of