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	04/10/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was protected from possible contamination at all times when fans and vents were free of dirt and dust, when staff failed to discard a box of baking soda in the walk-in cooler with black substance on the container, when staff failed to air dry dishes before stacking, and when staff failed to ensure dishes were clean before stacking. The deficient practice had the potential to harm all residents. The facility census was 57.1. Review of the 2022 Missouri Food Code showed food shall be protected from contamination by storing the food in a clean, dry location and where it is not exposed to splash, dust, or other contamination.Review of the US Food and Drug Administration policy, under the section of Food Labeling and Handling, updated 03/04/23, showed the following:-Facility staff must ensure their proper storage, keeping track of when to discard perishable foods, and covering, labeling, and dating all foods stored in the refrigerator or freezer as indicated;-Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use by date, or frozen (where applicable), or discarded.Review of the facility policy titled, Refrigerators and Freezers, dated May 2015, showed the following:-Refrigerators and freezers should be cleaned per cleaning schedule:-Fans and fan guards in all refrigerator and freezer units are to be routinely cleaned and be free of dust and dirt at all times.Review of the facility dayshift checklist showed to check air vents for dust and debris, and staff were to sign once tasks were completed. The facility did not provide a signed checklist of tasks completed.Observation of the walk-in cooler and kitchen on 04/06/26, at 10:44 A.M., showed the following:-Fans had substantial dirt and dust build up;-A box of baking soda in the corner was turned on its side and had black spots all over the outside of the box;-One vent in the ceiling near a dish storage rack and entry door had visible dirt and dust.Observation of the kitchen on 04/07/26, at 11:30 A.M., showed the following:-Fans had substantial dirt and dust build up;-A box of baking soda in the corner was turned on its side and had black spots all over the outside of the box;-One vent in the ceiling near a dish storage rack and entry door had visible dirt and dust.Observation of the kitchen on 04/07/26, at 12:10 P.M., showed the vent in the ceiling near a storage rack and entry door had visible dirt and dust. The hall trays were stored in a cart under the vent while preparing serve out.During an interview on 04/07/26, at 1:07 P.M., Dietary [NAME] (DC) H said the following:-There is a cleaning schedule for day and night shift responsibilities and cleaning fans is not on the list;-Kitchen staff are responsible for cleaning fans in the cooler, and they should not have dirt and dust on them;-Cooks are responsible for ensuring the coolers are free of items such as a box of baking soda with black spots all over the outside;-He/she saw the box of baking soda in the cooler a couple of days ago but could not reach it to discard.During an interview on 04/08/26, at 8:32 A.M., DC I said the following:-There is a day and night shift cleaning schedule, but no sign off sheet;-Kitchen staff are responsible for cleaning the fans in the coolers, and they should not have dirt and dust on them;-Cooks are responsible for the condition of items in the walk-in coolers, and there should not be a box of baking soda with black spots all over it in the cooler.During an interview on 04/09/26, at 2:41 P.M., the Dietary Manager (DM) said the following:-There is a weekly cleaning schedule, and staff are to initial and date as duties are completed;-She does not know who is (continued on next page)

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	04/10/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	responsible for cleaning the fans in the cooler;-Fans should not have dirt and dust on them;-All kitchen staff are responsible for the items in the cooler being in appropriate condition, and there should not be a box of baking soda with black spots all over it.During an interview on 04/10/26, at 11:36 A.M., the Maintenance Director said the following:-He knew he was responsible for keeping the vents free of rust and painted, but did not know it was his responsibility to keep the vents or the fans clean;-Fans and vents should not have dirt and dust on them.During an interview on 04/14/26, at 8:03 A.M., the Registered Dietician said the following:-Vents and fans should not have dirt and dust on them;-She assumed it is the responsibility of all kitchen staff to ensure items in the cooler are in appropriate condition. There should not be a box of baking soda with black spots all over the outside.During an interview on 04/10/26, at 2:59 P.M., the Administrator said the following:-There is a cleaning schedule for the kitchen, and staff check off the duties as they are completed. The DM is to review the cleaning schedule;-Maintenance is responsible for cleaning vents. There should be weekly checks and clean as needed;-The DM is responsible for cleaning the fans in the cooler;-The DM is responsible for the condition of items in the cooler, and there should not be a box of baking soda with black spots all over it in the cooler.2. Review of the 2022 Missouri Food Code showed food shall be protected from contamination by storing the food in a clean, dry location and where it is not exposed to splash, dust, or other contamination.Review of the facility policy titled, General Dish Room Sanitation, dated May 2015, showed the following:-All items are checked for cleanliness at the clean end of the dish machine. Items that are not clean will be re-washed;-All items are to be air dried. No moisture can be found on any stacked item.Observation of the kitchen on 04/06/26, at 10:44 A.M., showed the following:-Metal trays of multiple sizes were stacked wet and dirty with leftover food particles inside;-Small plastic cups ready for use were stacked wet.Observation of the walk-in cooler and kitchen on 04/07/26, at 11:00 A.M., showed the following:-Metal trays of multiple sizes ready for use were stacked wet and dirty with leftover food particles inside;-Plastic serving bowls ready for use were stacked with leftover food particles and wet.During an interview on 04/07/26, at 1:07 P.M., DC H said the following:-Staff should ensure all dishes are air dried before stacking;-Staff should inspect all dishes for cleanliness before stacking.During an interview on 04/08/26, at 8:32 A.M., DC I said staff should ensure dishes are air dried and clean before stacking.During an interview on 04/08/26, at 9:06 A.M., Dietary Aide (DA) J said the following:-Staff should ensure all dishes are air dried before stacking;-He/she inspects dishes for cleanliness out of the dishwasher and runs back through another cycle if not clean;-Staff should not stack dishes dirty. During an interview on 04/09/26, at 2:41 P.M., DM said the following:-Staff should ensure dishes are completely air dried before stacking;-Staff should inspect dishes for cleanliness before stacking.During an interview on 04/14/26, at 8:03 A.M., the Registered Dietician said the following:-Staff should ensure dishes are air dried before stacking;-Staff should inspect dishes for cleanliness before stacking.During an interview on 04/10/26, at 2:59 P.M., the Administrator said the following:-Staff should ensure dishes are air dried before stacking;-Staff should inspect dishes for cleanliness before stacking.

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	04/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents received care and treatment in accordance with professional standards of practice when facility nursing staff failed to provide appropriate neurological assessments (evaluation of the functioning of the nervous system, identifying any abnormalities or neurological deficits.) for three residents (Resident #5, Resident #15, and Resident #31) after each resident sustained a fall with potential for head injury. The facility census was 57.Review of the facility policy titled, Condition Change, Resident (Observing, Recording, and Reporting) (Includes Fall or Injury)), undated, showed the following: -Purpose: To observe, record, and report any condition change to the attending physician so that proper treatment can be implemented; -Guidelines: After all resident falls, injuries, or changes in physical or mental function, monitor the following: -Observe for lacerations. If present, clean and apply dry, sterile dressing or dressing of physician's choice. Note size, depth, and amount of bleeding or drainage; -Observe for swelling and discoloration. If present, chart size, site, amount, and color; -Observe for convulsions. Chart time began, precipitating factors, duration, vital signs, and time ended. Also chart whether or not resident had difficulty breathing; -Observe and inquire if resident has headache or pain; -Observe for personality changes; -Observe for alterations in consciousness; -Observe for incontinence; -Observe for sensory disorder; -Observe for generalized weakness; -Observe for speech disorder; -Observe for gait posture or balance disorder; -Observe for stiff neck; -Observe for proper reflexes (response to painful stimuli); -Take vital signs and include temperature; -Observe for abdominal spasms or pain; (continued on next page)

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	04/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Observe for bleeding from ears, nose, and throat; -Observed for unequal pupils; -Observed for dyspnea or variations in respiration (irregular); -Observe for flushing or cyanosis; -Observe for pain; -Observe for abduction, adduction, shortening, or improper position of extremities; -Have someone stay with the resident while the nurse is calling the attending physician, if necessary. If you are unable to reach the attending physician or the physician on call, call the medical director for emergency situations; -Complete an incident, accident, or risk management report per facility guidelines; -Notify the residents responsible party; -Monitor resident's condition frequently until stable; -Notify physician of condition change, need for treatment orders, and/or medication order changes. X. Review of Resident #31's face sheet showed the following: -admission date of 8/05/24; -Primary diagnosis of vascular dementia (a decline in thinking caused by conditions that block or reduce blood flow to the brain). Review of the resident's care plan, revised on 1/26/26, showed the following: -Resident at risk for falls due to unsteady gain, periods of fatigue. Resident ambulates with a walker; -Notify the resident's family and physician of any changes in condition; -Monitor the resident for increased weakness and unsteady gait; -Increased staff supervision with intensity based on the resident's needs; -Encourage the resident to do exercises targeting strength, gait, and balance; -Provide toileting assistance based on needs/patterns; -Fall 3/25/26: Provide the resident with a wheelchair for longer distance ambulation; -Fall 3/27/26: Give the resident verbal reminders not to ambulate/transfer without assistance. (continued on next page)

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	04/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 2/20/26, showed the following: -admitted to the facility on [DATE]; -Resident cognitively intact; -No rejection of care; -Required set-up or clean-up assistance of staff with meals; -Required supervision or touching assistance of staff toileting hygiene and personal hygiene; -Required partial or moderate assistance of staff with showering; -Independent with bed mobility and transfers; -Used walker for mobility; -Occasionally incontinent of bowel and bladder; -Diagnoses of vascular dementia, edema, and atrial fibrillation (irregular heart rhythm); -No history of falls. Review of the resident's progress note, dated 03/25/26 at 6:49 P.M., showed the following: -Resident in the main dining room for the evening meal and lost his/her balance and fell to the floor on his/her back; -Resident's range of motion (ROM) within normal limits, no complaints of pain to the lower extremities; -Resident hit the back of his/her head, resulting in a small 2.5 centimeter (cm) by 2.5 cm bump noted to the top of back of his/her head and a small 2.0 cm laceration to his/her left elbow. Area cleaned; -The nurse notified the resident's physician and family member. The resident's family member feels the resident may need to use a wheelchair for longer distance mobility when feeling weak. Review of resident's progress notes on 3/26/26, show staff did not complete a progress note or follow up on the resident's condition after hitting his/her head and did not document any neurological checks. Review of the resident's form Neurological Assessment Flow sheet, dated 03/27/26, showed the following: -The checklist should be completed at the following intervals for follow-up for all unwitnessed falls or falls where resident hit their head. Any changes in the resident's condition requires a phone call to the primary care physician; (continued on next page)

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	04/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Baseline vital signs (at the time of the fall) then neurological checks every 15 minutes for one hour, every 30 minutes for one hour, every hour for two hours, and every 12 hours for 6 shifts; -Staff documented the resident's level or consciousness, pupil response, motor function of all four extremities (arms and legs), and vital signs at 12:00 A.M., 12:15 A.M., 12:30 A.M., 12:45 A.M., 1:15 A.M., 1:45 A.M., 2:45 A.M., and 3:45 A.M. -Staff did not document under the category of observations (wounds, vomiting, headache). Review of the resident's progress note, dated 3/27/26 at 4:47 A.M., showed the following: -Fall follow up 6p-6a: No injuries or adverse effects noted from recent fall. Vital signs stable. Review of the resident's progress notes, dated 3/27/26 at 9:24 P.M., showed the following: -Staff found the resident in the bathroom; -Resident assessed and assisted to a wheelchair. The resident has a bruise on his/her tailbone. Vital signs stable. Neurological checks are intact; -The nurse notified the resident's family and the physician; -Staff will continue to monitor the resident. No complaints of pain; -Resident is oriented to person and family. Resident is exit seeking. Staff to encourage the resident to use a wheelchair instead of a walker. Review of the resident's form Neurological Assessment Flow sheet, dated 03/27/26, showed the following: -Staff did not document on the resident on the 6:00 P.M. to 6:00 A.M. shift; -On 03/28/26, at 6:00 A.M. to 6:00 .PM. shift, staff documented the resident's level or consciousness, pupil response, motor function of all four extremities (arms and legs), and vital signs. Staff did not document on the form under the category of observations (wounds, vomiting, headache); -On 3/28/26, 6:00 P.M. to 6:00 A.M. shift staff did not document on the resident; -On 3/29/26, 6:00 A.M. to 6:00 P.M. shift and 6:00 P.M. to 6:00 A.M. shift., staff documented the resident's level or consciousness, pupil response, motor function of all four extremities (arms and legs), and vital signs. Staff did not document under the category of observations (wounds, vomiting, headache). -On 3/30/26, 6:00 A.M to 6:00 P.M. shift, staff documented the resident's level or consciousness, pupil response, motor function of all four extremities (arms and legs), and vital signs. Staff did not document under the category of observations (wounds, vomiting, headache). During an interview on 4/10/26 at 10:00 A.M., Registered Nurse (RN) F said when a resident falls, the nurse should assess the resident for injuries, such as bruising and bleeding. The nurse should (continued on next page)

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	04/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document the resident's condition in the progress note, and then every shift for three days after a fall. During an interview on 4/10/26 at 10:16 A.M., the Director of Nursing (DON) said the following: -After a resident fall, the nurse should assess the resident for any injuries; -The nurse should assess the resident for any latent injuries every shift for three days following an injury or fall, and the nurse should document the assessment in the resident's progress notes. During an interview on 4/10/26 at 3:50 P.M., the Administrator said the following: -The nurses should document a resident's fall in the progress notes; -The nurse should monitor the resident after the fall for any changes in condition every shift for 4 days and document in the progress notes. X. Review of Resident #5's face sheet showed the following: -admission date of 01/31/25; -Diagnoses of dementia; heart disease; anxiety; depression; repeated falls. Review of resident's quarterly Minimum Date Set (MDS-a federally mandated assessment tool completed by facility staff), dated 03/20/26, showed the following: -Moderate cognitive impairment; -Requires partial/moderate staff assistance with toileting, personal hygiene, and transfers; -Wheelchair for mobility; -Frequent incontinence. Review of resident's Care Plan showed the resident is at risk for falls and has a history of falls. Review of resident's progress notes showed the following: -On 02/05/26, the resident fell, scraping and bruising his/her left eyebrow area. Staff completed a neurological check at the time of the fall. No additional documentation of follow-up neurological checks complete; -On 02/06/26, the resident fell, unwitnessed by staff. Staff found the resident on the floor, halfway under his/her bed. Staff noted a bruise on left temple but indicated it could have occurred during the fall on the previous day. The facility sent the resident to the hospital for evaluation, and they returned the same day. No documentation of neurological checks complete; -On 02/25/26, staff noted Fall follow-up, and neurological checks completed. No progress notes present showing the day or time of a recent fall; (continued on next page)

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	04/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 04/02/26, the resident fell and had a knot (swollen) on the left side of the forehead. A neurological check was completed at the time of the fall. No additional documentation of follow-up neurological checks complete; -On 04/07/26, the resident fell, unwitnessed by staff. No injuries were noted, and a neurological check was completed at the time of the fall. No additional documentation of follow-up neurological checks complete. X. Review of Resident #15's face sheet showed the following: -admission date of 12/17/24; -Diagnoses of Parkinson's disease; chronic kidney disease; osteoporosis (thinning and weakening of the bones); history of bone fractures; history of falls. Review of resident's comprehensive MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Dependent on staff for personal hygiene; -Requires substantial/maximum staff assistance with toileting and transfers; -Wheelchair for mobility; -Always incontinent. Review of resident's Care Plan showed the resident is at risk for falls and has a history of falls. Review of resident's progress notes showed the following: -On 02/08/26 the resident fell and scraped his/her forehead. A neurological check was completed at the time of the fall. No additional documentation of follow-up neurological checks complete; -On 3/30/26 the resident fell, unwitnessed by staff and had a raised (swollen) and bruised area around one eye, close to the nose. A neurological check was completed at the time of the fall. No additional documentation of follow-up neurological checks complete.

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	04/10/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure all food was served at a safe and appetizing temperature when staff failed to hold four pureed meals at an appropriate temperatures prior to serve out. The facility census was 57. Review of the facility policy titled, Food Temperatures, dated May 2015, showed the following:-The Dietary Manager (DM) or designee is responsible for seeing that all food is the proper serving temperature(s) before trays are assembled;-Keep the temperature of hot foods no less than 140degrees Fahrenheit (F) during meal service;-Hot food should be at least 120 degrees F when served to the resident.Review of the facility policy titled, Food Preparation and Distribution, dated May 2015, showed the following:-Food is not placed in the steam table more than 30 minutes before meal service. Food is not held in warm ovens more than 30 minutes before meal service. Do not hold food on a steam table longer than two hours;-Do not hold potentially hazardous foods at room temperature during meal service;-Do not portion out food items such as soup and pureed food ahead of time.Observation on 04/07/26, beginning at 11:12 A.M., showed the following:-Dietary [NAME] (DC) H began pureeing hot dogs and spinach for serve out of four puree meals;-DC H poured the finished pureed hot dogs and spinach in plastic serving bowls and covered them in plastic wrap and placed them directly on the steam table. Observation on 04/07/26, at 11:53 A.M., showed the temperature of the pureed hot dogs on the steam table to be 114 degrees F and the temperature of the pureed spinach to be 110 degrees F.Observation on 04/07/26, at 12:10 P.M., showed DC H served out two puree meals for the memory care unit without reheating the meals.Observation on 04/07/26, at 12:28 PM., showed DC H served out the remaining two puree meals to the dining room without reheating the meals. During an interview on 04/07/26, at 1:07 P.M., DC H said the following:-Foods on the steam table should be at a minimum holding temperature of 140 degrees F;-He/she should not have served the puree meals at the holding temperatures of 114 degrees F and 110 degrees F.During an interview on 04/09/26, at 2:41 P.M. the Dietary Manger (DM) said the following:-Pureed foods should not be portioned out before placed on the steam table;-Foods on the steam table should be holding at a minimum temperature of 155 degrees F;-Food temperatures should never be as low as 114 degrees F and 110 degrees F and should not be served at these temperatures. During an interview on 04/14/26, at 8:03 A.M., the Registered Dietician said the following:-Foods on the steam table should be holding at a minimum of 140 degrees F;-Food temperatures on the steam table of 114 degrees F and 110 degrees F are not appropriate for serve out.During an interview on 04/10/26, at 2:59 P.M., the Administrator said the following:-Foods on the steam table should be holding at a minimum temperature of 145 degrees F;-Staff should not serve food from the steam table holding at 114 degrees F and 110 degrees F.

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	04/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review and interview, the facility failed to maintain an effective infection prevention and control program when the facility failed to have processes in place to ensure all new staff were screened prior to employment for tuberculosis (TB - a serious illness that mainly affects the lungs and can be spread when a person with the illness coughs, sneezes or sings) when the facility failed to fully complete TB testing for five staff (Maintenance Director (MD), Medical Records (MR), Housekeeper (HK) C, Certified Nursing Assistant (CNA) A, and Registered Nurse (RN) B). The facility census was 57.Review of 19 CSR 20-20.100 Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities showed the following:-Long-term care facilities shall screen their residents and staff for tuberculosis using the Mantoux method purified protein derivative (PPD) five tuberculin unit (5 TU) test;-Each facility shall be responsible for ensuring that all test results are completed, and that documentation is maintained for all residents, employees, and volunteers;-All new long-term care facility employees and volunteers who work ten or more hours per week are required to obtain a Mantoux PPD two-step tuberculin test within one month prior to starting employment in the facility;-If the initial test is zero to nine millimeters (mm), the second test should be given as soon as possible within three weeks after employment begins, unless documentation is provided indicating a Mantoux PPD test in the past and at least one subsequent annual test within the past two years;-It is the responsibility of each facility to maintain a documentation of each employee's and volunteer's tuberculin status.Review of facility policy named Tuberculosis Control, undated, showed the following:-Initially, the facility provides a TB test to all employees prior to employment. If the initial skin test result is 0 to 9 mm, a second test should be given at least one week later and no more than three weeks after the first test;-All TB test results will be documented on the employee immunization record including new hires and annual administration;-After the test has been administered, the results will be documented in mm;-Documented evidence of prior PPD will be maintained with facility employee immunization records. 1. Review of the MD's personnel file showed the following:-A hire date of 07/11/25;-The first step of the TB skin test was administered on 12/02/25 (approximately five months after hire, and after contact with residents).2. Review of the MR's personnel file showed the following:-A hire date of 09/23/24;-The first step of the TB skin test was administered 06/26/25 (approximately nine months after hire, and after contact with residents). 3. Review of HK C's personnel file showed the following:-A hire date of 01/29/25;-The first step of the TB skin test was administered on 01/29/25;-The facility failed to complete and document a second-step TB test.4. Review of CNA A's personnel file showed the following:-A hire date of 12/15/25;-The first step of the TB skin test was administered on 12/15/25;-The facility administered the second TB skin test on 01/13/26 (approximately four weeks after the first TB test).5. Review of RN B's personnel file showed the following:-A hire date of 02/17/25;-The first step of the TB skin test was administered on 02/14/25;-The facility administered the second TB skin test on 03/28/25 (approximately six weeks after the first TB test).6. During an interview on 04/10/26, at 1:32 P.M., the Director of Nursing (DON) said all employees should have a TB test or screening prior to starting work at the facility with residents. During an interview on 04/10/26, at 1:52 P.M., the Administrator said all employees should have a negative TB test, or other screening like an x-ray, prior to working in the building.

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	04/10/2026

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN - form CMS-10055) at the initiation, reduction, or termination of Medicare Part A benefits for one of three sampled residents (Resident #1) who remained in the facility upon discharge from Medicare Part A services. The facility census was 57.Review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C -09-20), dated 01/09/09, showed the following information:-The Notice of Medicare Provider Non-Coverage (NOMNC - form CMS-10123) issued when all covered Medicare services end for coverage reasons;-If the skilled nursing facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by use of SNFABN (form CMS-10055);-The SNFABN provides an estimated cost of items or services in case the beneficiary has to pay for them his/herself or through other insurance they may have;-If the SNF provides the beneficiary with the SNFABN at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination.Review showed the facility did not provide a policy related to giving the residents or resident representative the the SNFABN form CMS-10055.1. Review of Resident #1's SNF Beneficiary Protection Notification Review showed the following information:-On 12/31/25, Medicare Part A skilled services started;-Staff noted 02/09/25 as the last covered day of Medicare Part A service;-A Notice of Medicare Non-Coverage (NOMNC - form CMS-10123) was provided in writing;-Facility staff did not provide the resident or his/her legal representative the SNFABN - form CMS-10055 or alternative denial letter.During an interview on 04/09/26, at 2:15 P.M., the Business Office Manager said she missed sending out the required notification (SNFABN form CMS-10055). The facility should have given the notification to the resident prior to being discharged from therapy.During an interview on 04/09/26, at 2:45 P.M., the Administrator said she didn't know all required forms were not sent to residents after Medicare Part A services were being terminated. The facility should have given the notification to the resident prior to being discharged from therapy.

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	04/10/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a clean, comfortable, and homelike environment when staff failed to ensure one resident's (Resident #19) room was free of odors. The facility census was 57.1. Review of Resident #19's face sheet (brief resident profile) showed the following:-admission date of 03/20/26;-Diagnoses included fracture of unspecified part of neck of left femur (broken hip), vascular dementia (progressive decline in thinking, memory and behavior caused by impaired blood flow to the brain), heart disease, stroke, and obsessive compulsive disorder (chronic mental health condition characterized by uncontrollable recurring thoughts and repetitive behaviors).Review of the resident's admission Minimum Data Set (MDS-a federally mandated comprehensive assessment tool completed by staff), dated 03/26/26, showed the following:-Cognitively intact;-Required substantial assistance from staff for toileting;-Frequently incontinent of bladder. Observation on 04/06/26, at 2:40 P.M., showed the resident lay in bed eating lunch. The area of his/her room had a very strong odor of urine.Review of the resident's care plan, last revised 04/08/26, showed the following:-Resident experienced occasional bladder incontinence and had a diagnosis of benign prostatic hyperplasia (BPH-common, non-cancerous enlargement of the prostate gland in men that compresses the urethra and disrupts urination);-Resident will maintain current level of bladder and bowel continence through review period;-Provide assistance for toileting;-Provide incontinence care after each incontinent episode;-Use chux (highly absorbent under pads used to protect mattresses), brief when resident is in bed. Use brief when out of bed.Observation on 04/08/26, at 9:08 A.M., showed the resident lay in bed eating breakfast. The area of his/her room had a very strong odor of urine. Observation on 04/08/26, at 2:17 P.M., showed the resident lay in bed. The smell of urine remained very strong. Staff came in to assist the resident with using the urinal. Observation on 04/09/26, at 10:55 A.M., showed the following:-Resident lay in bed with his/her eyes closed;-The resident's urinal sat on the dresser next to his/her bed and contained a small amount of urine;-The urinal had a residue-like substance all over the inside and had an extremely strong odor of urine when up close and caused the room to have a strong odor of urine.Observation on 04/09/26, at 12:30 P.M., showed the resident's room had a strong odor of urine when walking to the resident's side of the room. The urinal on the dresser by the bed, which contained about the same amount of urine continued to have an extremely strong odor of urine up close. During an interview on 04/10/26, at 9:56 A.M., Certified Nursing Assistant (CNA) D said the following:-Staff should provide incontinent care a minimum of every two hours;-Staff should empty urinals as needed when in the room providing care;-He/she emptied the urinal in the toilet and then rinsed it out with water in the sink and emptied it in the toilet again;-The resident used the call light to advise staff when he/she needs to use the urinal;-He/she has noticed the strong smell of urine in the resident's room;-Staff should replace urinals that have residue and odor. During an interview on 04/10/26, at 10:36 A.M., CNA E said the following:-Staff should provide incontinent care every two hours;-Staff should empty urinals when providing incontinent care;-He/she emptied the urinal in the toilet and does not rinse it out;-The resident wanted to use the urinal unassisted but struggled and spilled urine;-He/she had not noticed a strong smell of urine this week or that the resident's urinal had residue inside and a strong odor of urine;-He/she would notify the charge nurse if a urinal had odor and residue.During an interview on 04/10/26, at 12:34 P.M., Registered Nurse (RN) F said the following:-Staff should provide incontinent care and empty urinals every two hours or as needed:-Staff should empty the urinal, rinse the urinal, and empty it again ensuring it is clean;-Staff should replace the urinal if it has an odor and residue;-If there is an odor of urine in a resident room, staff should determine what is causing the odor and correct it. During an interview on 04/10/26, at 1:49 P.M., the Director of Nursing (DON) said the following:-Staff should provide incontinent care every two hours;-Staff should empty urinals every two hours. When staff observe urine in the urinal, (continued on next page)

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	04/10/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or when a resident requests, it should be emptied;-Staff should empty the urinal in the toilet and take it to the soil/utility room to rinse if needed;-Staff should replace urinals that have residue and odors;-The resident has worked with therapy to be able to use the urinal without spilling;-Staff should locate the origin of urine odor and correct the issue;-He/she noticed the odor of urine coming from the room last night and had staff go in to investigate.During an interview on 04/10/26, at 2:59 P.M., the Administrator said the following:-Staff should provide incontinent care a minimum of every two hours;-Staff should empty urinals when they observe urine in it, every two hours, or when a resident requests;-Staff should empty urinals in the toilet, rinse them from the sink, and empty them in the toilet again;-Staff should change urinals out monthly or as needed;-Staff should determine the cause of a urine odor in a resident's room and correct it.

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	04/10/2026

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a system in place that clearly and consistently represented each resident's choice of code status (whether or not the resident wished to receive cardiopulmonary resuscitation (CPR - an emergency procedure used during cardiac or respiratory arrest)) when staff failed to ensure two residents' (Resident #1 and Resident #26) code status was consistent throughout the medical record. The facility census was 57.Review of the facility policy titled, Advance Directive, undated, showed the following:-admission of a resident to the facility, the social services designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an advanced directive;-Upon admission of a resident, the social service designee will inquire of the resident, and/or his/her family members, about the existence of any written advanced directives;-Information about whether the resident has executed an advanced directive shall be displayed prominently in the medical record under the advanced directive tab. 1. Review of Resident #1's electronic face sheet (brief resident profile) showed the following:-admission date of [DATE];-Code status of do not resuscitate (DNR – does not wish to receive CPR). Review of the resident's current Physician Order Sheet (POS) showed an order, dated [DATE], for code status of DNR. Review of the resident's care plan, last revised [DATE], showed code status of DNR. Review of the binder titled, Resident Face Sheet, located at the nurses' station, on [DATE], showed full code (wished to receive CPR) on the resident's face sheet. The resident's Outside the Hospital Do-Not-Resuscitate Order (OHDNR) signed [DATE], was located behind the resident's face sheet. 2. Review of Resident #26's electronic face sheet showed the following:-admission date of [DATE];-Code status of DNR. Review of the resident's care plan, revised on [DATE], showed a code status of DNR. Review of the resident's current POS, dated [DATE], showed a code status of DNR. Review of the binder titled, Resident Face Sheet, located at the nurses' station, on [DATE], showed full code on the resident's face sheet. The resident's OHDNR signed on [DATE] by resident representative and physician, was located behind the resident's face sheet. 3. During an interview on [DATE], at 9:56 A.M., Certified Nursing Assistant (CNA) D said the following:-Staff can find a resident's code status on the name plate outside the rooms. [NAME] is for full code and red is for DNR;-He/she did not refer to the resident face sheet binder because it belonged to the nurses;-He/she would immediately notify the nurse if a resident was having a code situation. During an interview on [DATE], at 10:36 A.M., CNA E said the following:-Staff can find resident code (continued on next page)

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	04/10/2026

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status on the name tag outside the resident's room. Red is DNR and green is full code;-If a resident's name is not on the name tag, he/she would ask the charge nurse for the code status or refer to the care plan;-He/she would notify the nurse immediately of a code situation. During an interview on [DATE], at 12:34 P.M., Registered Nurse (RN) G said the following:-Staff can find resident code status on the outside of the resident's room on the name plate. Pink is DNR and green is full code. Code status is also located on the resident banner in electronic record system;-He/she printed the face sheet containing the code status from electronic record system and made a copy of the OHDNR from the Resident Face Sheet binder at the nurses' station to send with a resident going to the hospital;-He/she was unaware that Resident #1's and Resident #26's face sheets in the Resident Face Sheet binder showed full code, which was inconsistent with all other documentation of code status for the residents;-All resident records should reflect consistent code status. During an interview on [DATE], at 1:22 P.M., Social Services (SS) said the following:-She was responsible for the accuracy of the information in the Resident Face Sheet binder;-All documented code status for each resident should be consistent;-She recently checked all resident code status for accuracy and checked every couple of months. During an interview on [DATE], at 1:49 P.M., the Director of Nursing (DON) said the following:-Staff can find resident code status on the name plates outside a resident's door, the Resident Face Sheet binder at the nurses' station, or on the resident banner in electronic record system;-All resident records should reflect consistent code status;-She was responsible for the accuracy of code status; however, SS was responsible for the accuracy of the Resident Face Sheet binder;-There was no system in place for audits for code status. During an interview on [DATE], at 2:59 P.M., the Administrator said the following:-Resident code status should be consistent across all records;-SS was responsible for the accuracy of the Resident Face Sheet binder;-The DON and records staff conduct audits of code status on a bi-monthly basis.

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	04/10/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure all resident with pressure ulcers received care per standards of practice when staff failed to properly identify, adequately assess, and monitor the skin condition for one resident (Resident #2) with two pressure ulcers, one stage 3 (a full thickness skin loss injury, appearing as a deep crater extending through the dermis into subcutaneous fat), and one unstageable (a full thickness tissue loss where the actual depth is hidden below eschar (tan, brown, or black hardened tissue). The facility census was 57.Review of the facility policy titled, Care and Prevention of Pressure Ulcer, undated, showed:-Treatment of pressure ulcers will vary depending on the orders of the attending physician;-The nurse is responsible for carrying out the treatment as ordered by the attending physician and for implementing measure to prevent pressure ulcers;-Observe skin, any persistent reddened area that remains after pressure is relieved is a high-risk area for a pressure ulcer to begin. Review of the facility policy titled, Charting and Documenting, undated, section for skin lesions, showed documentation should include the following:-Specific location of the skin care problem;-Number, size, degree, and measurement of pressure sores;-Documentation that skin surfaces are looked at regularly for the resident at risk or residents exhibiting any rash, irritation, or other skin problem;-Regular observation of skin surfaces that touch each other;-Clear indication of contributing factors to the development of the skin condition (such as inactivity, incontinence, undernourished);-Documentation of the cause of pressure sores developed in-house, as well as substantiation of preventative interventions;-Turning and positioning schedules to prevent undue pressure, pressure sores, etcetera;-Any changes in the resident's condition or response to treatment;-Progress, deterioration, or the development or new problems;-Use of special creams, lotions, medications, or protective devices;-The cause of any bruise or wound;-Consultation of any bruise or wound;-Other pertinent observations;-Signature and title of person recording the data. 1. Review of Resident #2's face sheet showed:-admission date of 08/20/25;-Diagnoses includedstroke with hemiplegia (paralysis of one side of the body).Review of the resident's current Physician Orders (POS), dated 03/04/26, showed an order for weekly skin assessment completed on Wednesdays, 6:00 P.M. - 6:00 A.M. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 03/07/26, showed the following:-Moderate cognitive impairment;-Did not reject care;-The resident had no current pressure ulcers ;-At risk for development of pressure ulcers;-Presence of unhealed pressure ulcers;-Pressure reducing device for chair and bed. Review of the resident's March 2026 Medication Administration Record (MAR) showed staff initialed completion of the weekly skin assessment on 03/04/26.Review of the resident's weekly skin assessment, dated 03/05/26, showed a nurse documented the following:-Existing non-foot skin issue;-Edema (swelling of tissue);-Right heel soft;-Left heel soft;-Resident had pressure reducing device for bed and chair;-Left foot and ankle existing issue;-Resident had thin, dry, frail skin, with continued ulcer at foley catheter (a thin, flexible tube inserted into the body to drain fluids (like urine)) site, edema in groin, and intermittent scabs;-Treatment in place and effective;-Continue foley care, apply ointment to ulcer, and monitor for increased edema and any scabbed or open areas.Review of the resident's March 2026 MAR showed staff initialed completion of the weekly skin assessment on 03/11/26.Review of the resident's weekly skin assessment, dated 03/12/26, showed a nurse documented the following:-Existing non-foot skin issue;-Edema;-Right heel firm;-Left heel firm;-Resident had pressure reducing device for bed and chair;-Left foot and ankle, no issues;-Right foot and ankle, no issues;-Continue foley catheter care, apply ointment to ulcer, monitor for increased edema to groin and any scabbed or open areas;-Treatment in place, effective;-Continue foley care, apply ointment to ulcer, monitor for increased edema and any scabbed or open areas. Consult with podiatry as needed for any toenail issues.Review of the resident's care plan, revised 03/16/26, showed the following:-Resident at risk for skin breakdown related to impaired mobility, incontinence, (continued on next page)

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	04/10/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and disease process;-Report any areas of skin breakdown to the physician as needed for appropriate treatment orders;-Weekly skin checks by the licensed nurse with quarterly pressure ulcer risk assessments;-During staff assisted showers, note and report any areas of redness/breakdown to the charge nurse;-Provide resident treatments as ordered. Review of the resident's March 2026 MAR showed staff initialed completion of the weekly skin assessment on 03/18/26.Review of the resident's progress notes showed no entries from 03/18/26.Review of the resident's weekly skin assessment, dated 03/19/26, showed a nurse documented the following:-Existing non-foot skin issue;-Edema;-Right heel firm;-Left heel soft;-Resident had pressure reducing device for bed and chair;-Left foot and ankle, existing issues;-Right foot and ankle, existing issues;-Resident had thin, dry, frail skin, had an ulcer at foley catheter site, edema in groin area, and intermittent scabs;-Treatment in place, effective;-Continue foley care, apply ointment to ulcer, monitor for increased edema and any scabbed or open areas.Review of the resident's progress notes showed no entries from 03/19/26 to 03/25/26.Review of the resident's March 2026 MAR showed staff initialed completion of the weekly skin assessment on 03/25/26.Review of the resident's progress notes showed no entries from 03/26/26 to 03/29/26.Review of the resident's March 2026 MAR showed the following: -An order, dated 03/29/26, for left ankle. Staff to cleanse with pure and cleanse, pat dry, apply calcium alginate (advanced wound care products made from brown seaweed) to base of wound, apply border foam dressing. Change on Tuesday and Friday, 6:00 A.M.-6:00 P.M.;-Staff initialed completion of the treatment one time on Tuesday, 03/31/26.Review of the resident's progress notes showed no entries from 03/29/26 to 03/31/26.Review of the resident's progress note, dated 04/01/26, did not address the condition of the resident's skin. Review of the resident's weekly skin assessment, dated 04/02/26, showed:-Existing non-foot skin issue;-Edema;-Right heel firm;-Left heel firm;-Resident had pressure reducing device for bed and chair;-Left foot and ankle existing issue;-Right foot and ankle existing issue;-Resident had thin, dry, frail skin, has an ulcer at foley catheter site, edema in groin area, and intermittent scabs;-Treatment in place, effective;-Continue foley care, apply ointment to ulcer, monitor for increased edema and any scabbed or open areas.(The assessment did not include a wound assessment of the resident's left ankle wound.)Review of the resident's progress notes showed no entries for 04/02/26 to 04/03/26. Review of the resident's April 2026 MAR showed the following order:-An order, dated 03/29/26, for left ankle, staff to cleanse with pure and cleanse, pat dry, apply calcium alginate to base of wound, apply border foam dressing. Change on Tuesday and Friday, 6:00 A.M.-6:00 P.M.;-Staff did not initial completion of the treatment on Friday 04/03/26 (left blank); Review of the resident's progress notes showed no entry for 04/04/26. Review of the resident's progress note, dated 04/05/26, did not address the condition of the skin or the resident's left heel wound. Review of the resident's progress notes showed no entries for 04/06/26 to 04/07/26.Observation and interview with the resident on 04/07/26, at 1:25 P.M., showed the following:-The resident said he/she had a sore on his/her left heel;-The resident said his/her heels hurt but the padded heel protectors helped relieve the pain;-The resident wore socks with no heel protectors.Review of the resident's April 2026 MAR showed the following:-An order, dated 03/29/26, for left ankle, staff to cleanse with pure and cleanse, pat dry, apply calcium alginate to base of wound, and apply border foam dressing. Change on Tuesday and Friday, 6:00 A.M.-6:00 P.M.;-Staff initialed completion of the treatment on Tuesday, 04/07/26.Review of the resident's progress notes showed no entries for 04/08/26 to 04/09/26.Review of the resident's weekly skin assessment, dated 04/09/26, showed:-Existing non-foot skin issue;-Edema;-Right heel firm;-Left heel other;-Resident has pressure reducing device for bed and chair;-Left foot and ankle existing issue;-Right foot and ankle, no issues;-Resident with dry, fragile, flaky skin. Resident on blood thinners and noted to have scattered bruising to bilateral upper extremities. Resident with wound to left ankle/heel area with dressing in place. Resident with contracture to left lower extremity. Trace to 1+ edema noted. Steri-strips in place to the resident's right forearm due to old skin tear. No signs/symptoms of infection noted. Resident with foley catheter in place. No other skin issues or (continued on next page)

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	04/10/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns noted at this time. Continue with current plan of care.-Treatment in place, effective;-Comments regarding treatments and interventions was left blank.(The assessment mentioned the presence of the resident's left ankle wound, but did not include a complete wound assessment of the wound.) Observation and interview on 04/10/26, at 9:55 A.M., showed the following:-The Wound Nurse Practictioner (NP) and Registered Nurse (RN) F entered the resident's room to assess the residents wounds;-RN F removed a dressing from the resident's left lateral heel to expose an open pressure ulcer measuring 1.8 centimenter (cm) by 1.0 cm by 0.20 cm deep;-The wound NP said the wound was a Stage 3 pressure ulcer;-The resident also had a dark brown scabbed area to his/her right great toe;-The NP said the left great toe was an unstageable pressure ulcer measuring 0.25 cm, approximately;-The Wound NP said today, 04/10/26 was the first time the facility had asked him/her to see the resident and assess his/her wounds.Review of the resident's Wound Assessment Report, created 04/10/26, by the Wound NP, showed the following:-Date of service: 04/10/2026-Wound Evaluation Date: 04/10/2026-Location: Left lateral heel. Measurements: Length: 1.80 cm, Width: 1.00 cm, and Depth: 0.20 cm;-Pressure Ulcer/Injury, Stage 3;=Acquired in House: Yes;-Date Wound Acquired: 03/10/26; -Wound Status: First evaluation of existing wound by new provider;100% granulation tissue (healthy pink/red tissue);-Periwound: Fragile;-Exudate (drainage) Amount: Moderate;-Exudate Description: Serosanguineous;-Odor Post Cleansing: None;-Treatment: Dressing change frequency of every other day, clean wound with wound cleanser. Primary treatment of calcium alginate with skin prep surrounding tissue or peri wound. Other dressings of bordered foam.Review of the resident's medical record showed no wound assessment of the resident's left heel (ankle) pressure ulcer or right great toe pressure ulcer prior to skin wound note, dated 04/10/26. During an interview on 04/10/26, at 10:00 A.M., RN F said the following:-He/she suspected the resident developed the left lateral heel pressure ulcer due to his/her left leg contracture and the left heel rubbing against the other leg;-Staff repositioned the resident and applied heel protectors to the resident's feet to try to decrease pressure;-The resident had a left outer heel pressure ulcer for approximately one month;-The resident's left outer heel was scabbed over until about one week ago;-Prior to today 04/10/26, nurses had not been documenting wound assessments on the resident's left outer heel or right great toe. The nurse was not aware of the right great toe area until today;-Prior to today RN F did not realize the resident's wounds would be considered pressure ulcers. During an interview on 04/10/26, at 10:16 A.M., the Director of Nursing (DON) said the following:-The nurses were responsible for completing their assigned weekly skin assessments;-If nurses identified a pressure ulcer, they should notify the DON immediately, but no later than the next business day;-One of the nurses started a treatment on the resident's left outer heel pressure ulcer on 03/29/26, but failed to notify the DON;-The DON was not aware the resident had any pressure ulcers until 04/09/26;-The DON documented the weekly wound assessments in the electronic health record and if the wound company's NP assessed a resident, the DON would use the NP wound measurements/assessments;-The wound company's NP came to the facility weekly and completed assessments on resident's with open wounds;-The wound NP saw the resident for the first time today, 04/10/26.Review of the resident's skin and wound note dated 04/10/26, at 12:43 P.M., showed the Wound NP documented the following:-Reason for visit: First evaluation of existing wound patient by new wound care team;-Consulted for wound to left heel. First noted one month ago. Patient long termresident at facility;-Positive for contractures and edema to the left lower extremity (LLE);-Facility has been using autolytic (a wound dressing that uses the body's own enzymes to clean necrotic (dead) tissue), calcium alginate, and a foam dressing to the wound;-Skin: history of a chronic wound, history of a pressure ulcer;-Wound assessment: Wound: 1, location: Left lateral heel;-Pressure Ulcer/Injury. Stage/Severity: Stage 3;-Wound Status: First Evaluation of existing wound by new provider;-Size: 1.8 centimeter (cm) x 1.0 cm x 0.2 cm. Calculated area is 1.8 sq cm;-Odor Post Cleansing: None;-Peri wound: Fragile;-Wound Base: 100% granulation;-Exudate: Moderate amount of serosanguineous (plasma and blood);-Risk factors: The patient has the following (continued on next page)

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	04/10/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	factors that affect wound healing: Hemiplegia, bowel and bladder incontinence, high blood pressure, inability to position self, limited weight bearing status, reduced mobility, risk of pressure ulcer formation, muscle wasting, generalized weakness, and contractures. The following plan is in place to address these factors: behavioral redirection, air Mattress, heel offloading, offload pressure per facility protocol, offloading chair cushion , optimize nutrition, pressure redistribution mattress, protein supplements, and turn and reposition;-Wound treatment: Wound # 1 Left lateral heel Pressure Ulcer/Injury;-Treatment Recommendations: Cleanse with wound cleanser, apply calcium alginate, skin prep surrounding tissue, secure with bordered foam, and change every other day;-Assessment/plan: The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressurereduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. Float heels while in bed with use of the facility's preferred equipment, pillows/boots. Float heels while in bed with use of pressure relieving boots. Continue with turning and repositioning schedule per protocol for pressure prevention. Position patient side to side as tolerated. The resident is incontinent of bowel and bladder. Use appropriate moisture barrier creams per formulary to provide thorough skin care with each incontinent episode. Use formulary briefs when indicated to manage moisture and assess often. Rounded with floor nurse on initial visit today. Consulted for wound to left lateral heel. According to nurse first noted one month ago. Alert to self. Contractures present. Incontinent of bowel and bladder. Wearing heel protectors. Edema present to LLE, need to place tubi grips. Wound to left heel with good granulation tissue. Peri area fragile skin. According to nurse wound has improved since first started. Will start treatment of calcium alginate, border foam, and change every other day. Ensure patient heels are floating and staff should turn the resident every two hours. Frequent incontinence checks. Will reassess next week.During an interview on 04/10/26, at 1:05 P.M., Certified Nurse Assistant (CNA) E said the following:-He/she had not observed the resident's left outer heel open area, but the resident had been wearing a bandage for at least the last two weeks;-He/she thought the resident's pressure ulcer to his/her left outer heel was from lying in bed;-The resident had a scab on his or her right great toe, but the CNA was unsure how long the resident had the right great toe scabbed area. During an interview on 04/10/26 at 1:15 P.M. CNA K said the following:-He/she was aware the resident had an open area to his/her left outer heel, but the area generally had a bandage over it;-He/she was unsure how long the resident had the open area on his/her left outer heel.During an interview on 4/10/26 at 3:50 P.M., the Administrator said the following:-He/she expected nurses to complete and document weekly skin assessments on all residents; -The DON should review all the weekly skin assessments;-If staff observed a resident pressure wound, the CNA should report to the charge nurse, and the charge nurse should report to the DON;-The nurse should document an initial assessment of the wound in the progress notes or wound assessment;-The DON was responsible for completing the weekly wound assessments.

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	04/10/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to provide services to prevent possible urinary tract infections (UTIs) when staff allowed the resident's urinary catheter (a thin, flexible tube inserted into the body to drain urine) tubing to touch the floor, increasing the risk of infection for one resident (Resident #2). The facility census was 57. Review of the facility policy titled, Catheter, Emptying a Urinary Drainage Bag, undated, showed staff to keep the drainage bag and tubing off the floor, at all times, to prevent contamination and damage. 1. Review of Resident #2's face sheet showed:-admission date of 08/20/25;-Diagnoses included benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 03/07/26, showed the following:-Moderate cognitive impairment;-Dependent on staff for assistance with toileting hygiene, lower body dressing, taking shoes on and off, personal hygiene, transfers, and bed mobility;-Presence of indwelling urinary catheter. Review of the resident's care plan, updated 03/16/26, showed the following:-Resident required an indwelling catheter related to prostatic hyperplasia and frequent urinary tract infections;-Staff should not allow the resident's catheter tubing or any part of the drainage system to touch the floor;-Avoid obstruction in the drainage; -Position the drainage bag below the level of the bladder. Observations on 04/06/26, at 5:45 P.M. and 6:15 P.M., showed the following:-The resident sat in a wheelchair in the dining room;-The resident's catheter drainage bag hung under the resident's wheelchair in a dignity bag;-The resident's catheter tubing lay on the dining room floor under the wheelchair. Observation on 04/07/26, at 7:35 A.M., showed the following:-The resident sat in a wheelchair in the dining room eating breakfast;-The resident's catheter tubing lay on the floor under his/her wheelchair;-The tubing contained dark yellow urine. Observation on 04/10/26, at 8:10 A.M., showed:-A Certified Nurse Assistant (CNA) J propelled the resident from his/her room down the hallway to the dining room;-The resident's urinary catheter tubing drug the floor under the resident's wheelchair. During an interview on 04/10/26, at 8:12 A.M., CNA J said the following:-When he/she transferred the resident to his/her wheelchair, he/she placed the catheter bag into a cloth dignity bag under the resident's wheelchair;-He/she tried to ensure the catheter tubing did not drag the ground;-If staff allowed the resident's catheter tubing to drag the ground, this could increase the resident's risk of infection. During an interview on 04/10/26, at 9:46 A.M., CNA D said the following:-Some staff did not know to place the resident's catheter bag high enough under the wheelchair, so the tubing did not drag the ground;-He/she tried to elevate the catheter bag high enough under the wheelchair so that the tube did not drag.During an interview on 04/10/26, at 1:05 P.M., CNA E said when the resident's catheter tubing lay on the ground, the staff should raise the catheter bag and hook it in a higher location under the wheelchair or place the excess tubing in the privacy bag.During an interview on 04/10/26, at 10:16 A.M., the Director of Nursing (DON) said the following: -The resident's catheter tubing should not drag the ground;-The CNA or nurse should hang the catheter bag/tubing in a different location under the wheelchair to ensure the tubing does not drag on the floor;-Staff allowing a resident's catheter tube to drag the floor poses an infection risk to the resident. During an interview on 04/10/26, at 3:50 P.M., the Administrator said the following:-Staff should keep the resident's urinary catheter tube off the floor and in a dignity bag;-If staff allow a resident's catheter tube to drag the floor, this could lead to an increased risk of bacteria in the resident's urine.

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	04/10/2026

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #6) had physician orders for the care of his/her colostomy (a surgical procedure that creates an opening, called a stoma, in the abdominal wall) . The facility census was 57.Review of the facility policy titled, Colostomy and Ileostomy (a surgical procedure where the end of the small intestine (the ileum) is redirected through a new opening in the abdominal wall, called a stoma) Care, undated, purpose to prevent infection, skin irritation, alleviate unpleasant odors, and to obtain accurate bowel measurement output.1. Review of Resident #6's face sheet showed:-admission date of 02/04/25;-Diagnoses included paraplegia (paralysis of the lower half of the body), anxiety and depression. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 04/02/26, showed the following:-Resident cognitively intact;-Did not reject care;-Dependent on staff for assistance with toileting hygiene and lower body dressing;-Presence of colostomy. Review of the resident's care plan, dated 10/14/25, showed the following:-Resident at risk for constipation related to colostomy, decreased mobility;-Resident had a colostomy. Staff to provide cares each shift and as needed (PRN) and change the resident's bag as needed. Review of the resident's April 2026 Physician Orders showed the following:-An order, dated 11/26/25, for staff to assess the resident's stoma every shift to ensure functioning and color. Staff to document output color, consistency, and stoma color, stoma should be beefy red;-Staff did not document orders to change the resident's colostomy wafer or bag. Observation and interview on 04/06/26, at 11:05 A.M., showed:-The resident lay on his/her left side on the bed;-The resident said he/she had a colostomy and revealed a wafer and colostomy bag to his/her lower abdomen;-The resident said the staff change to colostomy wafer and bag when it leaks. During an interview on 04/09/26, at 9:30 A.M. Registered Nurse (RN) B said the following:-He/she thought the nurses changed the resident's colostomy wafer and bag approximately one time per week and more often if the wafer leaked stool;-The nurse said he/she was not certain of frequency of changes and would need to check the resident's physician's order;-The nurse checked the resident's electronic health record and did not find an order to change the colostomy wafer/stoma.-The resident should have a physician's order for colostomy wafer and bag changes.During an interview on 04/10/26, at 10:10 A.M., RN F said the following:-He/she was not aware the resident needed a physician's order for changing his/her colostomy wafer/bag;-He/she thought changing the wafer/bag was standard ostomy care;-He/she did not change the resident's colostomy wafer/bag unless it was loose or leaking.During an interview on 04/09/26, at 3:20 P.M., the Director of Nursing (DON) said the following:-Nursing staff should have obtained a physician's order for colostomy wafer/bag changes every four days and as needed;-The resident did not have a physician's order for changing of his/her colostomy wafer/bag, prior to 04/09/26. During an interview on 04/10/26, at 3:50 P.M., the Administrator said the following:-Nurses should obtain a physician's order for changing a resident's colostomy wafer/bag;-He/she was unsure how often a colostomy should be changed but thought probably at least every four days and as needed.

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	04/10/2026

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents with mental health services as needed when staff failed to consistently notify the physician and failed to develop a care plan regarding statement regarding death made by one resident (Resident #7) that made suicidal comments. The facility census was 57.Review of the facility policy titled, Suicide Threats, undated, showed the following:-Resident suicide threats shall be taken seriously and addressed appropriately;-Staff shall report any resident threats of suicide immediately to the charge nurse;-The charge nurse shall immediately assess the situation and shall notify the Director of Nursing (DON) of such threats;-A staff member shall remain with the resident until the charge nurse arrives to evaluate the resident;-After assessing the resident in more detail, the charge nurse shall notify the resident's attending physician and responsible party, and shall seek further direction from the physician;-All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately;-As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated;-If the resident remains in the facility, staff will monitor the resident's mood and behavior and updated care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present;-Staff shall document details of the situation objectively in the resident's medical record. 1.Review of Resident #7's face sheet showed:-admission date of 03/13/26;-Resident on hospice services;-Diagnoses included rectal cancer, liver cancer, pain, adjustment disorder, general anxiety disorder, depression, chronic fatigue, and weakness.Review of the resident's progress note dated 03/16/26, at 10:15 P.M., showed a nurse documented the resident had been making morbid jokes this shift. Resident had asked staff to bring him/her a gun and later wrapped a call light cord around his/her neck. Upon assessment the resident stated he/she was joking and denied any suicidal thoughts or ideation. The resident was placed on 15-minute checks out of an abundance of caution. The resident later made a joke to a nurse aide when they were getting him/her fresh linens to bring a body bag. Resident continued to deny suicidal thoughts or ideation. Resident laughing about making jokes. Continued on 15-minute checks out of abundance of caution. The resident was on hospice with rectal [NAME] and ceased cancer treatment prior to admitting to the facility. Resident pain controlled, call light and personal belongings in reach. (The nurse did not document notification of the resident's physician of the resident's comments.)Review of the resident's progress note dated 03/17/26, at 11:30 A.M., showed the Social Service Designee (SSD) documented the Social Services admission Assessment. This resident was admitted on [DATE], on hospice. The resident had stage 4 rectal cancer with chronic severe tumor related pain. Working on pain control. Most of the resident's depression stems from his/her medical condition. The resident stated if not for his/her pain he/she would not be nearly as depressed. Social services will continue to monitor and be available as needed.Review of the resident's progress note dated 03/23/26, at 3:07 A.M., showed a nurse documented the following:-Resident continued to request pain medication and pain medication administered twice;-No joking about death or dying this shift. Will continue to monitor for changes.Review of the resident's progress note, dated 03/23/26 at 11:19 A.M., showed a nurse documented the nurse aide came to the nurse and stated the resident told the aide, If I was strong enough, I would wrap the call light cord around my neck. Upon assessment resident stated he/she was in a lot of pain and no matter what position he/she was in it still hurt. The resident denied suicidal thoughts or ideation. Resident placed on 15-minute checks out of an abundance of caution. Resident received hospice services and had a terminal diagnosis of rectal cancer and had ceased cancer treatment. The resident did have a Fentanyl (a potent synthetic opioid medication used for (continued on next page)

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	04/10/2026

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain control) topical patch in place and given as needed (PRN) pain medication as prescribed. Resident's safety maintained throughout the shift. Call light, water, and personal belongings within reach. Staff to continue with current plan of care. (The nurse did not document notification of the resident's physician of the resident's comments.) Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 03/27/26, showed:-Moderate cognitive impairment;-Felt down, depressed, hopeless, 2 to 6 days;-Experienced hallucinations.Review of the resident's progress note dated 03/30/26, at 12:11 P.M., showed a nurse documented resident making multiple comments early this shift about wanting to die. When interviewed the resident denied having a plan though admitted feeling down and requested to speak to someone. The nurse contacted hospice and requested the social worker or chaplain come out to see the resident. Hospice social worker came to see the resident and updated this nurse afterward that the resident was struggling with his/her emotions due to uncontrolled pain. The nurse spoke with the medication technician and charge nurse and asked that the as needed pain medication be utilized to get the resident's pain under control The resident also expressed to the hospice social worker about wanting to see a psychologist. This nurse received physician orders for a psychologist referral, and the SSD sent a referral to psychologist. Review of the resident's progress note dated 03/30/26, at 3:13 P.M., showed a nurse documented the resident was very tearful this morning. The resident said, I just want to die. The nurse listened to the resident and offered to get clergy. The resident wanted a psychiatrist. The nurse told the resident he/she would try to find someone to talk with him/her. The resident was reassured. Resident is on as needed pain medication. Will continue to monitor. (The nurse did not document notification of the resident's physician of the resident's comments.) Review of the resident's progress note dated 03/31/26, at 2:08 P.M., showed the SSD documented he/she visited with the resident this afternoon and talked about how things have been very difficult to deal with. SSD asked the resident if that is why he/she makes comments such as wrapping a call light around his/her neck and the resident said yes. The SSD explained to the resident that everyone was working with the resident to get his/her pain under control. He/she asked the resident if he/she would like to talk to someone about everything that was going on regarding his/her cancer, emotions about it, and his/her future and the resident said he/she was willing to. SSD sent a referral to Licensed Clinical Social Worker (LCSW)/therapist to visit the resident. Review of the resident's progress note dated 03/31/26, at 9:19 P.M., showed a nurse documented resident seen by his/her medical physician this shift. The physician ordered Zoloft (an antidepressant), increased the resident's Fentanyl pain patch, and increased the resident's PRN pain pills. The resident notified and agreed with the changes. Review of the resident's care plan, revised 04/01/26 , showed the following:-Resident received antianxiety medication related to diagnosis of rectal cancer and anxiety diagnosis;-Resident received antipsychotic medication.-Assess if the resident's behavioral/mood symptoms present a danger to the resident or others. Intervene as needed;-Attempt non-pharmacological interventions;-Monitor for drug use effectiveness and adverse consequences;-Monitor the resident's mood and response to the medication;-Quantitively and objectively document the resident's behavior/mood. -Monitor the resident's behavior and response to the medication;-Monitor the resident's functional status every 3 months;-Review for continued need at least quarterly.(Staff did not care plan specifically regarding the resident's suicidal comments or any staff interventions specific to suicide prevention.)Review of the resident's Behavioral Health Diagnostic Assessment, signed 04/08/26, showed the Licensed Clinical Social Worker (LCSW) documented the following:-Resident reports worsening depression since cancer diagnosis, stating he/she had been really depressed particularly today as tomorrow was his/her birthday. The resident's primary concern was his/her unrelenting pain, loss of bowel control, and loss of independence after being self-sufficient in his/her entire life. Expressed that pain was the primary driver of distress, noting, If I could get over the pain, I would be 90% better. Goals include managing emotional impact of terminal illness and maintaining quality of life through activities like (continued on next page)

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	04/10/2026

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fishing;-Remote history of suicidal ideation in early 20's following broken engagement; resolved after approximately 5 years. Denies any suicidal ideation since that time. Currently, the resident denied suicidal thoughts, homicidal ideation, or intent to harm self or others. States I got over that and ever since then, no. No current safety concerns identified. Protective factors include spiritual beliefs, supportive relationships with sister and friends, engagement with hospice services, and desire to participate in meaningful activities like fishing. Does not fear something bad happening to him;-Initial plan and recommendations: Patient agreeable to weekly counseling visits. Treatment will focus on coping with terminal illness, managing emotional impact of severe chronic pain, adjusting to loss of independence, and supporting quality of life goals. Will explore opportunities for meaningful activities within physical limitations, particularly fishing outings with friend when feasible. Patient expressed that visits might help. Next appointment is in one week.Review of the resident's care plan, revised 04/01/26 , showed staff did not care plan specifically regarding the resident's suicidal comments or any staff interventions specific to suicide prevention. Observations and interview with the resident on 04/09/26, at 8:52 A.M., showed the following:-The resident sat in his/her room in a wheelchair eating breakfast;-When asked about depression, the resident said that he/she did feel down, despite his/her medication to treat depression;-The resident said his/her pain had improved since his/her pain medications were increased;-The resident said he/she did not have suicidal thoughts, but if he/she decided to commit suicide, no one would ever know until it was over. During an interview on 04/09/26, at 11:01 A.M. Registered Nurse (RN) B said the following:-The resident had pain, but he/she was on a lot of pain medication and was on hospice services;-The resident's pain was not well-controlled on admission;-The resident made suicidal comments, especially when he/she first came to the facility;-RN B had not heard the resident make suicidal comments, but some of the CNAs informed RN B;-The CNA's said the resident would wrap and call cord around his/her neck;-One of the other nurses documented the resident joked about wanting staff to bring a body bag and that he/she wanted to die;-When the CNAs reported the resident's behavior, the nurse placed the resident on every 15-minute checks and notified the DON;-The DON said the resident's comments and actions were his/her way of processing his/her terminal cancer diagnosis;-The nurse said he/she did not think about notifying the resident's physician.During an interview on 04/10/26, at 8:15 A.M., RN F said the following:-The resident made suicidal comments in the past;-The resident did not have a plan to kill him/herself;-The resident's physician knew about the resident's suicidal comments.During an interview on 04/10/26, at 8:16 A.M., the Hospice RN N said the following:-The resident reported depression, but denied suicidal thoughts;-RN N thought the resident might have said something about suicidal thoughts to the hospice admitting nurse and then hospice took steps, like getting the social worker and chaplain involved;-RN N thought when the resident's pain was out of control, he/she was making suicidal comments, but now that the resident's pain was under control, he/she was not making suicidal comments to staff. During an interview on 04/09/26, at 11:23 A.M. the Social Service Designee (SSD) said the following;-The SSD said the resident's comments were on the borderline of being suicidal;-The SSD said he/she and RN B recently discussed the resident's comments and, on a couple of occasions, CNAs reported to RN B the resident's comments and he/she placed the resident on 15-minute checks;-The resident reportedly told the CNA he/she hurt so much he/she wanted to put a cord around his/her neck;-The resident made suicidal comments, but had never attempted suicide;-The resident's pain was now under better control;-The SSD arranged for the resident to see a therapist, Licensed Clinical Social Worker (LCSW);-The LCSW visited the resident on 04/02/26;-The LCSW planned to see the resident weekly. During an interview on 04/09/26, at 3:20 P.M., the DON said the following:-The resident made comments about placing a call light cord around his/her neck and about ending his/her life;-When staff questioned the resident, he/she would say he/she was joking;-The resident denied suicidal ideation/thoughts;-When the resident's pain increased, the staff contacted hospice and was placed on a new pain regimen and since then had not been making comments;-The facility also made a psychology referral;-The resident had been up out of bed and (continued on next page)

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	04/10/2026

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	socializing more;-When the resident made suicidal comments, the nurse should have ensured the resident's immediate safety, notified the resident's physician, and documented notification, and any orders in the progress note. During an interview on 04/10/26, at 3:50 P.M., the Administrator said the following:-When the resident makes suicidal comments, the CNAs should notify the nurse, and the nurse should call resident's physician and responsible party;-The nurse should place the resident on 15-minute checks for at least 24 hours and then re-evaluate the resident's condition;-The nurse should document all in the progress notes;-Staff should care plan the resident's suicidal comments with specific interventions;-The facility should monitor the resident and possibly request a psychiatric evaluation.

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	04/10/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure a physician ordered medication was available for resident use for one resident (Resident #6) when staff did not obtain and did not administer his/her ordered bladder spasm medication for approximately four weeks. The facility census was 57.Review of the facility policy titled, Medications, Errors and Drug Reactions, undated, showed, in part, the following:-Purpose to safeguard the resident and provide emergency care as necessary;-Report all medication errors immediately to the resident's physician, Director of Nursing (DON), and Administrator;-Document and follow the physician orders. 1. Review of Resident #6's face sheet showed:-admission date of 02/04/25;-Diagnoses included overactive bladder, neuromuscular dysfunction of the bladder, anxiety and depression. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 04/02/26, showed the following:-Resident cognitively intact;-Dependent on staff for assistance with toileting hygiene and lower body dressing;-Presence of indwelling urinary catheter (a thin, flexible tube inserted into the body to drain fluids) and colostomy (a surgical procedure that creates an opening, called a stoma, in the abdominal wall).Review of the resident's care plan, dated 03/11/26, showed:-Resident had an indwelling urinary catheter related to a diagnosis of paraplegia and cauda equina syndrome (compression of the nerves at the base of the spine leading to paralysis of the lower body);-Resident will have his/her catheter care managed appropriately as evidenced by no signs of infection or trauma;-Administer medications. Evaluate, record, report effectiveness and any adverse side effects;-Assess the drainage every shift. Observe for leakage. Review of the resident's care plan, dated 03/11/26, showed:-Resident required a suprapubic catheter (a flexible tube surgically inserted through a small abdominal incision directly into the bladder to drain urine) related to a diagnosis of paraplegia and cauda equina syndrome;-Resident will have suprapubic catheter care managed appropriately as evidenced by not exhibiting obstruction, signs of infection, dislodgement of catheter, bowel perforation, or trauma;-Assess the drainage every shift. Observe for leakage;-Report complications. Review of the resident's March 2026 Physician Orders showed an active order, dated 02/09/26, for tolterodine (a bladder spasm medication), staff to administer 2 milligrams (mg) one tablet by mouth, two times per day, morning and night. Review of the resident's March 2026 Medication Administration Record (MAR) showed the following:-An order dated 02/09/26, for staff to administer tolterodine 2 mg one tablet two times per day, 6:00 A.M.-10:00 A.M. and 7:00 P.M.-10:00 P.M.;-On 03/11/26, 7:00 P.M.-10:00 P.M., medication not administered due to drug/item unavailable. Not in the stat safe (emergency medication);-On 03/12/26, 6:00 A.M.-10:00 A.M., medication not administered due to drug/item unavailable;-On 03/12/26, 7:00 P.M.-10:00 P.M., medication not administered due to drug/item unavailable and not in the stat safe;-On 03/13/26, 6:00 A.M.-10:00 A.M., medication not administered and discontinued. Medication was only for 30 days;-On 03/13/26, 7:00 P.M.-10:00 P.M., not administered due to drug/item unavailable and not in the stat safe;-On 03/14/26, 6:00 A.M.-10:00 A.M., not administered due to not in E-Kit (emergency medication);-On 03/14/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/15/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 03/15/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/16/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 03/16/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/17/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 03/17/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/18/26, 7:00 P.M.-10:00 P.M., not administered due to drug/item unavailable;-On 03/19/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 03/19/26, 7:00 P.M.-10:00 P.M., not administered due to drug/item unavailable and not in the stat safe;-On 03/20/26, 6:00 A.M.-10:00 A.M., not administered due to drug/item unavailable;-On 03/20/26, 7:00 P.M.-10:00 P.M., not administered due to drug/item unavailable and not in E-kit;-On 03/21/26, 6:00 (continued on next page)

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	04/10/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.M.-10:00 A.M., not administered due to drug/item unavailable;-On 03/21/26, 7:00 P.M.-10:00 P.M., not administered due to drug/item unavailable. Not in stat safe;-On 03/22/26, 6:00 A.M.-10:00 A.M., not administered due to drug/item unavailable and not in the stat safe;-On 03/22/26, 7:00 P.M.-10:00 P.M., not administered due to drug/item unavailable and not in the stat safe;-On 03/23/26, 6:00 A.M.-10:00 A.M., not administered due to drug/item unavailable;-On 03/23/26, 7:00 P.M.-10:00 P.M., not administered due to drug/item unavailable;-On 03/24/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 03/24/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/25/26, 6:00 A.M.-10:00 A.M., not administered due to refused;-On 03/25/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/26/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 03/26/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/27/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued.Review of the resident's progress note, dated 03/27/26, at 4:47 P.M., showed a nurse documented the following:-The resident's catheter was not flushing well with sediment noted in the tubing;-Resident noted to have yellow urine in the catheter bag, but stated, Maybe that is why I have been leaking a lot.;-The nurse changed out the resident's catheter using sterile technique;-After changing the catheter, the nurse noted urine as well as a moderate amount of sediment;-Nurse to continue with current plan of care. Review of the resident's March 2026 MAR showed the following: -An order, dated 02/09/26, for staff to administer tolterodine 2 mg one tablet two times per day, 6:00 A.M.-10:00 A.M. and 7:00 P.M.-10:00 P.M.;-On 03/27/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/28/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 03/28/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/29/26, 6:00 A.M.-10:00 A.M., not administered due to drug/item unavailable;-On 03/29/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/30/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 03/31/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 03/31/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued.Review of the resident progress notes, dated March 2026, showed staff did not document an order to discontinue the medication, physician notification of the missed doses, or pharmacy notification and follow-up regarding the medication not received. Review of the resident's April 2026 Physician Orders showed an active order, dated 02/09/26, for tolterodine staff to administer 2 mg one tablet by mouth, two times per day, morning and night. Review of the resident's April 2026 MAR showed:-An order dated 02/09/26, for staff to administer tolterodine 2 mg one tablet two times per day, 6:00 A.M.-10:00 A.M. and 7:00 P.M.-10:00 P.M.;-On 04/01/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 04/01/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 04/02/26, 6:00 A.M.-10:00 A.M., not administered due to waiting on clarification;-On 04/03/26, 7:00 P.M.-10:00 P.M., not administered due to drug/item unavailable;-On 04/04/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 04/04/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 04/05/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued;-On 04/05/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 04/06/26, 6:00 A.M.-10:00 A.M., not administered due to drug/item unavailable. Observation and interview with the resident on 04/06/26 at 11:05 A.M., showed the following:-The resident lay on his/her left side on the bed;-The resident had two urinary catheters, a Foley catheter and a suprapubic catheter;-The resident said his/her catheters leak urine at times due to bladder spasms.Review of the resident's April 2026 MAR showed:-An order dated 02/09/26, for staff to administer tolterodine 2 mg one tablet two times per day, 6:00 A.M.-10:00 A.M. and 7:00 P.M.-10:00 P.M.;-On 04/06/26, 7:00 P.M.-10:00 P.M., not administered due to drug/item unavailable;-On 04/07/26, 6:00 A.M.-10:00 A.M., not administered due to drug/item unavailable;-On 04/07/26, 7:00 P.M.-10:00 P.M., not administered due to discontinued;-On 04/08/26, 6:00 A.M.-10:00 A.M., not administered due to discontinued.Review of the resident progress notes, dated April 2026, showed staff did not document an order to discontinue the medication, physician notification of the missed doses, or pharmacy notification and follow-up regarding the medication not received. During an interview on 04/09/26, at 9:30 A.M. Registered (continued on next page)

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	04/10/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse (RN) B said the following:-The resident had an issue with bladder spasms due to his/her diagnosis of paraplegia;-The resident had both a suprapubic catheter and a foley catheter;-The resident's urine leaked from his/her urethra due to bladder spasms, and that issue had not improved despite the use of medications to help with bladder spasms. The physician had increased the bladder spasm medication;-The resident's urine leaking adversely affected the resident's wound healing;-He/she was not aware the certified medication technicians (CMT) had not administered the resident's tolterodine as ordered;-If a medication was not available for administration to the resident as ordered, the CMT should notify the nurse, verbally or leave a note for the nurse;-Some of the CMTs would call the pharmacy, but if not, the nurse should call the pharmacy and check on the status of the medication;-Re-ordering medication was a simple process and could be re-ordered by hitting a button in the resident's electronic health record (EHR) to ?re-supply' and the pharmacy would usually send out the medication;-The nurse should notify the resident's physician to see if the physician wanted to discontinue the medication or wanted to order something comparable. During an interview on 04/09/26, at 11:16 A.M., CMT L said the following:-If a resident medication was not available for administration, he/she would first check the emergency kit (E-Kit). If the medication was not available in the E-Kit, the CMT would notify the charge nurse. The nurse or CMT would then call the pharmacy. If the pharmacy did not plan to deliver the medication that same day, the CMT would re-order the medication;-The CMT said he/she thought the physician had discontinued the resident's tolterodine, but the nurses had not had a chance to remove the medication from the resident's physician order sheet;-The CMT said one of the other CMTs had placed a note on the resident's electronic medication administration record (eMAR) stating the medication was discontinued.During an interview on 04/10/26, at 10:05 A.M. CMT M said the following:-He/she thought the resident's physician had discontinued the tolterodine medication;-He/she was unsure why the medication was still listed as an active order on the MAR;-He/she always told the nurse when any resident medication was not available for administration;-The nurses were aware the resident did not have a supply of tolterodine.During an interview on 04/10/26, at 10:10 A.M., RN F said the following:-He/she was aware the resident did not have a current supply of tolterodine;-The nurse had been working with the pharmacy for approximately two weeks to attempt to get a substitute medication for the tolterodine due to insurance coverage issues;-He/she needed to address the medication issue again today, 04/10/26, with the pharmacy/physician. During an interview on 04/09/26, at 3:20 P.M., the Director of Nursing (DON) said the following:-If a CMT could not locate a resident medication, the CMT should check with the pharmacy to confirm the facility re-ordered the medication;-The CMT should then look for the medication in the stat safe;-If the facility did not have the medication on hand, the CMT should notify the nurse;-The CMT should notify his/her nurse each time the CMT did not have a resident medication dose;-The nurse should notify the resident's physician and document the notification of the physician in the resident's progress notes;-The DON said he/she tried to check the resident MARs to ensure staff were administering resident medications as ordered, but he/she had not checked the resident MARs in approximately 2-3 weeks. During an interview on 04/10/26, at 3:50 P.M., the Administrator said the following:-If staff did not have an ordered medication available for a resident, the CMT or nurse should call the pharmacy;-If the insurance company did not want to pay for the medication, the nurse should contact the physician to see if the physician wanted to order another medication or discontinue the order.

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	04/10/2026

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, interview, and record review, the facility failed to complete regular inspections of the bed frame and side rails for risk of entrapment for one resident (Resident #51) whose side rails were loose. The facility census was 57.Review of the facility policy, titled Bed Rails, undated, showed the following:-Bed rails are constructed of metal or plastic, and are available in various sizes (full length, half, or quarter rails). Bed rails may be positioned in various locations on the bed: upper or lower, one or both sides;-When installing or maintaining bed rails, staff should follow manufacturer's recommendations and specifications for applicable bed rails, mattresses and bed frames;-Staff will conduct regular inspections of all bed frames, mattresses, and bed rails to identify areas of possible entrapment. When bed rails and mattresses are used in purchases separately from the bed frame, the facility will select equipment such as bed rails, mattresses, and bed frames that are compatible.1.Review of Resident #51's face sheet (brief resident profile) showed the following:-admission date of 10/21/25;-Diagnoses included stroke, hemiplegia (severe or total paralysis of one side of the body cause by stroke or spinal cord injuries), type two diabetes mellitus (chronic condition here the body develops insulin resistance or fails to produce enough insulin, causing high blood sugar), depression, mixed anxiety disorders, insomnia, and contracture of left hand.Review of the resident's current physician order sheet showed an order, dated 11/21/25, for quarter upper bed rails for positioning.Review of the resident's bed rail and assessment consent, dated 11/21/25, showed the facility completed an assessment, including measurements, a clinical assessment, alternative attempts before considering bed rail use, and risks and benefits. Review of the resident's care plan, revised 03/16/26, showed the following:-Resident required bed rails;-Type: half rail;-Medical symptoms that warrant the use of side rails: hemiplegia to left side related to stroke;-Assess reasons for rail usage;-Assess resident's response to rails;-Re-evaluate the need for bed rails every three months. Review showed the facility did not provide documentation of regular safety checks for bed rails.Observation and interview on 04/07/26, at 2:52 P.M., showed the resident in bed with approximately quarter-size bilateral bed rails in the raised position. The resident said he/she asked staff to install the bed rails and used them for bed mobility. The right-side bed rail was extremely loose. It could be moved liberally up and down and side to side and was nearly at a 45-degree angle at the top due to being loose.Observation on 04/08/26, at 2:05 P.M., showed the following:-The resident lay in bed with quarter size bilateral bed rails in raised position;-The right bed rail was to be extremely loose and could be moved up and down and side to side liberally;-The top of the right bed rail was nearly at a 45-degree angle due to being loose.Observation on 04/09/26, at 3:30 P.M., showed the following;-The resident lay in bed with quarter size bilateral bed rails in raised position;-The right bed rail continued to be extremely loose and could be moved up and down and side to side liberally;-The top of the right bed rail was nearly at a 45-degree angle due to being loose.During an interview on 04/10/26, at 9:56 A.M., Certified Nursing Assistant (CNA) D said the following:-Residents use bed rails for bed mobility and transfers and it was unsafe for them to be loose;-Staff should notice if a bed rail was very loose;-Staff should notify the nurse and Maintenance Director of a loose bed rail and document in the maintenance book behind the nurses' station.During an interview on 04/10/26, at 10:36 A.M., CNA E said he/she would notify the nurse of a loose side rail because it was not safe for a resident to use it for bed mobility.Observation and interview on 04/10/26, at 11:36 A.M. showed the following:-The Maintenance Director said he installed bed rails after conducting appropriate measurements;-He conducted weekly safety checks on bed rails;-Staff should notify him of issues, including loose bed rails by writing in the maintenance log at the nurses' station;-Staff had not written any concerns about the resident's bed rails in the maintenance log;-The Maintenance Director checked the resident's bed rail and said it should not have been that loose and was a safety issue.During an interview on 04/10/26, at 12:23 P.M., Registered Nurse (RN) F said staff (continued on next page)

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	04/10/2026

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should notice if a bed rail is loose during cares and document it in the maintenance book.During an interview on 04/10/26, at 1:49 PM, the Director of Nursing (DON) said the following:-Residents use bed rails for independence with positioning and assisting with cares;-Residents must be assessed appropriately for risks and benefits and measurements must be completed before side rails can be installed;-All staff are responsible for observing if bed rails are loose and should notify both the nurse and maintenance;-Maintenance conducts quarterly safety checks and also checks the bed rails during mattress changes.During an interview on 04/10/26, at 2:59 P.M., the Administrator said the following:-Maintenance completed measurements and installation for bed rails;-Staff should observe loose bed rails and document in the maintenance book;-The Housekeeping Supervisor conducted weekly audits on the bed rails and notified maintenance of concerns.