STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265466	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Stockton Healthcare Facility	1523 3rd Road Stockton, MO 65785

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to fully implement their abuse and neglect prevention policies, when the facility failed to complete a criminal background check (CBC), an employee disqualification list (EDL - a list of individual prohibited from working in a long-term care facility in Missouri due to a finding of abuse or neglect) check, and a Nurse Aide (NA) Registry (list of individual with a Federal Indicator (a marker given to a potential employee who has committed abuse, neglect, or misappropriation of property against residents) prohibiting them from working in a certified facility) check for three sampled staff (Registered Medication Technician (RMT) G, Domestic Care Technician (DCT) M's, and Housekeeper (HK) N). The facility census was 85.Review of the facility's policy, Selection of Employee, dated September 2025, showed the following:-Applicants for employment will meet certain standard requirements before being accepted for employment with the organization;-To assure basic requirements are met for new employees and to assist in the selection of the best suited applicants for available positions;-Background checks will be performed for applicants being considered for employment;-Monitoring of the appropriate state agency disqualification list will be performed to ensure no applicant who will be performing direct resident care is on the list;-New employees are not authorized to begin work until completion of investigation of criminal background check and other required checks.1. Review of RMT G ?s personnel file showed the following:-Hire date of 02/23/26;-The facility requested a criminal background check 03/31/26;-The facility completed a check of the Family Care Safety Registry (FCSR - includes multiple registry checks including EDL and CBC) and EDL on 03/31/26. 2. Review of DCT M's personnel file showed the following:-Hire date of 05/06/24;-The facility completed a check of the of NA Registry on 03/31/26.3. Review of HK N's personnel file showed the following:-Hire date of 10/28/24;-The facility completed a check of the of NA Registry on 03/31/26.4. During an interview on 04/02/26, at 12:25 P.M., the Business Office Manager said new employees complete new hire paperwork with the corporate human resource office. All background checks should all be completed prior to orientation and before starting work in the facility.During an interview on 04/02/26, at 1:45 P.M., the Director of Nursing (DON) said new employees should have all background checks done prior to orientation and working on the floor. The corporate office completes the paperwork.During an interview on 04/02/26, at 2:25 P.M., the Administrator said the following:-When a new employee is offered a position, the corporate human resource office completes the background checks;-There is a checklist which includes running the CBC, EDL, FCSR, and NA checks;-New hires should not start working until background checks are complete.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents with an approved call light system when the facility failed to have a process in place to notify staff of call light notifications when they could not be heard on the halls, when the electronic scroll boards were not accurate on all boards, when call light boxes were not functioning for two residents (Resident #5 and #36), and when one resident (Resident #59) did not have an pull string on his/her bathroom emergency call light out of a sample of 18 residents. The facility census was 85. Review showed the facility did not provide a policy related to call lights. 1. Review of Resident #36's face sheet (brief information sheet about resident) showed the following:-admission date of [DATE];-Diagnoses included congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated [DATE], showed the following:-Cognitively intact;-Use of walker and wheelchair;-Set up or clean-up assistance for oral hygiene, toileting hygiene,-Partial to moderate assistance with dressing, personal hygiene,-Supervision or touching assistance for sit to stand and transfer, showering. During an observation and interview on [DATE], at 11:00 A.M., the resident said his/her call light did not work. He/she had to go tell staff when he/she needed assistance. The resident pressed the call button and observation of the light on the outside of the door showed no call light illuminated. During interview and observation on [DATE], at 11:15 A.M., the resident pressed his/her call light. The light outside the room did not illuminate, the resident said it often does not light up. The scroll board at the nursing station did not show the resident's room as requiring assistance. 2. Review of Resident #5's face sheet showed the following:-admission date of [DATE];-Diagnoses included CHF, chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should), and hemiplegia (paralysis of one side of the body) affecting left non-dominant side. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Use of wheelchair;-Partial to moderate assistance with oral hygiene;-Substantial to maximal assistance with dressing;-Dependent on staff for toileting hygiene, showering, personal hygiene, transfers. During an interview on [DATE], at 1:00 P.M., the resident said his/her call light had not been working properly. Staff came in and switched the cord. He/she was unable to tell if the call light was illuminated on the outside the door. He/she was unable to get up on his/her own to get staff for assistance. 3. Review of Resident #59's face sheet showed the following:-admission date of [DATE];-Diagnoses included Alzheimer's disease. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact;-Use of wheelchair;-Substantial to maximal assistance with toileting. Observation on [DATE], at 7:35 A.M., showed the resident's bathroom emergency call light button without a pull string. During an interview on [DATE], at 2:10 P.M., the Director of Nursing (DON) said the call lights in resident bathrooms should have a string that reaches to the floor to ensure the resident can activate the call light if they fell on the floor. During an interview on [DATE], at 3:55 P.M., the Administrator said the resident's emergency call (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	light button should have a pull string. 4. Observation on [DATE], at 11:33 A.M., showed the following:-The scroll board above 300 hall doors showed the time as 12:56 P.M., and showed no resident room numbers on the board;-The scroll board above 400 hall showed two room call lights, however the nurses' station scroll board did not show any lights on the 400 hall. 14. Observation on [DATE], at 8:30 A.M., the following was noted:-The 300 hall scroll board showed time as 9:53 A.M., with no call lights on;-The 400 hall scroll board showed two call lights on;-The 300 and 400 nurses' station scroll board showed two call lights on for the 300 hall and no call lights on for the 400 hall;-The 500 hall scroll board showed incorrect day of the week and two call lights on;-The 600 hall scroll board showed no call lights on;-The 500 and 600 nurses' station scroll board showed no call lights on. Observation on [DATE], at 12:41 P.M., of the call light scroll board in the secured unit showed the following:-A low battery alert for room [ROOM NUMBER], emergency spa;-Tamper warning, room [ROOM NUMBER], bed 2;-Tamper warning room [ROOM NUMBER], bed 2;-No call light was illuminated on the outside of room [ROOM NUMBER];-No lights on at the call box. During an interview on [DATE], at 12:50 P.M., Certified Medication Technician (CMT) B said there was no light on for room [ROOM NUMBER], bed 2, as the resident was not in the room. The battery was probably dead. During an interview on [DATE], at 2:10 P.M., the Director of Nursing (DON) said if the call light in spa was alarming and there was no one in the room, staff should put in a work order. During an interview and observation on [DATE], at 1:45 P.M., the Assistant Maintenance Superintendent said the lights on the secured unit were not used often. If the call light battery died, it would not work at all. The call light battery in room [ROOM NUMBER]-2 may be dead. 5. During an interview on [DATE], at 11:36 A.M., Registered Nurse (RN) A said the following:-Scrolling boards are located at each nursing station. The boards show which call lights are on for the hall;-The facility recently added scrolling board in each of the halls;-The hall scrolling boards and the scrolling boards at the nurses' station do not match due to a recent upgrade and the software being incompatible;-The system is a wireless system. The lights and scroll board are only visible and there is no audible sound;-The facility used to utilize pagers. During an interview on [DATE], at 12:50 P.M., Certified Medication Technician (CMT) B said the following:-The call lights do not sound when turned on;-The call lights were visible at the resident doors and at the scroll board at the nursing station;-The new boards are located at entrance of 300, 400, 500, and 600 halls;-If a scroll board shows a tamper warning or a low battery warning, staff should put a work order in the computer system for maintenance. During an interview on [DATE], at 12:55 P.M., RN C said the following:-If a call light had been turned on, the board at the nursing station showed the room number;-He/she did not know what a tamper warning meant on the scroll board, but would submit the concern to maintenance;-There was no noise from call light or scroll board;-Staff should be up and down the halls to see the call lights. During an interview on [DATE], at 1:25 P.M., CNA D said the following:-He/she looks up and down the halls while working to monitor for call lights;-The scroll boards at the entry of hallways do not work, but staff can check the scroll board at nurses' desk;-Staff used to have pagers that beeped and vibrated if a resident rang their call light; -If staff have concerns with the call light system, they should put in a work order for maintenance to review. During an interview and observation on [DATE], at 1:45 P.M., Assistant Maintenance Superintendent said the following:-The system was installed to make a more homelike environment without the beeping noise of call lights. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There is no audible sound at the nursing station or at the residents' rooms;-The facility used to have pagers, but they have all been lost or misplaced. New pagers have been ordered;-Each nursing station has a scrolling board;-The facility recently added scroll boards above the 300, 400, 500, 600 hall entry area to help with call light visibility; -The 300 hall scroll board does not work with the old system, as there was a communication issue between the boards;-The signal from the call light box goes to the scroll board above hall, to the nursing station, and to the pagers, if available;-It can take a few seconds for the connection to be made. Staff should be checking the scrolling boards at nursing stations and the call lights outside the resident's room; -A tamper warning message means someone pulled too hard, and the call light cord came out of the wall. If this occurs, staff should put in a maintenance order;-The call light does not illuminate at the resident room if pulled from the wall. The call light box in the room will initially illuminate but the light will turn off after a short time;-A low battery warning indicates a low battery in the resident room. If this occurs, staff should put in a work order for maintenance. The call system is made to work even if there is a low battery;-Maintenance staff check work orders periodically throughout the day and should be done by the end of the workday. During an interview on [DATE], at 2:10 P.M., the Director of Nursing (DON) said the following:-The scrolling screens at nursing stations and the lights outside the resident rooms notify staff if a resident pressed their call light;-Aides and charge nurses used to carry pagers, but they all broke or disappeared;-Maintenance staff were trying to find compatible pagers with the call system;-If the system did not work, staff should do frequent walking rounds; -If the scroll board shows a low battery or tamper warning, staff should put in a maintenance work order; -The scroll boards over 300, 400, 500, and 600 halls do not work correctly, but the nursing station board works. During an interview on [DATE], at 2:20 P.M. and 4:15 P.M., the Administrator said the following: -The facility had a wireless call light system;-The system did not have any audible sound except in the visitor bathrooms;-Currently, the facility does not have pagers. The facility attempted to purchase pagers that were compatible with the system;-The facility added scroll boards at the entry of 300, 400, 500, and 600 halls;-The newly installed boards and the old boards do not work together;-The scrolling boards above the halls are inaccurate;-Too many call lights going off at the same time causes the system to clog;-Maintenance staff randomly checks call light monthly or quarterly;-If staff have concerns with the call system, they should turn in a work order for maintenance;-If a resident voices call light concerns, he would review the cameras. Often it is discovered the resident has turned off the light.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview, and record review, the facility failed to provide care per standards of practice when staff failed to follow a physician order for daily weights, failed to consistently document weights, and failed to notify the physician on two occasions of a significant weight gain for one resident (Resident #43) with a diagnosis of congestive heart failure (CHF- chronic, progressive condition where the heart cannot pump blood effectively causing fluid buildup in the lungs and body) with bilateral lower extremity edema (swelling of both legs, ankles, or feet caused by abnormal fluid buildup in the tissues). The facility census was 85. Review of facility policy titled ?Patient Weights, dated April 2022, showed the following:-Facility weights will be done on admission, monthly, and as needed or as ordered;-The purpose is to monitor weight gain or loss. Review of a facility policy titled Changes in Resident Condition: Notification Guidelines, dated January 2025 , showed the following:-Physicians, residents, and families will be notified in a timely manner of changes in clinical conditions and environmental changes affecting the resident;-The purpose is to provide timely communication of condition and environmental changes to care providers, residents, and their families;-When resident changes are noted nursing staff will notify the resident's attending provider and the resident's legal representative or family member.-Messaging within the electronic medical record should be used for nonurgent information and should include a thorough assessment, detailed information, and/or specific resident details that need to be communicated to the provider;-A nurse's note in the electronic medical record should be completed after a provider phone call regarding any urgent resident changes, after receiving orders from a provider in person or through phone call, and after conversations with a provider regarding a resident that would be pertinent to include in the medical record;-Notification will occur as soon as possible when there is a significant change in the resident's acute medical condition; deterioration in health status in either life threatening or clinical complications; or the need to alter treatment significantly including but not limited to a need to discontinue a treatment or commence a new form of treatment. 1. Review of Resident #43's face sheet (a general information sheet) showed the following:-admission date of 08/06/24;-Diagnoses include CHF, chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood), and bilateral edema of lower extremities.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/25/26, showed the following:-Resident had moderate cognitive impairment; -Diagnoses include heart failure and respiratory failure;-Resident had taken a diuretic (medication that removes excess fluid from body);-Required substantial to maximum staff assistance for toileting, showering, and dressing and transfers.Review of resident's care plan, revised 04/02/26, showed the following:-Resident required substantial assistance bathing, dressing, and locomotion;-Staff should monitor weight as ordered;-Staff should complete a resident edema assessment twice daily.Review of the resident's current Physician Order Sheet (POS) showed the following:-An order, dated 11/14/25, for Lasix (medication used to treat fluid retention) 40 milligrams (mg) tablet, give one tablet once a day;-An order, dated 11/14/25, for Lasix 20 mg tablet, give one tablet once daily at 1:00 P.M.;-An order, dated 06/03/25, to cleanse the lower extremities with wound cleanser and pat dry, apply two-step zinc compression wraps from toes to knees on bilateral lower extremities. Change every Sunday and then change every Tuesday and Friday after shower.Review of the resident's medical record showed the resident weighed 220 pounds on 02/07/26. Review of the resident's physician progress note, dated 02/09/26, showed the following:-The resident needed daily weights;-Resident had chronic edema to the bilateral lower extremities;-Edema to bilateral lower extremities was 1+ pitting edema (a mild form of fluid accumulation characterized by a slight, 2 millimeter (mm) indentation that rebounds immediately upon pressure);-Resident continued Lasix 40 mg daily and Lasix 20 mg at 1:00 P.M.;-He/she currently utilized compression wraps by nursing staff twice weekly;-Resident to continue current medication;-Nursing staff to notify provider of any worsening of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition.Review of the resident's current POS did not show an order for daily weights.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 02/08/26 and 02/09/26.Review of the resident's medical record showed a weight of 235.8 pounds on 02/10/26 (weight gain of 15.8 pounds in 3 days). Review of the resident's nursing progress notes showed staff did not document physician notification of the 15.8-pound weight gain.Review of the resident's medical record showed a weight of 236 pounds on 02/11/26. Review of the resident's nursing progress notes showed staff did not document notification of the physician of a 16-pound weight gain.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 02/12/26 through 02/16/26. Review of the resident's medical record showed a weight of 234 pounds on 02/17/26.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 02/18/26 through 02/19/26. Review of the resident's medical record showed a weight of 226 pounds on 02/20/26. (weight loss of 10 pounds).Review of the resident's medical record showed staff did not document a check of the resident's weight document on 02/21/26. Review of the resident's medical record showed a weight of 225.8 pounds on 02/22/26.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 02/23/26. Review of the resident's NP progress note, dated 02/24/26, showed the following: -The resident needed daily weights;-Resident had chronic edema to the bilateral lower extremities;-Edema to bilateral lower extremities was 1+ pitting edema;-Resident continued Lasix 40 mg daily and 20 mg at 1:00 P.M.;-He/she was currently utilizing compression wraps by nursing staff twice weekly;-Resident to continue current medication;-Nursing staff to notify provider of any worsening of condition. Review of the resident's medical record showed staff did not document a check of the resident's weight document on 02/24/26 through 03/01/26.Review of the resident's NP progress note, dated 03/02/26, showed the following: -The resident needed daily weights;-Resident had chronic edema to the bilateral lower extremities;-Edema to bilateral lower extremities was 1+ pitting edema;-Resident continued Lasix 40 mg daily and 20 mg at 1:00 P.M.;-He/she is currently utilizing compression wraps by nursing staff twice weekly;-Resident to continue current medication;-Nursing staff to notify provider of any worsening of condition. Review of the resident's medical record showed staff did not document a check of the resident's weight document on 03/02/26 through 03/04/26.Review of the resident's medical record showed a weight of 240 pounds on 03/05/26 (weight gain of 14.2 pounds).Review of the resident's nursing progress notes showed staff did not document physician notification of the 14.2-pound weight gain.Review of the resident's medical record showed a weight of 239.8 pounds on 03/07/26.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 03/08/26 through 03/10/26.Review of the resident's medical record showed a weight of 235.8 pounds on 03/11/26.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 03/12/26.Review of the resident's medical record showed a weight of 237 pounds on 03/13/26.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 03/14/26 through 03/19/26.Review of the resident's medical record showed a weight of 236.5 pounds on 03/20/26.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 03/21/26 through 03/24/26.Review of the resident's medical record showed a weight of 231 pounds on 03/25/26.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 03/26/26 through 03/28/26.Review of the resident's medical record showed a weight of 228 pounds on 03/29/26.Review of the resident's medical record showed staff did not document a check of the resident's weight document on 03/30/26.Review of the resident's NP progress note, dated 03/30/26, showed the following: -Resident had chronic edema to the bilateral lower extremities;-Resident continued Lasix 40 mg daily and 20 mg at 1:00 P.M.;-Resident to continue current medication. Review of the resident's medical record showed a weight of 240.8 pounds on 03/31/26.Review of the resident's nursing progress note dated 03/31/26, at 6:54 P.M., showed the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following: -The nurse notified the NP of resident's change of condition;-NP assessed and placed new orders to change Lasix to Bumex (medication used to treat fluid retention) to start tomorrow and an order for a one-time dose of Lasix now;-The nurse noted edema to the resident's right hand;-The nurse noted increased edema and a 10-pound weight gain since 03/29/26 upon assessment.Review of the current POS showed the following:-An order dated 04/01/26, for Bumex 2 mg tablet once daily with no diagnosis listed;-An order dated 04/01/26, to discontinue Lasix.Review of a nursing progress note dated 04/01/26, at 5:10 A.M., showed a daily weight result of 232 pounds.During an interview on 04/02/26, at 9:30 A.M., Certified Nurse Assistant (CNA) E said the following:-CNA's were responsible for resident weights;-The nurse listed the weights for the day on the vital sign sheet;-The resident was a daily weight;-Resident weights are documented in the medical record after they are completed, and the vital sign sheet is left on the nurse's desk;-Residents are on daily weights to monitor fluid in the body;-The resident's legs were really swollen;-Staff elevate and wrap the resident's legs to help with swelling;-He/she would notify the nurse of increased swelling.During interview on 04/02/26, at 12:45 P.M., Registered Nurse (RN) F said the following:-CNA's were responsible for completing resident weights; -The nurse would create a list of weights to be completed for the CNA's daily;-The CNA's complete the weights and notify the nurse;-The resident was on daily weights;-He/she would notify the physician of a 15-pound weight gain;-He/she would give a PRN Lasix if a residents had a 3-pound weight gain in one day;-The resident did not have a PRN Lasix order;-The physician should be notified of a 3-pound weight gain in 24 hours or a gain of 5 pounds in a week;-Weight gain and physician notification should be documented in notes;-The resident should have been reweighed to double check weight gain;-The NP was notified of the resident's weight gain on Tuesday 03/31/26.During an interview on 04/02/26, at 10:45 A.M., the Nurse Practitioner (NP) said the following:-Staff notified him/her of the resident's weight gain during a facility visit on Tuesday;-The resident had increased edema and was not feeling well;-The resident had a swollen hand and eyelids;-The NP changed his/her orders to include an extra Lasix pill and change current Lasix order to Bumex;-The resident should be on daily weights;-Some residents have an as needed Lasix for weight gain, but he/she was unsure if the resident had one;-Staff should notify the physician or NP of a weight gain of 5 pounds in one day or use of an as needed Lasix two days in a row.During an interview on 04/02/26, at 2:37 P.M., RN A said the following:-CNA's obtain weights on night shift before breakfast;-Residents with CHF should have weights monitored daily;-He/she would reweigh the resident if they had a 10-pound weight gain;-He/she would notify the physician of a weight gain of three pounds;-The physician should be notified of a 3 pound or more gain in weight due to a diagnosis of CHF;-A 3-pound weight gain would initiate a flag in the medical record;-A 10-pound weight gain is extreme and would indicate a change in condition;-He/she would monitor the resident's cardiac status, lung sounds, and edema for a possible weight gain;-Physician notification and assessment should be documented;-CHF and edema should be included on a resident's care plan.During an interview on 04/02/36, at 2:50 P.M., Licensed Practical Nurse (LPN)/Infection Preventionist said the following:-A weight that is due should show up on the work list in the medical record;-The resident was on daily weight and had been for a long time;-Residents with a CHF diagnosis should have orders for daily weights upon admission;-He/she would reweigh a resident with an unusual weight gain;-He/she had talked to the family about the resident's weights;-He/she would notify the physician of a wright gain of 3 pounds in a day or 5 pounds in a week;-The CNA should notify the charge nurse of any out-of-range weights;-He/she would notify the physician and assess the resident;-He/she would document the assessment and notification to the physician.During an interview on 04/02/36, at 1:10 P.M., the Director of Nursing (DON) said the following:-The resident had an intervention to obtain weights; -The resident should be a daily weight;-The resident had an order for weight to be obtained every 30 days, and he/she changed the orders to daily weights;-The physician inputs his/her own orders unless nurses call for an order;-The physician will at times give a verbal order to nurses;-Staff should notify the physician of a weight gain of 3 pounds in a day or 5 pounds in a week;-Staff should (continued on next page)

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Lake Stockton Healthcare Facility	1523 3rd Road Stockton, MO 65785

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have reweighed the resident after weight gain and notified the physician and documented;-The note in the physician progress note regarding daily weights could be an order and should be followed.During an interview on 04/02/26, at 3:10 P.M., the Administrator said staff should complete daily weights everyday unless the resident refused. The physician or NP should be notified of a resident weight gain, and the nurse should document any notification.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure all residents maintained acceptable parameters of nutritional status when staff failed to document an unplanned weight loss, failed to notify the registered dietician (RD) of the weight loss, failed to modify care plan to reflect the weight loss, and failed to implement new interventions after a continued unplanned weight loss one resident (Resident #41). The facility census was 85.Review of the facility policy titled ?Patient Weights, revised April 2022, showed in long-term care setting, weights will be done on admission, monthly, and as needed or as ordered. 1. Review of Resident #41's face sheet (admission data) showed the following information:-admission date of 10/10/20;-Diagnoses included other symptoms and signs involving cognitive functions and awareness. Review of the resident's vital signs showed the following:-On 12/06/25, at 8:39 A.M., showed the resident weighed 160 pounds 3.2 ounces;-On 12/13/25, at 12:30 P.M., showed the resident weighed 160 pounds;-On 12/21/25, at 6:58 A.M., showed the resident weighed 158 pounds. Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) Coordinator/Registered Nurse (RN) J's note, dated 12/26/25, at 1:31 P.M. showed the following:-Weight meeting on 12/26/25;-Last documented weight 158 pounds;-Weight is stable;-Continue to monitor intake. Review of the resident's vital signs dated 1/03/26, at 5:07 P.M., showed the resident weighed 156 pounds 12.8 ounces. Review of the physician's note, dated 01/20/26, showed the following:-Routine rounds;-Weight 156 pounds 12.8 ounces;-The resident denied any pain or problems. The nursing staff have no new concerns. Review of the resident's NP's visit, dated 01/26/26, showed the resident's current weight was 159 pounds, on a five-foot one inch frame, with a Body Mass Index (BMI-a way to look at whether a person is at a healthy weight) of 30.1% (obesity is BMI of 30 or more). Review of the Registered Dietitian's (RD) note dated 01/31/26, at 1:56 P.M. showed the following:-Quarterly nutrition assessment;-BMI 29.6 (overweight for BMI of 25-29.9) calculated by electronic medical record 156 pounds;-Resident seen in the common area of the special care unit. Staff without concerns for his/her nutrition needs. Staff state the resident was predominantly independent with eating with an occasional reminder to continue to eat. The resident weight was stable (plus/minus 5 pounds) over the past three months. Continue current diet without change. No nutrition intervention. Review of the resident's vital signs dated 02/05/26, at 7:46 A.M. showed the resident's weight was 146 pounds 3.2 ounces (a 10-pound weight loss since the RD visit on 01/31/26). Review of the MDS Coordinator/ RN note dated 02/06/26, at 3:21 P.M., showed the following:-Weight meeting on 02/06/25;-Last documented weigh of 146 pounds 3.2 ounces;-Has lost 10 pounds in one month;-No supplements taken;-Consumed 25-75% of his/her meals;-Plan to continue to monitor.(Staff did not document physician or RD notification of the weight unplanned weight loss.)Review of the resident's MDS quarterly assessment dated [DATE], at 2:33 P.M., showed registered medication technician (RMT)/social service staff documented the resident's energy levels had decreased. The resident's appetite decreased significantly, with a reported weight loss of 10 pounds in the last month. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Short- and long-term memory problem;-Moderately impaired decisions, cues/supervision required;-Weight of 146 pounds;-Loss of 5% or more in last month or loss of 10% or more in the past six months;-Not on physician-prescribed weight loss regimen;-Required supervision or touching assistance with eating. Review of the resident's nurse's note dated 02/17/26, at 6:33 P.M. showed a nurse documented the resident received nurse practitioner geri-psych recommendation to stop Zoloft (treats depression) for depression and increase melatonin to 10 milligrams and start trazodone (an antidepressant) for insomnia and depression. Review of the resident's vital signs dated 02/22/26, at 11:00 A.M., showed the resident's weight was 140 pounds eight ounces (a six-pound weight loss in 16 days).Review of the resident's medical record showed staff did not document physician or RD notification of the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unplanned weight loss. Review of the resident's nurse practitioner's (NP) note, dated 02/27/26, showed the following:-The resident's vital signs were stable;-The resident's current weight was stable at 140 pounds, on a five-foot one-inch frame, with a BMI of 26.5% (overweight for BMI of 25-29.9). Review of the resident's vital signs dated 03/02/26, at 9:31 A.M. showed the resident's weight was 140 pounds 12.8 ounces. Review of the NP's visit, dated 03/10/26, showed the resident's weight was currently 140 pounds and stable over the month. The resident was down 16 pounds over the past two months. Continue to monitor closely. Review of the resident's psych follow-up consultation dated 03/14/26, at 10:56 A.M. showed the following:-The provider documented the resident's energy levels have decreased and his/her appetite has decreased significantly, resulting in a ten-pound weight loss in the last month. The resident had trouble concentrating, which could be due to significant hearing loss. Despite reports of appearing more depressed, the resident did not show outward signs of hopelessness, and the resident reported it's wonderful to be alive;-The planned initiation of Remeron (an antidepressant that and can also increase appetite) will address a potential depressive component as well as appetite and sleep;-The resident's insomnia and poor appetite to be managed by discontinuing trazodone and starting Remeron 7.5 mg at bedtime;-The primary clinical concerns was the resident's significant weight loss of 10 pounds in the last month, decreased appetite and decreased energy;-The overall plan has been changed from conservative monitoring to active management with a medication change to address the resident's significant weight loss and insomnia. Review of the resident's nurse's note dated 03/17/26, at 5:37 P.M. showed a nurse documented geri-psych consultant recommended to discontinue trazodone and start Remeron 7.5 mg at bedtime for appetite due to weight loss and insomnia/depression. Review of the resident's physician order, dated 03/17/26, showed an order with start date of 03/17/26 for Remeron 7.5 mg by mouth at bedtime for depression. Review of the resident's vital signs dated 03/28/26, at 9:00 A.M showed the resident's weight was 141 pounds 11.2 ounces. Review of the RD's progress note dated 03/30/26, at 11:40 A.M., showed the following:-Last documented weight 141 pounds 11.2 ounces;-Weight change: negative 9.6% in three months, negative 14% in six months;-Soda pop with every meal, double dessert with lunch, and the resident was allowed soft breads, cakes, cookies;-Resident with decreasing weight trend as well as decreasing oral intake. Body Mass Index 26.8 (overweight for BMI of 25-29.9). Continue to monitor weight and intake. Resident may benefit to move to assisted table to have cueing to continue eating. Review of the resident's care plan, reviewed 04/02/26 showed the following:-The resident has a minced and moist 5 diet due to holding food in his/her mouth and spits the food out;-The resident's appetite has significantly decreased;-The resident had a diagnosis of major depressive disorder, the resident has times of being down, feeling hopeless, feeling tired and having little appetite.(Staff did not update the resident's care plan related to the unplanned weight loss or current interventions in place.) During an interview on 03/31/26, at 5:45 P.M., Certified Nurse Aide (CNA) I said the following:-Staff should report to the nurse of a change in weight;-The nurses inform the aides of weights to obtain;-Staff switched the resident's diet from regular to minced and moist;-The resident required cueing to eat and does a little better;-The resident had a weight loss.During an interview on 04/01/26, at 11:52 A.M., Registered Nurse (RN) C said the following:-Staff compare weights from the last weight on the vital sign sheet;-The aides get the weights on the residents;-The charge nurse oversees the aides obtaining residents' weights;-Staff report residents' weight loss to RN J;-He/she did not attend the weight meetings which include administration staff;-Kitchen staff or RN J informed nurses of an intervention or diet change for a resident;-Staff started the resident on Remeron on 03/17/26. During an interview on 04/01/26, at 1:15 P.M., the Dietary Manager (DM) said the following:-She and RN J were the weight team;-She prints out weights once a week on Friday and reviews them;-The Registered Dietician comes to the facility two times a month, she gives the RD a list of new residents;-The RD reviews new residents, annual assessments, and weights;-RN J and the RD calculate the percentage of weight loss of residents;-RN J documents on the residents related to weight loss;-She did not document on (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents who have a weight loss, she is still learning his/her position;-The RD sends recommendations after her visit and notifies her and RN J;-She did not see orders for supplements or interventions for the resident until the Remeron on 03/17/26;-The last time the RD saw the resident was 01/31/26.During an interview on 04/02/26, at 8:44 A.M. RN P said the following:-Nurses notify the physician of a weight loss;-RN J monitored weight loss of residents;-He/she was not aware of the resident's weight loss;-The resident was slow and normally feeds himself/herself. During an interview on 04/01/26, at 1:32 P.M., the RD said the following:-She comes to the facility three days a month;-The DM is in charge of the weekly weight meetings;-The DM notified her of residents' weight loss;-She prints out a weight report of the residents every time she visits the resident;-She assesses residents if they have a weight loss or gain and she asks residents about appetite and supplements;-The weight report only shows 30-day, three month and 6 month weights;-She only saw her progress note of the resident's 01/31/26 visit and the visit yesterday (03/31/26);-She considered the resident's weight loss semi beneficial, the resident's BMI was high, right now the resident's BMI was 26% (overweight for BMI of 25-29.9). This should be documented and care planned if beneficial;-She expects staff to notify her if a resident has 7.5% weight loss for three months;-She had the resident's 01/31/26 weight and the 02/05/26 weight of 146 lbs;-Staff should have informed her of the resident's weight loss. She feels she should have had a note for February 2026 for the resident's weight loss and did not know why she did not. During an interview on 4/01/26 at 2:20 P.M. MDS/Care Plan Coordinator/RN J said the following:-She prints out the weight report every week and reviews the weights;-The aides weighed the residents. The nurses were responsible for the aides obtaining the weights;-He/she evaluated residents with weight loss triggers which included anyone had greater than 5% in one month, or 10% in 6 months of weight loss or weight gain;-He/she and the DM had a weight meeting weekly and review one hall at a time;-He/she and the DM discussed options if a resident has a significant weight loss and he/she documents a weight meeting note in the resident's chart;-The RD comes to the facility weekly;-He/she or the Director of Nursing (DON) entered orders into the computer of supplements;-The RD reviewed the weight report and messaged him/her or the Administrator of recommendations and documents in the resident's chart;-He/she copied the note and sent the recommendation to the provider;-He/she did not see any messages to the physician of the resident's weight loss from 01/03/26 through 03/03/26.During an interview on 04/02/26, at 10:55 A.M. the NP said the resident had a steady decline of weight loss. She expected staff to document the resident's weight loss.During an interview on 04/02/26, at 12:13 P.M. the Director of Nursing (DON) said the following:-The DM and RN J run a weight report;-She and the DM and RN J met weekly for weight meetings;-The weight team reviewed percentages of weight loss, how a resident eats, staff should document weights;-She expected staff to document and notify the RD and provider of a resident's weight loss. During an interview on 04/02/26, at 2:25 P.M., the Administrator said he expected staff to document on weight loss.