STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265656	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strafford Care Center	505 West Evergreen Strafford, MO 65757

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure all allegations of abuse and neglect were reported immediately to facility management and to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required two-hour time frame when staff failed to report an allegation of employee to resident abuse of one resident (Resident #1) in a timely manner. The facility census was 62. Based on interview and record review, the facility failed to ensure all allegations of abuse and neglect were reported immediately to facility management and to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required two-hour time frame when staff failed to report an allegation of employee to resident abuse of one resident (Resident #1) in a timely manner. The facility census was 62.The Administrator was notified on the morning of 9/15/25, at approximately 10:15 A.M., of the Past Non-Compliance which occurred on 9/11/25, between 10:00 P.M. and 12:00 A.M. The accused certified nurse aide was suspended on 9/15/24. Staff assessed the resident for injuries, and none were found. On 9/15/25, in-service of all staff was started. Staff began the full investigation on 9/15/25 and completed interviews on 9/15/25. The facility implemented training of all employees, including asking two staff members a day, five days a week on the abuse policy and reporting policy. The noncompliance was corrected on 9/16/25. Review of the facility's policy titled, Abuse, Prevention and Prohibition Policy, dated 3/2025, showed the following: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion;-The facility prohibits mistreatment, neglect, or abuse of residents;-The facility employee or agent, who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident property, shall immediately report the matter to the facility administrator or his/her designated representative in the administrator's absence;-An employee or agent or any covered individual will make or cause a report to be made to law enforcement and the facility;-The administrator, or his/her designated representative if administrator is not present, will notify the regional corporate nurse;-The facility administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report or cause a report to be made to the mandated state agency per reporting criteria. Such reports may also be made to the local law enforcement agency in the same manner. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the administrator. The person made aware of allegations of abuse or neglect, or the administrator will report the allegations of abuse and neglect to the mandated state agency and law enforcement. The allegation will be reported no later than two hours, or per state regulations, after the allegation is made.Review of the facility's policy titled When and Who to Call List, not dated, showed the following: -Call the Director of Nursing (DON) immediately for abuse;-Call the Administrator immediately for abuse.1. Review of Resident #1's face sheet (resident's information at a quick glance) showed the following: -admission date of 09/08/25;-Diagnoses included dementia (a general term for a number of neurological conditions that cause a decline in cognitive abilities).Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 09/15/25, showed the following: -The resident had moderate cognitive impairment;-The resident was dependent on others for assistance in completing the activities of daily living (ADL - dressing, grooming, etc.).Review of the resident's care plan, revised on 9/16/25, showed the resident preference was not to have ethnic/color care givers.Review of the facility's Investigation Summary, dated 9/16/25, showed the following:-The Administrator was notified on 9/15/25, at 10:15 A.M., of an allegation of employee to resident abuse, that had occurred on 9/11/25, between 10:00 P.M. and 12:00 A.M.;-The staff reported the allegations of abuse to DHSS on 9/15/25 at 12:10 P.M.Review of DHSS's intake information dated 09/15/25, at 12:10 P.M., showed the facility self-reported an allegation of abuse by a CNA. Review of a written statement, dated 9/15/25, showed Certified Nurse Aide (CNA) A noted the following:-On 9/12/25, at around 12:30 A.M., the resident told CNA A that a man wearing all blue came in his/her room. He/she stood over there with his/her hands in his/her pants, moving them around and masturbating;-CNA A then went to the nurses' desk and asked CNA B and CNA D, who the man in all blue was and they stated it was CNA C; -CNA B and CNA D told CNA A that the incident had been reported to the nurse on duty.Review of a written statement, dated 9/15/25, showed CNA F noted the following: -The resident told CNA F that CNA C came in his/her room thinking he/she was asleep, but the resident was awake. The resident told CNA B that he/she saw CNA C playing with his/her private area; -CNA B asked the resident if he/she reported that to anyone and the resident said yes, to that

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of significant medication errors when staff failed to transcribe new admission orders resulting in one resident (Resident #2) not receiving insulin for six days. The facility census was 62.Review of the facility policy titled Medication Administration-General Guidelines, dated July 2021, showed the following: -Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system;-Medications are administered in accordance with written orders of the prescriber.Review of the facility policy titled Medical Errors & Adverse Events, dated December 2024, showed the following: -When medical errors or adverse resident events are identified, the facility will analyze the cause, implement corrective actions to prevent future events, and conduct monitoring to ensure desired outcomes are achieved and sustained. 1. Review of Resident #2's face sheet (a brief summary of the resident's medical and admission history) showed the following: -admission date of 09/02/25;-Diagnoses included type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). Review of the resident's care plan, dated 09/15/25, showed the following: -Resident had unstable blood glucose levels;-Administer medications as prescribed;-Evaluate blood glucose level per ordered frequency;-Monitor medication effectiveness for management of blood glucose level.Review of the resident's admission Minimum Data Set (MDS - a federally required assessment tool completed by facility staff), dated 09/19/25, showed the following: -The resident was cognitively intact;-The resident did not have orders for insulin and did not receive insulin injections during the last 7 days or since admission. Review of the resident's hospital Discharge summary, dated [DATE], showed the following medications to be continued on discharge: -Humalog (fast acting insulin) KwikPen 100 units/milliliter (ml), medium dose sliding scale with meals and bedtime. Medium dose correction scale as follows:-If blood glucose level of 150 milligrams/deciliter (mg/dL) to 199 mg/dL, staff to administer 2 units of insulin;-If blood glucose level of 200 mg/dL to 249 mg/dL, staff to administer 4 units of insulin;-If blood glucose level of 250 mg/dL to 299 mg/dL, staff to administer 6 units of insulin;-Date/Time of next dose due on 09/08/25 before next meal;-Insulin glargine (long actin insulin), 75 units, at bedtime. Date/Time of next dose due on 09/08/25 at bedtime.Review of the resident's September 2025 Physician Order Sheet (POS) showed staff did not transcribe the hospital orders for Humalog and insulin glargine to the resident's physician's orders. Review of the resident's medical record showed staff documented the following: -On 09/15/25, at 7:50 A.M., the nurse checked the resident's blood sugar and result was 157 mg/dL. The nurse then began looking up discharge medications from hospital per resident's request, specifically regarding insulin; -On 09/15/25, at 1:31 P.M., the nurse called and spoke with the physician regarding resident's blood sugars and insulin. New orders received at this time to add Humalog, sliding scale and to increase Lantus from 60 units to 65 units at bedtime. Review of the resident's September 2025 Physician Order Sheet (POS) showed the following: -An order, dated 09/15/25, Lantus (insulin glargine) 100 unit/ml, inject 65 units at bedtime for diabetes;-An order, dated 09/15/25, for Humalog injection, injects as per following sliding scale:-If blood glucose level of 150 mg/dL to 199 mg/dL, staff to administer 2 units of insulin;-If blood glucose level of 200 mg/dL to 249 mg/dl, staff to administer 4 units of insulin;-If blood glucose level of 250 mg/dL to 299 mg/dl, staff to administer 6 units of insulin.Review of the resident's September 2025 Medication Administration Record (MAR) showed the following: -Staff did not document administration of the ordered Humalog from admission until 09/15/25 at 5:00 P.M.;-The resident did not receive the ordered Lantus 100 units/ml until 09/14/25 at 8:00 P.M.During an interview on 09/19/25, at 8:47 A.M., the resident said the following: -The facility had contacted the doctor and received orders for blood sugar checks and insulin;-The resident had been getting his/her blood sugars checked before meals and at bedtime;-The resident received insulin when needed per sliding scale and at bedtime. During an interview on 09/19/25, at 1:17 P.M., Certified Nurse Aide (CNA) E said the following: -The resident was upset because the facility had not contacted the doctor regarding her blood sugars;-The resident told CNA E that he/she had been on insulin prior coming to the facility and since the resident arrived at the facility, he/she had not received it. During an interview on 09/19/25, at 1:29 P.M., Certified Medication Tech (CMT) H said the admitting nurse was responsible for transcribing medications order by the discharging physician to the facility MAR. During an interview on 09/19/25, at 1:35 P.M., Licensed Practical Nurse (LPN) I