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	02/25/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all resident representatives were notified of changes in condition in a timely manner when staff failed to inform one resident's (Resident #2) representative of falls resulting in bruising and skin tears. The facility census was 66.Review of the facility policy entitled Significant Condition Change and Notification, dated 12/24, showed the following:-Purpose is to ensure that the resident's family and/or representative and medical practitioner are notified of resident changes;-Examples of changes include new wounds, bruises or skin tears, head trauma, and mobility changes;-Licensed nurse will contact the resident's representative and medical practitioner;-Calls will be made until the residents' representative is reached;-Each attempt will be charted as to what time the call was made, who was spoken to, and what information was given.1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following information:-admission date of 09/09/24;-Diagnoses included Parkinsons disease (a progressive neurological disease characterized by abnormal movements, tremor and stiffness), cognitive communication deficits, and history of falling.Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/04/25, showed the following information:-Cognitively intact;-Able to walk with a walker;-Maximum assistance for toileting. Review of the resident's care plan, updated 01/28/26, showed the following:-He/she had limited physical mobility due to weakness;-He/she was a risk for falls due to disease process and muscles weakness;-He/she used a wheelchair;-He/she had unwitnessed falls on 02/11/26, 02/19/26, and 02/21/26.Review of the resident's nursing progress note dated 02/11/26, at 12:52 P.M., showed staff documented an unwitnessed fall. (Staff did not document responsible party notification.)Review of the facility fall risk data collection (a tool used by facility to track falls) dated 02/13/26, at 12:59 A.M., showed staff documented a fall occurring on 02/11/26. (Staff did not document responsible party notification.)Review of the resident's nursing progress note dated 02/14/26, at 2:03 A.M., showed staff documented an unwitnessed fall that resulted in skin tear to the resident's right forearm. (Staff did not document responsible party notification.) Review of the resident's nursing progress note dated 02/19/26, at 1:21 A.M., showed staff documented an unwitnessed fall resulting in a hematoma (bruise) to the right side of the resident's forehead. (Staff did not document responsible party notification.)Review of the facility fall risk data collection dated 02/19/26, 1:25 A.M., showed staff documented a fall occurring on 2/19/26. (Staff did not document responsible party notification.)Review of the resident's nursing progress notes, dated 02/21/26, showed no documentation of a fall occurring.Review of the facility fall risk data collection dated 02/22/26, at 2:19 A.M., showed staff documented a fall occurring on and 2/21/26. (Staff did not document responsible party notification.)Review of the resident's nursing progress note dated 02/22/26, at 12:30 P.M., showed staff documented the residents' son requested he/she be (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sent to the hospital due to a head injury that occurred on the previous shift. Review of the resident's nursing progress note dated 02/23/26, at 9:26 A.M., showed staff documented the resident had a fall on 02/21/26. (Staff did not document responsible party notification.) During an interview on 02/25/26, at 11:50 A.M., Licensed Practical Nurse (LPN) E said the following: -If a resident had an unwitnessed fall they are started on neurological checks (a rapid, periodic assessments performed by healthcare professionals to monitor brain, spinal cord, and nerve function) and they notify the doctor and the family;-If a fall happens in the middle of the night and it is a non-injury fall, the fall can be reported on day shift. During an interview on 02/25/26, at 12:31 P.M., Registered Nurse (RN) F said the following: -On Sunday (02/22/26) the night shift nurse reported that the resident had fallen, and he/she was started on neurological checks;-The night shift nurse reported that he/she did not notify the family of the fall;-He/she did not notify the residents' family of the fall;-Later that day the resident's family member came to visit and requested he/she be sent to the hospital for evaluation of bruising to the resident's head.During an interview on 02/25/26, at 12:40 P.M., LPN G said the following;-He/she was monitoring the resident due to the resident falls;-The resident had bruising to the right side of the forehead that started as a goose egg and turned into a black eye;-He/she did not notify the family since he/she had not done the initial assessment and was currently just monitoring the resident.During an interview on 02/25/26, at 1:30 P.M., LPN H said the following;-He/she was the nurse on duty when the resident fell on [DATE];-He/she started the resident on neurological checks;-He/she did not notify the residents family and asked the day shift to do so. During an interview on 02/25/26, at 2:55 P.M., the Director of Nursing (DON) said the following:-He/she expected staff to start neurological checks on all unwitnessed falls;-He/she expected the doctor, his/herself, and the resident's family to be notified of all falls by staff;-If a non-injury fall happens on night shift, staff can report fall in the morning;-He/she expected all falls and fall notifications to be documented in the nursing progress notesDuring an interview on 02/25/26, at 4:15 P.M., the Administrator said the following:-He/she expected staff to notify the physician and the family for all resident falls;-He/she expected the fall and all notifications to be documented. Complaint 2784842

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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 for all residents when staff failed to follow physician orders to obtain an x-ray and failed to follow-up regarding completion of the orders for x-rays for one resident (Resident #1) after a fall. The facility census was 66. Review of the facility policy titled, Test Results, dated 01/2017, showed the following: -Results of laboratory, radiological, and diagnostic tests shall be reported to the facility;-The medical practitioner shall be notified of the results;-The Director of Nursing Services, or nurse receiving the test results, shall be responsible for notifying the medical practitioner of such test results.1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 09/13/22;-Diagnoses included Type 2 diabetes mellitus (a chronic metabolic disorder where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond properly to insulin) with hyperglycemia (high blood sugar levels), chronic right heart failure (occurs when the right ventricle becomes too weak or stiff to effectively pump blood to the lungs, leading to systemic venous congestion, fluid retention, and reduced oxygenation), chronic respiratory failure with hypoxia (lack of oxygen), muscle wasting, pain in right knee and lymphedema (a chronic swelling, usually in the arms or legs, caused by a buildup of protein-rich lymph fluid due to damaged or blocked lymph vessels).Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/23/25, showed the following: -Cognitively intact;-Required moderate assistance for transfers.Review of the resident's care plan, dated 02/25//26, showed the following:-At risk for falls;-Educate the resident/family/caregivers about calling for assistance prior to cares and what to do if a fall occurs;-Encourage the resident to participate in activities that promote exercise, physical activity strengthening ,and improved mobility;-Resident had an unwitnessed fall on 02/16/26. Encourage the resident to utilize call light prior to transfers and to check to make sure his/her wheelchair is locked;-The resident had a witnessed fall 02/11/26. Educate the resident prior to transferring to complete task more quickly.Review of the resident's progress notes dated 02/16/26, at 7:30 P.M., showed Registered Nurse (RN) A said the resident was found on the floor laying on his/her left hip beside the bed. The resident said he/she was attempting to transfer from the bed to wheelchair when he/she slid out of bed. The fall was unwitnessed. A head-to-toe assessment and skin assessment was performed. The resident was complaining of bilateral (both sides) hip pain. The resident's family, physician and management were notified of event. A new order was received for bilateral hip x-rays to be obtained.Review of the resident's fall risk data collection dated 02/16/26, at 5:25 P.M., showed the resident had an unwitnessed fall on 02/16/26.Review of the resident's Physician Order Sheet (POS), dated February 2026, showed an order, dated 02/17/26, for bilateral hip x-rays due to a fall and increase pain in both hips entered by RN A.Review of the resident's progress notes showed the following:-On 02/17/26, at 8:58 A.M., RN A said the resident continued to be on fall follow-up charting for a fall that occurred on 02/16/26. The resident denied any pain or discomfort. The resident complained earlier of bilateral hip pain post fall. The order was received for a left and right hip x-ray to be obtained. Vital signs and neuro-checks were within normal range. Staff will continue to monitor any needs. (Staff did not document regarding the ordered x-ray or the results.);-On 02/18/26, at 6:55 P.M., staff noted no complications from previous fall and no concerns. (Staff did not document regarding the ordered x-ray or the results.);-On 02/19/26, at 12:39 A.M., staff noted the resident continued on all follow up following unwitnessed fall. Resident vital signs and neurological check within normal limits. There were no delayed injuries. The resident was resting in bed with eyes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closed and call light within reach. There were no signs of pain or discomfort. (Staff did not document regarding the ordered x-ray or the results.)Review of the resident's record showed staff did not have results for an X-ray of the resident's noted or copied. During an interview on 02/25/26, at 3:21 P.M., the resident said the following:-He/she had a fall about a week ago. He/she was assessed by the nurse and had pain in his/her legs;-He/she had not had an x-ray since then.During an interview on 02/25/26, at 9:54 A.M., Certified Nurse Aide (CNA) B said he/she gets the nurse if a resident has a fall. The resident is assessed by the nurse, and he/she will call the physician if there appears to be injury. The nurse will follow the instructions from the physician.During an interview on 02/25/26, at 11:48 A.M., Licensed Practical Nurse (LPN) D said the following:-He/she assessed a resident after a fall. He/she called the physician immediately if there was any sign of injury. If they are having increased pain the physician may want an x-ray to further assess the resident;-The nurse puts in an order for the x-ray. He/she thought the order automatically went to the x-ray company after he/she put in the order;-If x-ray does not come that day, he/she would call them to follow up and let the physician know there was a delay.During an interview on 02/25/26, at 3:24 P.M., RN A said the following:-He/she assessed the resident after he/she had a fall on 02/16/26, while attempting to transfer to a wheelchair. It was unwitnessed. He/she did neurological checks and everything was normal;-The resident was complaining of pain in both hips. He/she called the physician and got orders to get an x-ray;-He/she put orders into the computer and called the radiology company to come to the x-ray. He/she put in the orders later in the day and they said they would come the next day;-He/she got the packet ready to give them with the resident's information;-They did not come the next day. He/she called again to get the x-ray and they said they would come. He/she told the oncoming nurse that radiology should be coming to do the x-ray. He/she did not work the following day and was not sure what happened after that;-He/she did not write a note in the resident's record regarding attempts to reach radiology;-He/she was not sure why the x-ray was never done but staff should have continued to follow up on it and let the physician know if they were unable to get it. The packet that he/she prepared for the radiology staff was still at the facility.During an interview on 03/02/26, at 1:30 P.M., the radiology company staff said the following: -The facility staff did not notify them that an x-ray needed to be done. They have no record of the facility contacting them on 02/16/26 or on 02/17/26;-They document every call that they get and there should be something documented if it occurred. During an interview on 02/25/26, at 2:55 P.M., the Director of Nursing (DON) said the following:-He/she contacted the radiology company, and they said that they never received an order to do the x-ray for the resident;-The facility staff put an order in the computer but have to call the radiology company for them to come onsite to do the x-ray;-He/she was not sure why the x-ray orders were not followed up on;-The physician orders should have be followed and an x-ray should have been done.During an interview on 02/25/26, at 4:13 P.M., the Administrator said the following:-He/she would expect resident's to be assessed after a fall. If the physician recommended an x-ray, the nurse should put in the order and call the radiology company to come do the x-ray;-If radiology does not come. The nurse should continue to follow up and call them;-He/she would expect x-rays to be done.2784842