STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Strafford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 West Evergreen Strafford, MO 65757	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record review, the facility failed to protect all residents' right to be treated with dignity and respect when one staff member (Registered Nurse (RN) F) insisted one resident (Resident #2) to be placed in a wheelchair and moved against his/her wishes. Seven residents were sampled in the facility with a census of 62. Review of the facility policy titled Resident Rights Policy, dated December 2024, showed the following:-Each resident residing in this community has the right and will be afforded the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the community without interference, coercion, discrimination or reprisal;-It is the responsibility of all who work in this community, including employees of the community and any others who provide services to the residents of the community, to advocate and protect the rights of each resident;-All staff members are trained on the Resident Rights policy at the time of employment, prior to providing care to residents, and at least annually to ensure full understanding related to ensuring each resident's rights;-Each resident will have the opportunity to exercise his/her rights as a citizen or resident of the United States and staff members will assist with exercise of those rights as needed. 1. Review of Resident #2's face sheet (admission date) showed the following:-admission date of 10/06/25;-Diagnoses included Alzheimer's disease (dementia), anxiety (worried thoughts, and increased heart rate), depression (persistent sadness, hopelessness), low back pain, cognitive communication deficit, and unspecified dementia, severity with agitation (cognitive decline). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), showed the following information:-Memory problems;-No behaviors;-Impairment on one side.Review of the resident's current care plan showed the following:-The resident had a behavior problem of lowering him/herself to the floor and scooting around;-When the resident gets restless, assist him/her to the floor to scoot around;-Resident is care planned that he/she doesn't think it's wrong to scoot around on the floor.Review of the resident's progress note dated 03/14/26, at 3:15 P.M., showed Licensed Practical Nurse (LPN) D documented the following;-This nurse went into the stockroom to get medical supplies for RN F. When this nurse came out of the stock room, yelling was heard;-Certified Nurse Aide (CNA) B and CNA E reported that RN F yelled at them to help get the resident up from the floor, even though the resident was care planned to be on floor;-RN F was told the resident did not want to get up, and RN F replied, I don't care what the resident wants;-Staff placed resident into the wheelchair and the resident took a backhanded swing at RN F.During interviews on 03/23/26, at 2:13 P.M., and on 03/25/26, at 9:58 A.M., LPN D said the following:-He/she did not witness the incident between RN F and the resident;-The LPN D heard CNA B yelling;-LPN D asked CNA B and CNA E what happened, and they had the exact same story. Both aides said RN F told the resident when the resident didn't want to get into the chair, that RN F didn't care what the resident wanted. RN F then preceded to put his/her hand under the resident's arm to lift him/her to the chair and for safety reasons CNA B assisted with the transfer;-The aides said the resident swung his/her arms at RN F;-RN F should have asked the resident if he/she wanted to get into the wheelchair;-It's the resident's right to scoot around on the floor. They should not be forced to do things. -The resident is care planned to scoot on (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the floor.Review of CNA B's written statement, dated 03/14/26, showed the following:-The resident was on the floor as per his/her care plan;-Resident took him/herself into the office and CNA B was trying to guide the resident out of the office;-A separate issues occurred, and CNA B ran over to handle that;-RN F was in the doorway of the office. RN F yelled at CNA B to help move the resident out of the floor;-CNA B came back to the resident and asked the resident if he/she wanted to get up. The resident did not want to get up;-RN F said he/she didn't care what the resident wanted;-Staff picked up the resident up and put him/her in the wheelchair. Immediately the resident backhanded the nurse;-If the resident was respected and not forced, he/she wouldn't have made contact.During an interview on 03/23/26, at 1:39 P.M., CNA B said the following:-The resident sometimes stood and would become wobbly. He/she did not always like to sit in the chair so he/she would want to scoot. The resident would scoot around the unit. The resident was care planned to scoot;-On 03/14/26, RN F came to the unit, and the resident had scooted into the nurses' station behind RN F. RN F said you need to get the resident to come out. The resident was slowly scooting out. LPN D had gone to the stock room for supplies;-He/she asked the resident to come out and then was distracted by the need of another resident, so he/she left;-CNA B got back to the nurses' station and asked the resident if he/she wanted to get up. The resident said no and did not want to get up;-RN F said he/she did not care what the resident wanted; he/she wanted the resident to get into the chair;-RN F had his/her arm under the resident's arm so CNA B felt like he/she needed to help RN F, so the resident was transferred safely;-After the resident was put into the chair the resident took his/her hand and hit RN F in the belly;-The resident has the right to scoot around on the floor and should not be made to get into the wheelchair if he/she doesn't want too.Review of CNA E's written statement, dated 03/14/26, showed the following: -CNA E noticed the resident sitting on the floor in the nurses' station and CNA B was trying to convince the resident to scoot his/her way out the door;-CNA E grabbed the resident's wheelchair from the dining room to bring it closer in case the resident wanted to get off the floor;-RN F was trying to keep the resident lined up with his/her wheelchair and yelled at CNA B to help RN F get the resident in his/her chair;-CNA B was trying to get our other residents settled;-CNA E held the wheelchair ready for whatever the resident wanted to do;-CNA B got on the other side of the resident and said I don't think the resident wants back in his/her chair;-RN F said I don't care what the resident wants;-Staff put the resident back in his/her wheelchair and the resident smacked the nurse.During an interview on 03/23/26, at 3:18 P.M., CNA E said the following:-The resident was sitting in the nurses' station. The resident was care planned to sit and scoot around on the floor;-CNA B tried to get the resident to come out of the nurses' station;-LPN D went to the storage room to get something for RN F;-He/she went and got the resident's wheelchair out of the dining room in case the resident wanted to get into it;-The resident was making his/her way out of the nurses' station slowly;-RN F came out of the office to line the resident up with the wheelchair. RN F then yelled at CNA B to help him/her get the resident into the wheelchair;-CNA B asked the resident if he/she wanted to get into the wheelchair and the resident said no. RN F told the resident he/she didn't care what the resident wanted and told CNA B to help;-RN F get the resident into the wheelchair;-The resident was angry and smacked RN F on the arm or hip. -Staff should not make a resident get into a wheelchair, it's unsafe. Staff should allow a resident to scoot on the floor, especially if it's care planned.During an interview on 03/24/26, at 8:32 A.M., Registered Nurse (RN) F said the following:-He/she went back to the unit to get supplies. He/she didn't work in the unit and didn't know the resident;-The resident was scooting around in the floor, and he/she was told it's the resident's normal behavior. The resident was scooting into the office, and it's small and he/she almost stepped on the resident's hands;-One of the CNA's tried to get the resident to come out, and so did he/she;-One of the CNA's got the resident's wheelchair;-The resident kept scooting out of the office. He/she thought the aide that tried to get the resident to come out, was going to help him/her put the resident into the wheelchair;-The aide was doing something with another resident. He/she asked the aide to help, and he/she screamed as the aide wasn't listening;-He/she was afraid he/she (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure residents right to receive services in the facility with reasonable accommodation of resident needs when staff failed to follow up on and order a customized wheelchair for one resident (Resident #5), which would increase his/her ability to get out of bed and stay out of bed longer. The facility census was 62.Review of a facility policy titled Durable Medical Equipment Manual, dated 04/08/25, showed the following information:-The health plan is financially responsible for custom and power wheelchairs that have been prior authorized by the health plan prior to the enrollment effective date in the fee for service (FFS) program, but placement occurs after the effective date of FFS program enrollment;-Durable medical equipment (DME) is not covered for those participants in a nursing home. DME is included in the nursing home per diem rate and not paid for separately with the exception of custom and power wheelchairs;-Missouri HealthNet Division (MHD) requires all providers of custom and wheelchairs provide equipment that meets the participant's needs for mobility and positioning in a cost-effective manner for participants in a nursing home;-When submitting a prior authorization (PA) request for a custom or power wheelchair, there must be comprehensible written documentation submitted with the PA request. Letters of medical necessity LMNs) and supporting documentation must be signed by the prescribing physician as well as the nursing home's director of nursing or the nursing homes employed or contracted licensed physical or occupational therapist;-In addition, LMSs generated by the supplier must be written on the supplier's letterhead and signed by both the supplier and the prescribing physician as well as the nursing homes director of nursing or the nursing homes employed or contracted licensed physical or occupational therapist;-Custom or power wheelchairs for participants residing in a nursing home must be supplied by a DME provider that employs a Rehabilitation Engineering Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) who specializes in wheelchairs. The ATP must meet the supplier and quality standards established for DME suppliers and must be present during the patient evaluation;-The provider record should document how the ATP was involved and directed the wheelchair selection process;-For a custom or power wheelchair to be covered for a participant residing in a nursing home, a treating physician must be the first point of contact with the participant and conduct a face-to-face examination of the participant before writing an order for the custom or power wheelchair. The physician's required face to face examination must be completed prior to any evaluation or contact by any person associated with the DME provider, including an ATP. Physicians shall document the face-to-face examination in a detailed narrative note in the participant's chart in the format they use for other entries. Forms or sample documentation created by a supplier or facility that the physician completes are not substitute for the comprehensive medical record/chart note indicated above. The physician face to face examination must provide the following information, symptoms that limit ambulation, diagnoses that are responsible for symptoms, progression of ambulation difficulty over time, other diagnoses that may relate to ambulatory problems, cardiopulmonary examination, and weight and height;-The physical examination that is related to mobility needs shall include existing ambulatory assistance, ability to stand up from a seated position without assistance, description of the ability to perform activities of daily living, distance the participant can walk without stopping, pace of ambulation, musculoskeletal examination to include arm and leg strength and range of motion, neurological examination to include documentation of functional ambulation and balance and coordination, and weight and height;-After the face-to-face examination with the physician, the physician may choose to refer the participant to a licensed physical therapist or occupational therapist for completion of the physical portion of the exam. If utilized, the therapy examination must be authorized by the therapist and reviewed by the physician after completion, agreed upon or amended. The therapy evaluation would complete the physical portion of the face-to-face examination and would contain all the required items listed under the (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical portion of the face-to-face examination. This would be a therapy evaluation only, not a wheelchair evaluation;-A prior evaluation completed by a licensed physical or occupational therapist within the past 90 days may also be utilized for the physical portion of the examination. All areas noted above for the physical examination must be addressed. If utilized, the physical or occupational therapist examination must be reviewed by the physician after completion, agreed on or amended and signed before issuing the physician order;-The face-to-face examination must be completed by the physician or nurse practitioner prior to any evaluation performed by the DME provider, including the ATP. The DME provider must receive the written report of this examination within 90 days after completion of the face-to-face physician examination. A date stamp or equivalent must be used to document the date that the provider receives the report of the face-to-face physician examination. The written report of the physician examination must be submitted with the PA request;-Evaluations written or scribed by the DME provider and signed by the therapist is not acceptable as an occupational/physical therapist evaluation. All documentation from the DME provider shall be separate from the therapy evaluation. All documentation submitted by the ATP should be on DME letterhead signed and dated by the ATP;-All documentation explaining medical necessity for items requested on the PA request must be reviewed and approved by the physician/practitioner as indicated by signing and dating the document;-When requesting a custom or power wheelchair for a nursing home participant, a physician order must be received by the DME provider within 90 days after the completion of the face-to-face physician examination and prior to any DME provider evaluation. The physician's order must contain the participant's name, description of the item that is ordered, date of the face-to-face examination, pertinent diagnoses/conditions that relate to the need for the custom or power wheelchair, length of need, physician's signature, and date of physician's signature;-A date stamp or equivalent must be used to document receipt date of the physician or nurse practitioner order. This order must be included with the PA request. If it is not included, the PA request will be returned as incomplete;-MDS will reimburse for medically necessary custom wheelchairs for participants residing in a nursing facility. A custom wheelchair is defined as a chair that is tailor made for one participant and cannot be used by anyone else. PA required. All PA requests must indicate why a less costly wheelchair is unable to meet the participant's needs.Review showed the facility did not provide a policy related to physician's orders.1. Review of Resident #5's face sheet (brief information sheet about the resident) showed the following information:-admission date of 01/16/25;-Diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (partial weakness or inability to move one side of the body) following a stroke affecting the left side, muscle wasting and shrinking, need for assistance with personal care, depression (feelings of sadness, chronic obstructive pulmonary disease (progressive and incurable lung disease that makes breathing difficult), unsteadiness on feet, cervicalgia (pain in the neck region), and low back pain.Review of the resident's progress notes, dated 06/24/25, showed the resident currently sitting up in wheelchair, denies having any pain or discomfort at this time.Review of the resident's progress notes, dated 10/24/25, showed a social services note stating the spouse called and wanted the facility to get a new wheelchair for the resident. The social worker informed the spouse that he/she would have to pay out of pocket for the wheelchair. The spouse stated that he/she could not afford to pay for a wheelchair out of pocket. The social worker spoke with the resident, and he/she stated he/she would like to try one of the facility's wheelchairs and see what happens. The social worker spoke with the Physical Therapy Director, and he/she said he/she would get one out and have the resident try it out on Monday.Review of the resident's care plan, revised 01/08/26, showed the following:-Had hemiplegia/hemiparesis related to a stroke;-Will maintain optimal status and quality of life within limitations imposed;-Pain management and alternative comfort measures as needed;-Had pain and will not have an interruption in normal activities due to pain;-On pain medication therapy;-Will be free of any discomfort or adverse side effects of pain medication;-Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident a different wheelchair to try, but the resident refused it;-The wheelchair that was offered was bigger than the wheelchair the resident has now;-When Resident #5 was in the 500 hall for approximately 2 1/2 years, staff stored his/her wheelchair in the spa room on 400 hall;-The resident had never told him/her that he/she does not like the wheelchair that he/she currently has;-He/She recalls putting the resident's wheelchair form in one of the previous physician's folders for approval and an order, but he/she does not recall the exact date or timeframe;-For three weeks, he/she kept moving the wheelchair form to the front of the previous doctor's folder;-The last time he/she went to see if the wheelchair form was signed, all the papers were gone from the physician's folder, so he/she assumed the form went to the next person in the facility;-Two months later, the physician's nurse practitioner came to him/her and asked for the resident's wheelchair form;-He/She told the nurse practitioner the physician already had the form in his/her folder to sign;-The nurse practitioner reported that he/she had not seen the form for Resident #5;-The Physical Therapy Director completed another wheelchair form for Resident #5 and put it back in the same previous physician's folder;-During that time, none of the three physicians that were coming to the facility were coming in at all and their folders were growing and growing with paperwork;-Another physician started coming to the facility, but he/she did not do anything with the resident's wheelchair form again because he/she thought the form was sent to the wheelchair company the second time;-He/She suddenly saw an order pop up for January or February of 2026 for a custom wheelchair again;-The January or February 2026 order was not brought to his/her attention until three weeks ago by the administrator;-In a recent morning meeting, he/she told the administrator they could streamline the wheelchair order for the resident if the family would pick a wheelchair provider;-At this point, the wheelchair evaluation for the resident is too old, but if someone will get with the family to pick a medical device company, he/she will assist with getting the wheelchair evaluation company here to help get the resident a custom wheelchair;-He/She recalls telling the resident's family in June of 2025 that they would need to pick a wheelchair company, but he/she never heard back from anyone;-Since January of 2026, the resident has been up more in his/her wheelchair since he/she got the new roommate that gets out of bed and uses his/her wheelchair;-If the social worker will come to him/her and tell him/her which wheelchair company the family wishes to use, he/she will complete the wheelchair evaluation again even though the resident is not enrolled in therapy.-He/She does not have any paperwork in his/her therapy file for the resident's custom wheelchair process;-The custom wheelchair request occurred June of 2025 during Resident #5's care plan meeting;-He/She got a facility wheelchair from the shed to let the resident try before they tried to order him/her a new custom chair, but the resident refused to try it;-He/She asked the resident if he/she would get up in a wheelchair if he/she had one that was more comfortable;-He/She recalls that he/she got a stack of signed paperwork back from the physician's folder that he/she placed other paperwork in, but Resident #5's signed paperwork was never returned to him/her;-He/She plans to talk with the Social Services Director after he/she returns to work after his/her training is finished to let him/her know that he/she will need to tell the family that the custom wheelchair will depend on payment and the family's willingness to pay for it.During interviews on 03/24/26, at 2:00 P.M., and on 03/25/26, at 10:55 A.M., the facility's medical director said the following:-In January of 2026, he/she did sign an order for the resident to receive a custom wheelchair;-He/She would expect the wheelchair to be at the facility by now.-He/She recalls calling the wheelchair company and followed up on the wheelchair for the resident;-He/She could not find any documentation in the resident's electronic medical record that showed what day and time he/she called, who he/she called, or what the outcome was;-He/She knows that the order did get to the wheelchair company, but he/she does not recall which wheelchair company;-He/She does not think the resident's insurance will pay for the specialty wheelchair.During a phone interview on 03/25/26, at 9:16 A.M., the business office manager said the following:-The process of ordering a new wheelchair goes through the therapy department;-He/She does not have any paperwork regarding the custom wheelchair that was ordered for Resident #5 on 01/22/26;-The (continued on next page)

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	03/26/2026

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy department uses a mobility equipment supplier to measure and size a wheelchair for a resident;-Even if the resident is not on therapy services, the therapy department completes the evaluation for a wheelchair and sends it through the equipment supplier company.During a phone interview on 03/26/26, at 3:45 P.M., the Social Services Director said the following:-He/She has not heard anything about the resident's custom wheelchair order;-He/She knows that he/she was not much help and would have to defer questions about Resident #5's custom wheelchair order to the Administrator or Business Office Manager.During an interview on 03/25/26, at 10:35 A.M., the Director of Nursing (DON) said the following:-The resident only gets out of bed to get a shower;-The resident refuses to get out of bed all the time and staff should be documenting that;-He/She does not know why the resident requested a custom wheelchair;-He/She has not complained to him/her about his/her wheelchair hurting him/her;-Therapy said they cannot get the resident to get up out of bed, so there is no need for the resident to get a new wheelchair;-A mobility equipment supplier was supposed to be involved with the new wheelchair process for the resident;-The DON received a call from the equipment supplier regarding the resident's wheelchair order about a month ago or longer and he/she tried to get the physical therapy department to look into it;-The resident does not qualify to get the wheelchair paid for;-If the resident will get out of bed and prove he/she will get up out of bed, it may be easier for him/her to get a new wheelchair;-The resident's wheelchair issue is new for him/her;-He/She would expect the 01/22/26 physician's order for the custom wheelchair to be resolved by now or at least something documented about the progress on it;-He/She does not have any paperwork regarding the custom wheelchair that was ordered for the resident on 01/22/26.During an interview on 03/25/26, at 3:45 P.M., the Administrator said the following:-There was a face-to-face meeting about the resident's custom wheelchair request, but he/she is not sure who the face-to-face meeting was with;-There is an active order, dated 01/22/26, in the resident's chart for a custom wheelchair;-He/She is not sure if anyone is working on getting the custom wheelchair for the resident as it was ordered;-He/She will check with the physical therapy director and the DON to follow up on where things are at with ordering the resident's custom wheelchair;-After the therapy department did their part and talked to the medical equipment company, he/she is not sure what happened with the process to obtain the resident's wheelchair;-He/She does not have any paperwork regarding the custom wheelchair that was ordered for the resident on 01/22/26.2. During an interview on 03/23/26, at 12:35 P.M. and 03/24/26, at 11:57 A.M., the physical therapy director said the following:-To get a new wheelchair, staff have to identify the need for a new wheelchair and then do a wheelchair evaluation assessment;-After the assessment is completed, someone at the facility should contact the company that the resident would potentially get a new wheelchair from, complete a form and send it back to the company. After that, the form is put into the physician's folder for approval and an order;-An occupational therapy wheelchair therapist at the facility works with the medical supply company;-Before the facility had the current medical director, they had three other physicians in the facility;-He/She thinks the social worker was supposed to work with the family to pick a medical device company, but he is not sure. That is something that he/she is not involved in.-He/She does not usually get the signed forms back. Someone else at the facility takes care of the wheelchair process after the form is signed, but he/she does not know whose responsibility that is;-The facility was bought out by another company a little over a year ago and he/she is not familiar with the new company's policy on ordering a wheelchair for a resident that is not on therapy services.3. During an interview on 03/24/26, at 11:00 A.M., Licensed Practical Nurse (LPN) D if any resident wanted a new wheelchair, he/she would refer them to the therapy department.4. During a phone interview on 03/26/26, at 3:45 P.M., the Social Services Director said the following:-He/She has only worked at the facility for three weeks, so he/she does not know anything about the process for ordering a custom wheelchair for a resident;-He/She is not aware of a medical equipment ordering policy;-He/She only knows that the maintenance department would order beds and similar equipment;-If he/she needed to have anything ordered for a resident, he/she would get it cleared (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through the Administrator first.5. During an interview on 03/25/26, at 10:35 A.M., the Director of Nursing (DON) said the following:-He/She does not know what the facility process is for assisting resident with getting a customized wheelchair;-The DON thinks the therapy department heads that up and communicates with the family;-He/She thinks the social worker would potentially be involved with ordering a custom wheelchair for a resident, but he/she is not sure;-Even if a resident is not enrolled in therapy, the physical therapy department would still evaluate them for a wheelchair; -The therapy department would start the process for a new wheelchair;-The family would pick the durable medical equipment company they want to use.6. During an interview on 03/25/26, at 3:45 P.M., the Administrator said the following:-The DON should be following and reviewing physician orders to make sure they are taken care of;-The social worker has no role in assisting a resident with obtaining a new wheelchair;-The maintenance director, DON, and/or the administrator orders equipment. Complaint 2806439 and 2794316

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on observation, interview, and record review the facility failed to provide one resident (Resident #8) or the resident's representative with notice regarding a room change, including the reason for the room change, before the facility moved the resident to another room. The facility's census was 62.1. Review of Resident #8's face sheet (brief information sheet about the resident) showed the following information:-admission date of 05/16/25;-Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris (a condition where plaque builds up in the heart's arteries and restricts blood flow), high blood pressure, dementia (a progressive decline in memory and thinking), anxiety (excessive uncontrollable fear), and age-related cognitive decline.Review of Resident #8's care plan, dated 5/19/25, showed the resident preferred to have his/her family involved in care discussions.Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 3/20/26, showed the following:-Severe cognitive impairment;-Used a wheelchair.Review on 03/25/26, at 4:45 P.M., of the facility census report for Resident #8 showed the following:-Staff moved the resident to a different room on 05/16/25;-Staff moved the resident to a different room on 06/12/25; -Staff moved the resident to a different room on 12/10/25;-Staff did not document a room change for 03/25/26;-Room change documentation for 03/25/26 was requested from the facility but not provided.Review on 03/25/26, at 4:45 P.M. of the resident's nurses' notes showed the following:-Facility staff did not document any information regarding a room change for the resident. -Facility staff did not document discussing the room change with the resident or the resident's representative.Observation and interview on 3/25/26, at 5:00 P.M., showed the following:-Resident #8's room on the special care unit was empty; -Resident's #8's name showed on the name tag outside of a new room.During an interview on 3/25/26, at 5:00 P.M., Certified Nursing Assistant (CNA) P said the following:-Resident #8 was moved to a different room around 2:00 P.M. today;-The resident was moved because the facility is getting a new resident that will be private pay;-Resident #8 is not moved from his/her room a lot;-Resident #8 gets along well with other residents;-He/She has not seen any visitors for the resident today or any other day that he/she has cared for Resident #8;-Resident #8 may or may not understand that he/she has been moved to a new room with a resident. It is hard to say if he/she fully understands.-The facility has two rooms in the special care unit that are used for private pay residents.During an interview on 3/25/26, at 5:10 P.M., Resident #8 said the following:-Staff did not ask him/her if he/she wanted to be moved to a different room, but he/she is fine with the move;-He/She does not know when he/she was moved to a different room;-He/She has a new apartment and a new roommate.During an interview on 3/25/25, at 5:33 P.M., Licensed Practical Nurse (LPN) D said the following:-He/She is the charge nurse on the special care unit, but he/she was not the one that moved Resident #8 to a different room. He/She was recently informed by staff that the resident was moved;-He/She thought the facility was supposed to notify the family before the room change was made, but that did not happen with Resident #8;-The housekeeping staff moved the resident to the new room this afternoon and the Maintenance Director came by the nurse's station and handed him/her a written note that said Resident #8 was moved from one room to another;-The resident was moved to a different room because the facility was supposed to get a new admission, but no one seems to know about the new admission;-He/She just spoke with the corporate nurse on the phone and was informed that notifying the family of the room change was just a courtesy call;-LPN D did not tell Resident #8 or his/her family about the move, so there is no documentation in the resident's progress notes regarding the room change;-He/She will call the family soon to notify him/her that the resident was moved this afternoon, and he/she will document it in the resident's progress notes.During an interview on 3/25/26, at 5:10 P.M., the Director of Nursing (DON) said the following:-There was a resident moved earlier today, so staff could make the room a private room for (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a new resident;-LPN D should have notified the resident and/or their family and documented it.-Residents are moved if there is a reason to move them;-If the resident is their own person, staff would let the resident know and the social worker would document the resident was notified of the room change in their medical record notes.During an interview on 3/25/26, at 5:43 P.M., the Corporate Nurse and the Administrator said the following:-Resident #8 was moved to a different room today due to a new admission needing a private room;-Resident #8 is his/her own person and his/her family member is his/her emergency contact;-Resident #8 was not notified of the room change before he/she was moved;-No documentation or paperwork is available showing that Resident #8 and/or his/her family was notified of the room change prior to the room change being completed.-The facility does let the family or responsible party know when a room change is made;-The staff member that moves the resident should document the move and notification to the resident or family.Complaint 2964439

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect each resident's right to self-determination through support of resident choice when the facility failed to honor the reasonable shower preferences for four residents (Resident #3, #4, #5, and #6). The facility census was 62.Review showed the facility did not provide a policy on showers.1. Review of Resident #3's face sheet (brief information sheet about the resident) showed the following information:-admission date of 02/10/25;-Diagnoses included hemiplegia (paralysis of one side of the body), heart disease, type II diabetes (body develops insulin resistance and fails to use insulin properly), Chronic obstructive pulmonary disease (constriction of the airways and difficulty breathing), and major depressive disorder (persistent feelings of sadness). Review of the resident's shower sheets, titled bathing for February 2026 showed the following:-On 02/05/26, six days after the last shower, the resident received a shower;-On 02/09/26, the resident received a shower;-On 02/12/26, the resident received a shower;-On 02/19/26, the resident received a shower (seven days after the last documented shower);-On 02/24/26, the resident received a shower (five days after the last documented shower). Review of the resident's care plan, last revised 02/25/26, showed the following:-Potential for skin integrity related to decreased mobility;-Resident had bladder incontinence;-Resident had an adult daily living self care deficit;-Resident required two staff assist for bathing,Review of the resident's progress notes, dated February 2026, showed staff did not document any additional showers or shower refusals by the resident.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 03/04/26, showed the following:-Cognitively intact;-Very important to the resident to choose between a tub bath, shower or bed bath;-Set up for personal care assistance;-Partial assistance with upper body dressing;-Substantial assistance for showers;-Dependent upon staff for toileting hygiene and lower body dressing;-Frequently incontinent of the bowel and bladder. Review of the resident's shower sheets, titled bathing for March 2026, showed the following:-On 03/10/26, the resident received a shower (fourteen days after the last documented shower);-On 03/15/26, the resident received a shower (five days after the last shower);-On 3/24/26, the records showed the resident had not received a shower in the last nine days. Review of the resident's progress notes, dated March 2026, showed staff did not document any additional showers or shower refusals by the resident.During an interview on 03/23/26, at 9:25 A.M., Resident #3 said his/her last shower was on 03/15/26. The last few times he/she was supposed to have a shower, they were short staffed and he/she doesn't get a shower. The resident believes he/she smells and feels others probably doesn't want to be around him/her. He/she would like two showers per week. During an interview on 03/24/26, at 9:51 A.M., Certified Nursing Assistant (CNA) H said the following:-Resident #3 never refuses showers. He/she asked for one yesterday but he/she didn't get to it. He/she gave Resident #3 a shower today. Resident #3 told him/her it had been over a week since the last shower.During an interview on 03/24/26, at 2:00 P.M., the Director of Nursing (DON) said the following:-He/she has not received any complaints from Resident #3 regarding showers.During an interview on 03/25/26, at 3:26 P.M., the administrator said the following:-Resident #3 caught him/her a couple of weeks ago and said he/she didn't get a shower as he/she was scheduled to earlier in the day. 2. Review of Resident #4's face sheet showed the following information:-admission date of 03/22/23;-Diagnoses included lumbar region spondylosis with myelopathy (a severe age-related degenerative condition where wear and tear in the lower spine compresses the spinal cord), depression (persistent feelings of sadness, osteoarthritis of the knee (breakdown of cartilage in the knee that causes joint pain), osteoporosis (a decrease in bone mass), muscle wasting and shrinking, and difficulty walking.Review of the resident's shower sheets, titled bathing for February 2026, showed the following:-On 02/02/26, the (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident was offered a shower, but did not receive a shower due to the resident requesting to take a shower on 02/03/26;-On 02/03/26, the resident did not receive a shower;-On 02/09/26, the resident received a shower (11 days after the last documented shower);-On 02/20/26, the resident received a shower (11 days after the last documented shower).Review of the resident's care plan, last revised 02/25/26, showed the following:-Had an activities of daily living self-care performance deficit of fatigue;-Resident required the assistance of one staff for bathing.Review of the resident's progress notes, dated February 2026, showed staff did not document any additional showers or shower refusals by the resident. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Very important to the resident to choose between a tub bath, shower or bed bath;-Used a wheelchair and/or scooter;-Partial to moderate assistance with tub/shower transfer and showering/bathing self;-Supervision or touch assistance with personal hygiene;-Setup or clean up assistance with toileting hygiene. Review of the resident's shower sheets, titled bathing for March 2026, showed the following:-On 03/10/26, the resident received a shower (18 days after the last documented shower);-On 03/15/26, the resident received a shower (five days after the last documented shower);-On 3/24/26, the records show the resident has not received a shower in the last nine days. Review of the resident's progress notes, dated March 2026, showed staff did not document any additional showers or shower refusals by the resident. During an interview on 03/23/26, at 10:30 A.M. and 03/25/26, at 12:45 P.M., Resident #4 said the following:-His/Her last shower was one week and one day ago (03/15/26), but sometimes he/she does not get a shower for two weeks or longer;-The timeframe between his/her showers varies because the facility always has someone different giving the showers;-Recently, one staff member said they did not want to get wet, so he/she had to do his/her own shower without assistance;-The inconsistencies in receiving showers has been happening for a while;-When he/she does not receive a shower in several days, it makes him/her feel dirty and embarrassed;-He/She has itching of his/her skin when he/she does not receive showers consistently;-He/She knows that his/her hair looks greasy right now;-The facility lost their beautician in September of 2025 and there has not been a beautician at the facility since.-His/her hair is oily. 3. Review of Resident #5's face sheet showed the following information:-admission date of 01/16/25;-Diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (partial weakness or inability to move one side of the body) following a stroke affecting the left side, muscle wasting and shrinking, need for assistance with personal care, depression (feelings of sadness, chronic obstructive pulmonary disease (progressive and incurable lung disease that makes breathing difficult), unsteadiness on feet, cervicalgia (pain in the neck region), and low back pain. Review of the resident's care plan, last revised 01/08/26, showed the following:-Had hemiplegia/hemiparesis related to a stroke;-Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility;-Dependent on staff for activities, cognitive stimulation, and social interaction;-Will maintain involvement in cognitive stimulation and social activities as desired;-Does not mind or care who takes care of him/her as long as they respect him/her and take care of him/her;-Prefers to have his/her spouse involved in discussions of care:-Had potential/actual impairment to skin integrity related to hemiplegia;-Monitor pressure areas for changes in color, sensation, and temperature and report any changes to the nurse;-Had an activities of daily living self-care performance deficit;-Will maintain current level of function;-Often refuses to get up for showers, offer a bed bath or a partial bed bath when he/she refuses;-Totally dependent on staff for repositioning and turning in bed;-Totally dependent on staff for dressing;-Required total assistance with personal hygiene:-Required mechanical aid (sling) for transfers;-Required total assistance with transfers.Review of the resident's shower sheets, titled bathing for February 2026, showed the following:-On 02/02/26, the resident received a shower;-On 02/05/26, the resident received a shower;-On 02/24/26, the resident refused a shower;-On 02/25/26, the resident refused a shower.Review of the resident's progress notes, dated February 2026, showed staff did not document any additional showers or shower refusals by the the (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Used a wheelchair;-Occasional urinary incontinence;-Always incontinent of bowel;-Risk of pressure ulcer/injury;-Partial to moderate assistance with upper body dressing;-Supervision or touch assistance with personal hygiene;-Setup or clean up assistance with eating and oral hygiene;-Dependent for toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear, tub/shower transfer, chair/bed to chair transfer, and rolling left and right. Review of the resident's shower sheets, titled bathing for March 2026, showed the following:-On 03/02/26, the resident received a shower (25 days after the last documented shower);-On 03/09/26, the resident received a shower (seven days after the last documented shower);-On 03/23/26, the resident received a shower (14 days after the last documented shower).Review of the resident's progress notes, dated March 2026, showed staff did not document any additional showers or shower refusals by the resident. During an interview on 03/23/26, at 10:00 A.M., Resident #5 said the following:-He/She just received a shower;-He/She is supposed to get a shower two times per week;-He/She is lucky if heshe gets one shower every two weeks;-Prior to today, his/her last shower was on a Tuesday and quite a few Tuesdays ago;-Staff kept promising him/her a shower on 03/10/26, but it did not happen;-He/She does not refuse his/her shower;-He/She would like to have at least two showers per week;-It makes him/her feel neglected when he/she does not get a shower like he/she is supposed to;-He/She would like to be shaved with every shower, but he/she forgot to ask the aides to shave him/her when he/she got his/her shower this morning. During an interview on 03/24/26, at 2:00 P.M., the DON said Resident #5 always complains about not getting his/her showers, even after he/she just had one. 4. Review of Resident #6's face sheet (brief information sheet about the resident) showed the following information:-admission date of 10/03/23;-Diagnoses included osteoarthritis (breakdown of cartilage in the joints that causes joint pain), muscle wasting and shrinking, dementia (progressive memory loss), spinal stenosis (narrowing of the spinal canal that compresses nerves), adult failure to thrive (a decline in physical and cognitive function), and need for assistance with personal care. Review of the resident's care plan, last revised 01/29/26, showed the following:-Had an activities of daily living (ADL) self-care performance deficit requiring staff assistance with ADL and cares;-Resident required assistance from one staff for bathing, dressing, personal hygiene and oral care, and using the toilet;-Had bladder incontinence and needed assistance with toileting needs;-Will be free from skin changes related to incontinence and brief use;-Required monitoring of pressure areas for changes in color, sensation, and temperature;-Required staff to check for incontinence, and wash, rinse, and dry his/her perineum (area located between the thighs and buttocks), and change clothing as needed after incontinence episodes.Review of the resident's shower sheets, titled bathing for February 2026 showed the following: -On 02/12/26, the resident received a shower;-On 02/19/26, the resident received a shower (seven days after the last documented shower);-On 02/24/26, the resident received a shower (five days after the last documented shower). Review of the resident's progress notes, dated February 2026, showed staff did not document any additional showers or shower refusals by the resident.Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Very important to the resident to choose between a tub bath, shower or bed bath;-Used a wheelchair and walker;-Partial to moderate assistance for sit to stand;-Supervision or touch assistance with toilet transfer and tub/shower transfer;-Substantial/maximal assistance with upper body dressing;-Dependent with toileting hygiene, shower/bathe self, lower body dressing, personal hygiene, and putting on/taking off footwear;-Occasional urinary incontinence;-Continent of bowel. Review of the resident's shower sheets, titled bathing for March 2026, showed the following:-On 03/15/26, the resident received a shower (26 days after the last documented shower);-On 3/24/26, the records showed the resident had not received a shower in the last eight days.Review of the resident's progress notes, dated March 2026, showed staff did not document any additional showers or shower refusals by the resident. During an interview on 03/23/26, at 11:00 A.M., Resident #6 said (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Strafford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 West Evergreen Strafford, MO 65757	

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the following:- He/She only gets one shower per week on Tuesdays, if there is enough staff available;-His/Her last shower was about a week ago;-He/She would like to have two showers per week;-When he/she came to the facility approximately three years ago, he/she received a shower two times per week;-He/She feels better after he/she has a shower;- The resident was concerned about stinking and hoped he/she did not stink;-When he/she does not get a shower, he/she uses more deodorant than normal so other people will not smell him/her.5. During an interview on 03/23/26, at 1:39 P.M., Certified Nursing Assistant (CNA) C said the following:-Residents are supposed to be offered showers two times per week;-There is a problem with residents receiving showers;-The staff working on the hall providing direct care are responsible for giving showers. The resident's showers are split between the day and evening shift staff;-He/she has received complaints from various residents, some say it's been two weeks since they received a shower;-Staff documented showers on shower sheets until two weeks ago when the staff began documenting them in the medical records; -If a resident has non-applicable (N/A) marked on their sheet, it means they did not receive a shower as it wasn't their day.During an interview on 03/24/26, at 9:51 A.M., CNA H said the following:-Nurse's aides are expected to give resident showers;-There are usually three aides working outside of the unit to cover 100, 300, 400 and 500 halls;-If they have enough staff, they offer showers two times per week;-If the residents don't get showers on the day shift, the evening shift is supposed to do them;-The schedule goes by room number, they have a list in the three ring binder;-There have been complaints from residents not getting showers, he/she doesn't believe any residents are getting them consistently;-They used to complete shower sheets but now everything is documented in the medical records;-If there is no documentation, there was no shower.During an interview on 03/24/26, at 9:35 A.M., Certified Medication Technician, (CMT) G said the following:-No certain staff are appointed to do showers. The aides are supposed to split the residents up, but he/she is not certain exactly how that's supposed to work;-He/she has heard residents are complaining of not receiving showers;-The staff are supposed to document showers in the medical record;-The residents should be offered showers two times per week.During an interview on 03/24/26, at 10:12 A.M., CMT I said the following:-He/she doesn't know how the shower schedule works. He/she believes there is a book and the aides split the showers between days and evenings;-He/she has not heard complaints recently;-He/she knows the showers are documented in a book, he/she doesn't know if they're documented in the electronic medical record;-He/she doesn't know which residents have or have not received showers.During an interview on 03/25/26, at 9:44 A.M., CMT M said the following:-They have a list of residents to shower daily. It's set up by room numbers;-Each of the aides have the responsibility of completing showers for their halls;-When they have enough aides, the showers are completed, and that's not always the case;-Some residents have complained about not getting showers. They should be offered two showers per week;-He/she doesn't know where the showers are documented.During an interview on 03/23/26 at 2:13 P.M., and on 03/25/26, at 9:58 A.M., Licensed Practical Nurse (LPN) D said the following:-Residents receive showers two days per week, he/she has not heard of any issues with residents not offered showers.During an interview on 03/23/26, at 2:59 P.M., Registered Nurse (RN) Q said the following:-The aides are responsible for providing the residents with a shower two times per week;-The shower schedule is put on a daily assignment sheet;-Sometimes daytime showers get pushed to the evening;-He/She did not know of any residents going two weeks without getting a shower;-Some residents have asked him/her what day they are going to get a shower.During an interview on 03/24/26, at 2:00 P.M., the DON said the following:-He/she knows showers have been a problem in the past;-He/she came up with a new formula. Each room is given a shower day two days per week;-First two rooms of each hall get them on Monday and Thursday, the next two rooms on Tuesday and Friday, and the next two rooms on Wednesday and Saturday and it starts over;-He/she should be looking over the shower sheets to ensure they are completed, but he/she has not done that. LPN D looks over the electronic shower charting too;-If the not applicable is marked on the electronic (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record, that would mean it wasn't their shower day and they did not receive a shower.During an interview on 03/25/26, at 3:26 P.M., the Administrator said the following:-Residents should be offered two showers per week;-These are documented in the electronic records; however, some may still be completing the shower sheets;-If the electronic medical record shows not applicable, the resident did not get a shower.Complaints #2790852, 2794316, 2806439, 2960762

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	265656	A. Building B. Wing	03/26/2026

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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 protect each resident's right to a safe, clean, comfortable, and homelike environment when staff failed to properly and frequently clean the floor in a resident room for two residents (Resident #5 and Resident #9) resulting the floor being sticky The facility census was 62.1. Review of Resident #5's face sheet (brief information sheet about the resident) showed the following information:-admission date of 01/16/25;-Diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (partial weakness or inability to move one side of the body) following a stroke affecting the left side, and unsteadiness on feet. Review of the Resident #5's care plan, last revised 01/08/26, showed the following:-Had hemiplegia/hemiparesis related to a stroke;-Dependent on staff for activities, cognitive stimulation, and social interaction.Review of Resident #5's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 03/16/26, showed the following:-Cognitively intact;-Used a wheelchair.During interviews on 03/23/26, at 10:00 A.M., and on 03/23/26, at 1:00 P.M., Resident #5 said his/her family member recently brought a wet Swiffer sweeper in to mop his/her floor twice due to it being sticky.2. Review of Resident #9's face sheet (brief information sheet about the resident) showed the following information:-admission date of 03/26/24;-Diagnoses included chronic right heart failure and high blood pressure.Review of Resident #9's care plan, last revised 03/11/26, showed the following:-The resident had a communication problem;-The resident will be able to make basic needs known on a daily basis;Review of Resident #9's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 03/19/26, showed the resident was cognitively intact.During an interview on 03/24/26, at 10:14 A.M., Resident #9 said the following:-Staff does not mop his/her room every day.-The floor stays sticky in his/her room because he/she has urine incontinence;-The aides do mop the floor, but he thinks they do not change the water in the mop bucket, so that is why his/her floor stays sticky.3. Observation on 03/23/26, at 10:00 A.M., showed Resident #5 and Resident #9's floor in their room was sticky. Observation on 03/23/26, at 1:00 P.M., showed Resident #5 and Resident #9's floor in their room was sticky.Observation on 03/24/26, at 10:14 A.M., showed Resident #5 and Resident #9's floor was sticky.4. During an interview on 03/24/26, at 10:08 A.M., Housekeeper R said the following:-Earlier, he/she was in Resident #5 and Resident #9's room mopping and he/she noticed the floor was sticky before and after he/she mopped;-He/She plans to tell his/her supervisor that the floor in the residents' room is sticky;-He/She does not know if the residents' floor was mopped yesterday because he/she worked in laundry and did not mop any floors.-He/She mops the floor in every room every day;-He/She changes his/her mop water frequently. During an interview on 03/24/26, at 11:06 A.M., Housekeeper S said the following:-Resident #5 and Resident #9's floor is just that sticky all the time because Resident #9 is incontinent and urinates everywhere;-He/She sees urine on the floor all the time.-The urine comes out of Resident #9's depend;-He/She assumes the nurse aides mop the floor when Resident #9 is incontinent and they clean him/her up, but he/she is not sure.-He/she changes his/her mop water with every hall.During an interview on 03/25/26, at 10:06 A.M., Housekeeper T said the following:-He/She is aware of the sticky floor in Resident #5's and Resident #9's room and he/she thinks it is caused by Resident #9 having urinary incontinence;-The housekeepers use their disinfectant mop to mop their room the same as they mop all other resident rooms;-Resident #5's and Resident #9's floor in their room is sticky almost every day, but he/she has not mentioned it to his/her supervisor.-All resident rooms are mopped every day;-The new housekeeping supervisor just started on 03/20/26, and he/she is still learning. During an interview on 03/24/26, at 11:25 A.M., Certified Medication Technician (CMT) G said the following:-Staff cleans the urine off of Resident #5's and Resident #9's floor with towels or a mop, or they let the housekeepers know they need to mop.-Resident #5's and Resident #9's floor in their room (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is sticky;-If he/she uses a mop to clean the urine off the residents' floor, he/she changes the mop bucket water.-Resident #9 is incontinent of urine;-He/She is aware of the sticky floor in their room and he/she thinks it is caused by Resident #9 having urinary incontinence;-The housekeepers use their disinfectant mop to mop their room the same as they mop all other resident rooms;-The floor in their room is sticky almost every day, but he/she has not mentioned it to his/her supervisor. During an interview on 03/25/26, at 10:14 A.M., RN Q said he/she is aware of the floor being sticky in Resident #5's and Resident #9's room, but the residents have not complained to him/her about it. During an interview on 03/25/26, at 10:35 A.M., the Director of Nursing (DON) said the following:-Resident #5's room is usually a mess because of Resident #9;-He/She has not noticed the floor in Resident #5's and Resident #9's room being sticky;-Resident #5 may spill his/her urine on the floor;-Staff tried to use special cleaning wipes in their room and they mop;-The DON has never seen Resident #5's family mopping his/her room.-Housekeeping staff is here every day;-The head housekeeper walked out about two weeks ago and took all the housekeepers with her;-The facility just hired new housekeeping staff, and it has been hard to get things done;-Nursing is picking up the laundry task to help the new housekeepers out;-The new housekeeping supervisor started two days ago;-He/She sees the housekeepers mopping all the time. During an interview on 03/25/26, at 3:45 P.M., the Administrator said the following:-Resident #5 bangs his/her urinal on the wall in his/her room;-He/She did not know Resident #5's family brought in a Swiffer mop to mop the floor in his/her room;-He/She did not know Resident #5's and Resident #9's floor was sticky, but he/she is not in that room a lot;-If a resident is incontinent of urine on the floor of their room and housekeeping is not here, the nurse aides are expected to clean it up, but he/she is not sure what they would use. Complaint 2960762

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	265656	A. Building B. Wing	03/26/2026

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

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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 staff failed to provide wound care per standards of practice when staff failed to obtain physician ordered wound treatment supplies and failed to complete dressing changes as ordered by the physician for one resident (Resident #7's) amputation site and left ankle pressure ulcer (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) out of four sampled residents. The facility census was 62.Review showed the facility did not provide a policy regarding physician's orders.Review showed the facility did not provide a wound care treatment and management policy.Review of the facility's policy titled, Skin Identification, Evaluation, and Monitoring Policy, dated 01/25, showed the following information:-Complete a weekly skin check to evaluate for changes in skin integrity;-Document in the medical record the following findings: appearance of wound, including measurements if the wound is due for a treatment change. If not, access the dressing and document this in the assessment;-Update the plan of care with each intervention;-The certified nurse assistant should cleanse the skin with bath/shower and after each incontinence episode;-Document completion of bath in the plan of care (POC);-Pressure injuries are staged using the National Pressure Injury Advisory Panel (NPIAP) guidelines. 1. Review of Resident #7's face sheet (brief look at resident information) showed the following information:-admission date of 03/05/26;-Diagnoses included type 2 diabetes mellitus (a chronic condition where the body resists insulin and fails to use glucose (sugar) properly), cellulitis (bacterial infection that causes, red, hot, swollen, and tender skin) of right lower limb, pressure ulcer of left ankle, surgical removal of right foot, and non-pressure chronic ulcer of right ankle.Review of the resident's progress note, dated 03/05/26, showed an admission note stating wound measurements were not documented as part of the assessment due to staff being unable to remove the outer dressing until the resident's next appointment with the orthopedic physician. The resident has a hard brace on the surgical wound to decrease swelling. Review of the resident's progress note, dated 03/06/26, showed skin issues had not been evaluated related to the right below the knee amputation site. The surgical wound was present on admission, and it was unknown how long the wound had been present. Review of the resident's care plan, initiated on 03/06/26, showed the following information:-Administer treatments as ordered and monitor for effectiveness;-Monitor dressing to right stump and left ankle when providing care to ensure it is intact and adhering. Report loose dressing to nurse;-Consult wound, ostomy, and continuance nurse (WOCN) as appropriate;-Wound management;-Wound will show signs of improvement;-Monitor ulcer for signs of infection;-Provide wound care per treatment order. Review of the resident's after visit summary orders/post care instructions from an outside clinic nurse practitioner, dated 03/10/26, showed the following information:-Below-knee amputation (BKA) on 02/20/26;-Evaluation of below-knee amputation site showed the resident was experiencing pain and was concerned about a potential infection at the site. The resident has been using a soft stump shrinker since his/her discharge from the hospital and has been maintaining hygiene by washing the area;-During the exam, the physician noted the skin at the incision site was inflamed and red. Sutures intact, but the area was dry and causing itchiness;-Diagnosis suspected as surgical site infection following below-knee amputation;-Treatment plan for below-knee amputation site and left ankle included starting an antibiotic to treat the suspected infection, begin local wound care using medical-grade honey (TheraHoney-medical grade wound care product to promote faster healing) applied along the incision line, change the dressing and cleanse the wound daily, and follow-up in 1 1/2 weeks;-The physician emphasized the importance of daily wound care and vigilance for signs of infection. If the infection does not improve, revision surgery may be necessary. Review of the resident's 03/01/26 through 03/31/26 physician order sheet (POS) showed the following:-An order dated 03/10/26 with an ending date of 03/23/26 for wound care: Cleanse amputation site with generic wound cleanser, pat dry with gauze pads, apply TheraHoney along the incision line, place ABD (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(highly absorbent sterile dressing) over. Change dressing daily and as needed if soiled one time a day for wound care.Review of the resident's progress note, dated 03/10/26, at12:30 P.M., showed the resident had a follow up appointment with the surgeon today. New orders were received to begin Augmentin two times per day for seven days. The resident also had three other follow up appointments listed on the paperwork. Review of the resident's March 2026 treatment administration record (TAR) showed the following:-A wound care order with a start date of 03/11/26 to cleanse the amputation site with generic wound cleanser, pat dry with gauze pads, apply TheraHoney (Medihoney) along the incision line, place ABD pad over. Change the dressing daily and as needed if soiled one time a day;-On 03/11/26, staff documented the wound care was on hold (see progress note). Review of the resident's progress note, dated 03/11/26, showed a note from an Licensed Practical Nurse (LPN) stating the resident keeps telling him/her that he/she would prefer to have his/her dressing changed later. The LPN documented that he/she would ask the night shift nurse if he/she could do the wound treatment. Review of the resident's progress note, dated 03/11/26, showed staff documented the resident continued on Amoxicillin for a wound infection. No additional progress notes were documented on 03/11/26 regarding the wound.Review of the resident's March 2026 TAR showed the following:-On 03/12/26, staff documented the wound care as provided. No progress note provided;-On 03/13/26, staff documented the wound care was on hold (see progress notes).Review of the resident's progress note, dated 03/13/26, showed TheraHoney as not available for the ordered wound care, so triple antibiotic ointment was used instead. Review of the resident's March 2026 TAR showed the following:-On 03/14/26, staff did not provide the wound care. No progress note provided.-On 03/15/26, staff documented the resident refused the wound care. No progress note provided.Review of the resident's progress note, dated 03/15/26, showed the resident informed the registered nurse (RN) that his/her dressing did not need to be changed right now, and he/she will maybe want it changed later in the night. The RN explained the importance of wound care and frequency to the resident.Review of the resident's March 2026 TAR showed on 03/16/26, staff documented the wound care as provided. No progress note found or provided showing TheraHoney as not available.Review of the resident's progress note, dated 03/16/26, showed the resident received oral antibiotics and staff changed the dressing to the left ankle per orders. No outward signs and symptoms of infection noted.Review of the facility provided supply company order submitted at 11:59 A.M., on 03/16/26 showed the following:-Two dressing, honey, TheraHoney 0.5-ounce tubes were ordered for a total of $13.32;-The status showed Backordered;-A pending note with an estimated ship date of 04/20/26.Review of the resident's March 2026 TAR showed on 03/17/26, staff documented the wound care as provided. No progress note found or provided showing TheraHoney as not available.Review of the resident's progress note, dated 03/17/26, showed the resident continued on antibiotic therapy for a wound infection.Review of the resident's March 2026 TAR showed the following:-On 03/18/26, staff documented the wound care provided. No progress note found or provided showing TheraHoney as not available;-On 03/19/26, staff documented the wound care provided. No progress note found or provided showing TheraHoney as not available;-On 03/20/26, staff documented the wound care provided. No progress note found or provided showing TheraHoney as not available;-On 03/21/26, staff documented the wound care provided. Review of the resident's progress note, dated 03/21/26 showed staff documented TheraHoney as not available for the wound care provided, so triple antibiotic ointment used in place of the TheraHoney. Review of the resident's March 2026 TAR showed the following:-On 03/22/26, staff documented the wound care as provided. No progress note found or provided showing TheraHoney as not available;-On 03/23/26, staff documented the wound care as provided. No progress note found or provided showing TheraHoney as not available. Review of the resident's after visit summary orders from an outside clinic nurse practitioner, dated 03/23/26, showed the following information:-Medical history of right below-knee amputation (BKA) on 02/20/26;-The resident visited for a follow-up of his/her right below-knee amputation. He/She has ongoing wound care concerns and phantom pain. He/She also has a wound (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on his/her left ankle;-During the physical exam, necrotic tissue was found on the right below-knee amputation stump. The left ankle wound showed evidence of healing;-Treatment plan for the right below-knee amputation stump included applying a wet to dry dressing with Vashe (professional grade, non-cytotoxic wound cleanser) twice daily and use Aquaphor (healing ointment) to moisturize the surrounding skin;-Treatment plan for the left ankle wound included applying a wet to dry dressing twice daily. Medihoney may be used if available to assist with debridement and healing. Review of the resident's progress note, dated 03/23/26, showed the resident had a scheduled physician's appointment with the surgeon today. New orders received for wound care to the right below the knee amputation and left ankle. The new orders were entered into the resident's electronic health record. Review of the resident's 03/01/26 through 03/31/26 POS showed the following:-An order dated 03/23/26 with an ending date of 03/24/26 for wound care for left ankle wound. Apply wet to dry dressings with Vashe twice daily. Medihoney may be used if available to assist with debridement and healing two times a day for wound care;-An order dated 03/23/26 with no ending date for wound care for right below-knee amputation stump. Apply dry dressing twice daily. Medihoney may be used if available to assist with debridement and healing every day and night shift for wound care;-An order dated 03/24/26 with no end date for wound care for left ankle wound. Wash with soap and water. Apply dry dressing twice daily. Medihoney may be used if available to assist with debridement and healing every day and night shift for wound care;-An order dated 03/24/26 with no ending date to remove shrinker from right amputation, assess skin, and complete proper hygiene, reapply with proper alignment. Monitor skin integrity and notify physician of any abnormalities every day and night shift related to acquired absence of right foot.Review of the resident's March 2026 progress notes showed staff did not document notification to the physician or the pharmacy about the Medihoney not being available. During an interview on 03/23/26, at 12:15 P.M. and on 03/24/26, at 10:04 A.M., Resident #7 said the following: -He/She is happy with the nursing staff, but he/she is not happy with the amount of time he/she has had to wait for his/her wound care supplies;-He/She went to a follow up visit at the surgeon's office this morning and the physician that removed the dressing and shrinker on his/her right leg surgical site was upset that the facility has not had Medihoney available for his/her dressing changes;-Today, the physician changed the wound care order to change the dressing two times per day;-Certified Medication Technician (CMT) G was the transportation driver that took him/her to the physician's appointment today, and CMT G told the physician's office staff that the facility has not had the Medihoney available for his/her wound care dressings as ordered.-He/She is currently on an oral antibiotic;-Facility staff used a triple antibiotic ointment on his/her surgical wound instead of the Medihoney that was ordered by the surgeon;-Facility staff only changed his/her wound dressing three times since 03/10/26;-Facility staff did not change his/her dressing yesterday evening as the physician ordered on 03/23/26, and no one has changed his/her dressing so far today (03/24/26). During an interview on 03/23/26, at 12:20 P.M. and 2:59 P.M., RN Q said the following:-Resident #7 had an order to use Medihoney for his/her dressing changes, but the pharmacy never sent it, so he/she called the pharmacy and was told the pharmacy was sending it. -He/She did not recall what date he/she called the pharmacy, and he/she did not document the call.-He/She called the pharmacy again today and was informed that the Medihoney was on backorder due to it being contaminated. The pharmacy did not tell him/her this the first time he/she called;-He/She should have documented his/her calls to the pharmacy to ask about the Medihoney, but he/she failed to document the calls;-He/She asked the transport driver, CMT G, that took Resident #7 to his/her physician's appointment this morning to ask the surgeon's office if they could send Medihoney back to the facility with the resident;-The transport driver reported back to him/her that the surgeon's office discontinued the Medihoney order and removed the resident's sutures during the visit;-Prior to Resident #7's appointment, he/she noticed drainage on his/her ace wrap;-Resident #7 was upset about his/her dressing not being changed per physician orders, which was prior to the resident being started on an antibiotic;-Staff at the facility have been using an antibiotic ointment on the resident's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Strafford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 West Evergreen Strafford, MO 65757	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surgical wound instead of Medihoney since it was not available;-RN Q does not know if anyone at the facility called the surgeon's office to inform them that they were using an antibiotic ointment on the resident's surgical wound instead of Medihoney per the physician's orders;-The facility never had Medihoney for Resident #7;-The facility staff should have called the physician and asked to have the order changed;-RN Q brought some Medihoney from his/her home and used it on Resident #7 on the days he/she changed the resident's dressing;-He/She knows that bringing Medihoney from home was not what he/she should have done;-He/She put the Medihoney that he/she brought into the facility into a cup after he/she removed the foil that sealed the medication, and he/she used it on Resident #7 two times. He/She did not document this anywhere;-No other staff had access to the Medihoney that he/she brought into the facility to use on Resident #7;-He/She should have called the physician, but he/she did not.During an interview on 03/24/26, at 11:00 A.M., LPN D said he/she was not familiar with Resident #7 or his/her dressing changes. During an interview on 03/24/26, at 11:14 A.M., CMT G said the following:-He/She drove Resident #7 to his/her trauma surgery physician's appointment on 03/23/26;-He/She informed the staff at the physician's office that the facility did not have any Medihoney for the resident's dressing changes because the facility was not able to get it from the pharmacy;-The physician's office staff said they would not send Medihoney to the facility;-He/She knows that staff at the facility called the supply company regarding the Medihoney not coming in but even after the call the Medihoney still did not come in. He/She does not know if anyone documented the call to the supply company;-The facility planned to go to a store and buy the Medihoney if the surgeon's office did not send any back to the facility with the resident after his/her 03/23/26 appointment, but the physician's office changed the order on 03/23/26.During an interview on 03/25/26, at 10:35 A.M., the Director of Nursing (DON) said the following:-Resident #7 sees his/her wound physician every week, so the outside wound care company, did not want to see him/her because the surgeon was still following him/her;-The surgeon's office recently changed Resident #7's dressings to a wet to dry dressing;-He/She did not know what staff was using for Resident #7's dressing changes in place of Medihoney since it was not available; -No staff told him/her that they did not have the Medihoney available for Resident #7's dressing changes; -He/She would expect the nurses to call the physician about the medication/ointment not being available and then tell him/her what happened;-The nurses should have made a progress note showing that they did not have the Medihoney available;-The nursing staff should not documented that they were changing Resident #7's dressings with Medihoney when it was not available;-He/She was just told today by RN Q that he/she brought Medihoney from home and used it on Resident #7;-There was a risk for Resident #7 to get an infection in his/her wounds when RN Q used the Medihoney that he/she brought from home on his/her wounds. During an interview on 03/25/26, at 3:45 P.M., the administrator said the following:-The nursing staff should have put Resident #7's wound care order on hold and contacted the physician to ask for an alternative treatment;-He/She was told by RN Q that the Medihoney he/she used on Resident #7 had a foil seal on the container, so he/she could not say for sure if the resident would be at risk for an infection in his/her wound since the Medihoney was reported to be sealed.During an interview on 03/23/26, at 2:59 P.M. and 03/25/26, at 10:14 A.M., RN Q said the following:-Staff should not document that a dressing was changed with the ordered supplies if the correct supplies were not used or if the dressing change was not done at all;-He/She does not usually bring Medihoney in to use on residents;-The wound care nurse is normally the Assistant Director of Nursing (ADON), but the facility does not have an ADON right now;-The nurses are responsible for dressing changes and an outside wound management company comes to the facility on Fridays;-When a new ADON is hired, they will take over as the wound care nurse;-The pharmacy orders come in during the night and he/she thinks the medication technicians, or the DON checks the medications in. During an interview on 03/24/26, at 11:00 A.M., LPN D said the following:-If the facility did not have a wound care supply for a resident, staff should call the physician and get an order for something different;-He/She would not bring a medication/ointment to the facility from home and use it on a (continued on next page)

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	265656	A. Building B. Wing	03/26/2026

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident;-It is not appropriate for staff to bring a medication/ointment from home and use it on a resident;-Staff should not document that they completed a dressing change if it was not completed or document that they completed the dressing change using a medication that was not available;-If the physician's order was not followed for a dressing change, staff should document the situation in a progress note in the resident's medical record. During an interview on 03/24/26, at 2:00 P.M., the facility's medical director said the following:-He/She would expect staff to follow wound care orders as written and notify him/her if a wound care supply or medication was not available for the dressing change, so he/she can consider an alternative treatment.During an interview on 03/25/26, at 10:35 A.M., the Director of Nursing (DON) said the following:-The facility does not get Medihoney from the pharmacy. It is ordered through the facility supply company or purchased over the counter;-The administrator is working on printing the order sheet for the Medihoney/TheraHoney that was ordered from the supply company;-It is not acceptable for staff to bring in their own Medihoney from home to use on a resident.During an interview on 03/25/26, at 9:00 A.M. and 3:45 P.M., the administrator said the following:-He/she would expect staff to let the DON or him/her know if they did not have the wound care supplies or medications they need;-It is not appropriate for staff to bring their own Medihoney in from home and use on a resident;-An outside company is serving as the facility's wound care nurse since the facility does not have an ADON that would normally be assigned that task. The ADON position has been vacant since mid-February 2026.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility staff failed to ensure all meals met the nutritional needs of residents when staff failed to follow approved menus, including appropriate serving sizes, for all residents including two residents (Resident #3 and #4) who stated portion sizes were not sufficient. The facility census was 62. Review of the facility's policy titled, Standardized Recipes, undated showed the following:-Standardized recipes will be used for all menu items;-The registered dietician will approve recipe changes or new recipes utilized for a menu item.Review of the facility's policy titled, Diet Spreadsheet, Portion Serving Communication Tool, undated , showed the following:-Diet spreadsheets or similar meals and portion serving communication tools are available to the serving staff for reference and serving guidance;-Diet spreadsheets are based on the planned menu and reflect serving portions for regular and therapeutic diet orders offered in the community;-Diet spreadsheets are dated for each day of the menu cycle and are reviewed and approved by the registered dietician;-Specific portion serving information for regular and therapeutic diets may be communicated to the serving staff, in place of diet spreadsheets, during meal service, by utilizing innovative communication tools such as meal cards. 1. Review of the facility menu, dated 03/24/26, showed three chicken tenders, macaroni and cheese, mixed vegetables, and chilled peaches to be prepared and served.Observation on 03/24/26, beginning at approximately 11:30 A.M., showed Dietary [NAME] K added two chicken strips to each resident's plate.2. Review of the facility menu, dated 03/24/26, showed for the following pureed diet serving sizes:-Chicken tenders - 2/3 cup;-Macaroni and cheese - 1/2 cup;-Mixed vegetable 2/5 cup of mixed vegetables;-Chilled peaches to be prepared and served.Observation on 03/24/26, at approximately 11:30 A.M., showed Dietary [NAME] K placed 1/2 cups of pureed chicken tenders, 1/2 cups of macaroni and cheese and 1/4 cup of mixed vegetables on all three residents receiving pureed meals.3. Review of Resident #3's face sheet (brief information sheet about the resident) showed the following information:-admission date of 02/10/25;-Diagnoses included hemiplegia (paralysis of one side of the body), type II diabetes (body develops insulin resistance and fails to use insulin properly, and major depressive disorder (persistent feelings of sadness). Review of the resident's care plan, revised 02/25/26, showed the following:-Resident's dietary preferences will be honored;-Favorite food was brats with sauerkraut. Review of the resident's quarterly, Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 03/04/26, showed the resident was cognitively intact.During an interview on 03/23/26, at 9:25 A.M., the resident said he/she got small portions almost every meal. Last night the only food he/she got was a chicken pot pie. He/she doesn't really like the food.4. Review of Resident #4's face sheet showed the following information:-admission date of 03/22/23;-Diagnoses included pre-diabetes (body develops insulin resistance and fails to use insulin properly), depression (persistent feelings of sadness), and diverticulitis (inflammation of the colon that causes abdominal pain).Review of the resident's care plan, revised 02/25/26, showed the following:-Resident's dietary preferences will be honored;-Favorite food was spaghetti. Review of the resident's quarterly MDS), dated [DATE], showed the resident was cognitively intact.During an interview on 03/24/26, at 12:25 P.M., the resident said the following: -They do not get enough food;-One night they got a hotdog and one teaspoon of sauerkraut;-The food they received today was more than they normally receive.5. During an interview on 03/24/26, at 1:30 P.M., Dietary [NAME] J said the following:-The Dietary Manager (DM) prints out the menus and they're placed on the board in the kitchen;-The menus tell him/her the quantity of food to serve, and they're supposed to serve that amount unless told otherwise;-He/she relied on the DM to tell him/her the quantity of food that needed to be prepared to ensure all residents receive enough food;-He/she saw the menu said three chicken strips and didn't know why Dietary [NAME] K only served two;-He/she has heard some residents complaining about not getting enough food when Dietary [NAME] L worked;-He/she was at (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the facility one evening when Dietary [NAME] L made sauerkraut and he/she only gave the residents 1 ounce and the guidance called for 4 ounces. During an interview on 03/24/26, at 1:39 P.M., Dietary [NAME] K said the following:-They receive the menus from their home company, and the DM posts them daily;-Each menu has the quantity of food to be served;-He/she saw that the menu said three chicken strips, but the DM told him/her to serve two;-He/she knew the quantity of food to prepare for each food item by calculating how many residents and how many servings each;-He/she has heard of residents complaining about not getting enough food. It started about month ago or sooner, he/she reported this to the DM.During an interview on 03/25/26, at 10:44 A.M., Dietary [NAME] L said the following:-He/she usually worked evenings and weekends;-He/she didn't really know how much food to cook, he/she just eyeballs the food to know how much to cook;-They were supposed to serve what the menu says, however, if there was not enough food, the DM tells staff to serve smaller serving sizes;-The sheet in the kitchen had scoop sizes and the menu had the scoops to use;-Not having enough food happens three to four times per week. When he/she did pudding, it's supposed to be a gray scoop which is 4 ounces, but he/she used a smaller scoop almost daily;-The other day there was a casserole, and it said to use two #8 scoop (1 cup), and they only gave 1/2 cup;-He/she didn't know if there were different sizes for residents on puree foods;-He/she assumed the DM knew there wasn't enough food since the DM told them to use smaller scoops. During an interview on 03/23/26, at 1:39 P.M., Certified Nurse's Aide CNA (B) said the following:-The residents consistently receive small portions. The unit gets half the amount they do in the rest of the facility;-One day for lunch there was a 1/2 pork chop. He/she struggled to get seconds if a resident wanted seconds;-It's been that way for the last year. He/she has tried to bring that up to the DM and he/she said the residents in the unit eat less. During an interview on 03/23/26, at 1:55 P.M., CNA C said the following:-He/she believed some residents do not get enough food, especially some receiving puree foods;-He/she said the food seems less at certain times, one day he/she was feeding someone on mechanical foods, and he/she had eaten 8 spoonsful, and it was all gone;-They can usually get more food. During an interview on 03/23/26, at 2:13 P.M., Licensed Practical Nurse (LPN) D said the following:-The residents don't receive enough food. When they make a sheet cake the residents in the unit might get a half slice;-The ones on puree foods don't get enough food, sometimes they have to order more;-There are times they only get soup and a piece of bread for dinner;-They can get seconds if they haven't cleaned the steam table and if they have food. During an interview on 03/24/26, at 9:35 A.M., Certified Medication Technician (CMT) G said the following:-Food portions are not big enough. For dinner they may only get a sandwich and chips;-They seem to receive less food in the evenings and weekends.During interviews on 03/23/26, at 11:33 A.M.; on 03/24/26, at 1:45 P.M.; and on 03/25/26, at 9:00 A.M., the DM said the following:-He/she made the menus, and the dietician signs off on the menus;-Staff know the portions as there is the chart in the kitchen that shows the spoon sizes and the menu with the quantities are there below;-Dietary [NAME] L consistently served less food than what the menu required. He/she has received complaints from staff and residents. He/she had educated the cook on multiple occasions, and the cook would do better for a while and then went back to the same bad habits;-He/she had been in when Dietary [NAME] L had been serving food out and he/she has seen only small amounts of food such as one time when the cook served out a chicken sandwich, fries and mixed vegetables. There were only a few fries and not 1/2 cup of mixed vegetables;-He/she expected staff to serve the amount of food on the menu.During an interview on 03/25/26, at 8:43 A.M., the Registered Dietician (RD) said the following:-The menus are generated, and the DM can make adjustments. There is a substitution log where the DM puts any changes, and he/she signs off on them;-The staff should be serving what the menu says. If it says three chicken strips, the staff should serve three chicken strips;-The staff know how much food to ensure all residents have sufficient amounts by using the production sheet that tell show much food to fix;-He/she was in the facility last week and he/she was told by various residents they were not receiving enough food. This has been passed on to the Director of Nursing (DON) as the DM was not in (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the facility when he/she was there on 03/20/26.During an interview on 03/24/26, at 2:00 P.M., the Director of Nursing (DON) said the following:-He/she had heard residents are not getting enough food to eat;-He/she knew there were serving sizes on the menus, and the staff should be following those;-If the menu said three chicken strips, they should serve three not two;-The residents should always be able to get seconds as well. During an interview on 03/25/26, at 3:26 P.M., the Administrator said the following:-He/she didn't know how the staff determined how much food was needed to ensure all residents receive the amount required;-He/she expected the staff to serve the amount of food the menu required;-If the menu said three chicken strips, they should be serving three not two.Complaint #2790852

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility staff failed maintain an effective pest control system when were present in one resident's (Resident #6) room. The facility census was 62.Review showed the facility did not provide a pest control policy. 1. Review of a pest control invoice, dated 12/12/25, showed the following:-General pest control maintenance;-Scion insecticide treatment applied to the interior perimeter of the building for the aid and control of occasional invaders;-Mouse caught in snap trap by the refrigerator in the employee breakroom;-Spoke with staff who had no other pest concerns at this time of service;-Call with any concerns between now and next visit. Review of a pest control invoice, dated 01/16/26, showed the following:-General pest control maintenance for rodents;-Treatment applied to interior perimeter of the building and all accessible areas for the aid and control of occasional invaders, ants, roaches, crickets, and beetles;-Serviced, cleaned, and reset all interior rodent stations and found no activity of pests;-Inspected all temporary traps and found one dead mouse under the vending machine. Was informed of mouse sighting in the breakroom;-Installed mechanical rodent trap by the refrigerator, along with two snap traps;-Spoke with multiple staff members who had no other pest concerns at the time of this service;-Call with any concerns between now and the next visit.Review of a pest control invoice, dated 02/20/26, showed the following:-General pest control maintenance for rodents;-Manager had no other pest control concerns at the time of the service;-Call with any concerns between now and the next visit. Review of a pest control invoice, dated 03/09/26, showed the following:-General pest control service provided;-Chemically treated room [ROOM NUMBER] for potential bed bugs;-Treatment applied to interior perimeter of building and all accessible areas for the aid in control of occasional invaders such as crickets, ants, cockroaches, beetles, and spiders;-Spoke with multiple staff members who had no other pest concerns to report at this time of service;-Please call with any concerns between now and your next visit. 2. Review of Resident #6's face sheet (brief information sheet about the resident) showed the following information:-admission date of 10/03/23;-Diagnoses included osteoarthritis (breakdown of cartilage in the joints that causes joint pain), muscle wasting and shrinking, dementia (progressive memory loss), spinal stenosis (narrowing of the spinal canal that compresses nerves), adult failure to thrive (a decline in physical and cognitive function), and need for assistance with personal care.Review of Resident #6's progress note dated 03/17/26, at 8:00 A.M., showed the following:-A progress note with no documentation of which department or who wrote the note;-Resident #6 reported having a lot of ants in his/her room;-The resident is possibly seeing things due to poor vision or could be hallucinating;-The reporter of the note said he/she did not see any ants in the resident's room;-The facility staff does not know of any ant issue. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 03/19/26, showed the following:-Moderate cognitive impairment;-Used a wheelchair and walker;-Required partial to moderate assistance (the resident can perform 50 percent of the mobility task, while the caregiver assists with 50 percent from sit to stand;-Required supervision or touch assistance with toilet transfer and tub/shower transfer;-Required setup or clean up assistance with eating and oral hygiene;-Required substantial/maximal assistance with upper body dressing;-Dependent with toileting hygiene, shower/bathe self, lower body dressing, personal hygiene, and putting on/taking off footwear. During an interview on 03/23/26, at 11:00 A.M., Resident #6 said the following:-For a few weeks he/she has had multiple ants in his/her room;-Housekeeping staff just mopped his/her floor, and they have seen the ants. Observation of Resident #6's room on 03/23/26, at 11:05 A.M., showed the following:-Live ants crawled on various areas of the floor in the resident's room;-The resident only had one package of sealed crackers in his/her room that sat on the bedside table. No ants were present on the bedside table or around the crackers;-Resident #6's room was located next to the 100 hall exit door. During an interview on 03/25/26, at 9:34 A.M., the (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintenance director said the following:-He/She has not been informed by facility staff of live ants in Resident #6's room;-Staff have not documented any concerns regarding live ants in Resident #6's room, but he/she is having problems with staff using the log to communicate maintenance concerns to him/her;-If there are ants in Resident #6's room, staff should have written that on the maintenance log sheet at the nurse's station, but no one has;-When the pest control company comes back to the facility on Friday, 03/27/26, he/she will ask what they can do about the ants in Resident #6's room. He will need to find a material safety data sheet (MSDS) for the pest control company, so they will know what they are allowed to use to help eliminate the ant issue.Observation and interview on 03/25/26, at 9:38 A.M., showed live ants observed on the floor in Resident #6's room;-The maintenance director was in the room and killed the live ants with his/her finger;-Resident #6 said there were a lot of live ants in his/her room yesterday. During an interview on 03/25/26, at 10:06 A.M., Housekeeper T said the following:-He/She has seen ants in just a few rooms recently, especially on the 100 hall and in Resident #6's room a few days ago;-Resident #6 complained to him/her about the ants in his/her room;-He/She has not let the maintenance director know about the ants in Resident #6's room;-The maintenance director has a maintenance logbook at the nurse's desk where he/she can report maintenance issues, but he/she has not written the ant issue in the logbook yet for Resident #6's room. During an interview on 03/25/26, at 10:35 A.M., the Director of Nursing (DON) said the following:-He/She knew about the ants in Resident #6's room, because he/she recently saw them, but he/she does not know the exact dates;-He/She told the maintenance director about the ants in Resident #6's room on a Thursday, approximately a week or two ago;-When he/she informed the maintenance director that the resident had ants in his/her room, the maintenance director said he/she noted his/her complaint and that the pest control company would be at the facility on Friday, but the DON did not know which Friday he/she referred to. During an interview on 03/25/26, at 3:45 A.M., the administrator said the following:-Pest control comes to the facility one time per month;-He/She is not sure when the pest control company was at the facility last;-He/She thinks the pest control company may have sprayed at the facility a month ago;-He/She is not sure about this facility, but other facilities he/she has worked at had a pest control company spray inside and outside the facility, but he/she did not know if the pest control company would spray in resident rooms.-Staff should tell the maintenance director or add it to his/her maintenance log that is located at the nurse's station if they become aware of ants in the facility;-He/She plans to talk to the maintenance director and find out when the pest control company will be coming back to the facility. 3. During an interview on 03/25/26, at 9:34 A.M., the Maintenance Director said the following:-The facility recently had problems with mice in the facility, and the pest control company has been coming to the facility every Friday since at least June of 2025 to help eliminate the mice;-While at the facility, the pest control company goes around and checks the containments for mice and monitors treatment areas for mice;-He/She is not allowed to spray any pest sprays in the facility;-The resident rooms are sprayed on a case-by-case basis;-He/She knew of an ant problem by the 100 hall exit door a few days ago, but he/she did not know of any ants in resident rooms;-He/She used hot water to kill the ants at the 100 hall exit door and he/she has not noticed any ants at that door since then;-When he/she started at the facility, there were no inspection forms for him/her to use, so he/she has been trying to develop forms as things come up;-The facility maintenance person before him/her did not have any maintenance records for the facility;-He/She developed a maintenance request folder in December of 2025 that he/she keeps at the nurse's station for staff to communicate maintenance concerns to him/her. The only request on the log is a concern about a call light not working in room [ROOM NUMBER] and it was entered on the log on 03/23/26;-He/She has not seen any live ants in any rooms recently, so he has not addressed any ant concerns within the facility;-He/She looks in every resident room every week, but he/she does not document the inspection anywhere. He/She did not say what he/she looks for in each resident room;-Staff need to start using the maintenance log that is at the nurse's station instead of just walking up to him/her and telling him/her about issues because he/she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026

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

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cannot remember everything;-He/She thinks the pest control company sprayed for ants at the facility in the past, but he/she could not provide the last date, and he/she did not have any pest control maintenance receipts to provide;-He/She recently called a different pest control company to see if they will give him an estimate to take over pest management at the facility because he/she does not like the current pest control company. He/She is waiting on a response from the pest control company he left the message at a few days ago.During an interview on 03/25/26, at 10:35 A.M., the Director of Nursing (DON) said the following:-The DON has never seen a pest control company spray at the facility;-The maintenance director informed him/her that he/she could not spray for the ants, but the pest control company could. During an interview on 03/25/26, at 3:45 A.M., the Administrator said the following:-Pest control comes to the facility one time per month;-He/She is not sure when the pest control company was at the facility last;-He/She thinks the pest control company may have sprayed at the facility a month ago;-He/She is not sure about this facility, but other facilities he/she has worked at had a pest control company spray inside and outside the facility, but he/she did not know if the pest control company would spray in resident rooms.-Staff should tell the maintenance director or add it to his/her maintenance log that is located at the nurse's station if they become aware of ants in the facility;-He/She plans to talk to the maintenance director and find out when the pest control company will be coming back to the facility.Complaint 2959539