STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265688	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Center, The	2506 Linden Tree Parkway Marshall, MO 65340

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide adequate supervision for one resident (Resident #1), in a review of seven sampled residents. Staff failed to monitor Resident #1, who was taken outside by staff, at approximately 1:27 P.M. to 3:30 P.M. The resident sat in the courtyard under the gazebo and self-propelled him/herself in the courtyard with temperatures between 78 degrees Fahrenheit (F) and 86 degrees F. When discovered by staff at approximately 3:30 P.M., the resident had wheeled himself/herself out from under the gazebo, had his/her back wheel of the wheelchair off of the sidewalk, had taken his/her shoes and socks off and had a red face and his/her skin was hot to touch. The resident was assessed and noted to have an elevated temperature of 101.3 degrees F (normal temperature is between 97.8 degrees F and 99.1 degrees F), had lethargy (sluggish, drowsy and lack of energy), was dry heaving and leaning to the right with reddened skin. The facility census was 64. The administrator was notified of the past noncompliance on 07/09/25 which occurred on 06/28/25. On 06/28/25, the facility began an investigation into the failure, in-serviced staff and put corrective measures in place. In-servicing was completed on 07/08/25. This deficiency was corrected on 07/08/25 as confirmed by the surveyor's investigation on 07/09/25. The facility did not have a policy related to heat precautions for outdoor activities prior to 06/28/25. 1. Review of wunderground weather data for 06/28/25 showed the following:-At 12:54 P.M., temperature 85 degrees F, dew point 70 degrees F, humidity 61 percent (%), winds: from the south at five miles per hour (mph) and condition: fair;-At 1:54 P.M., temperature 86 degrees F, dew point 71 degrees F, humidity 61%, winds: from the south at three mph and condition fair;-At 2:54 P.M., temperature 78 degrees F, dew point 71 degrees F, humidity 79%, winds from south southwest at 13 mph and condition mostly cloudy;-At 3:54 P.M., temperature 76 degrees F, dew point 71 degrees F, humidity 85%, winds from the south at 13 miles per hour (mph) and condition fair. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 06/17/25, showed the following:-Severely impaired cognition;-Mobility per wheelchair with substantial/maximum staff assistance for motivating wheelchair 50 feet and dependent on staff for motivating wheelchair 150 feet;-Substantial/Maximum staff assistance for transfer from sitting to lying, lying to sitting on the side of the bed, sit to stand and chair/bed-to-chair transfer;-Diagnoses included congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), hypertension (high blood pressure) and dementia (a group of thinking and social symptoms that interferes with daily functioning). Review of the resident's care plan, last reviewed by the facility on 06/02/25, showed the following:-He/She has severely impaired cognition related to dementia with mood disturbances and needed staff to provide redirection;-Provide him/her with oversight to dependent help for one to two staff members for transfers;-Provide him/her with oversight to dependent help of one staff for mobility using his/her wheelchair. He/She will propel self at times. Review of the resident's nursing progress notes, in his/her electronic health record, dated 06/28/25, showed the following:-At 4:13 P. M., this nurse was notified as Certified Nursing Assistant (CNA) was bringing the resident in from the courtyard. Resident was dry heaving and lethargic looking, leaning to the right. Resident was assisted to bed and vital signs obtained as follows: blood pressure (B/P) 104/68 (normal B/P 90/60 to 120/80), pulse 63 (normal rate 60-100 beats per minute), temperature 38.5 Celsius (101.3 F - normal temperature between 36. 5 degrees C and 37.3 degrees C, or 97.8 degrees F and 99.1 degrees F). Cooling cloths were immediately applied to the resident's neck, groin and arm pits. Clothing removed and cooling cloths applied to any reddened areas. Thighs were reddened as well as his/her ankles, arms and face. Registered Nurse (RN) notified as well as physician. After about 15 minutes the resident was able to respond to staff appropriately. Resident is taking small sips of cool water and able to keep it down. Received instructions from the physician to check vital signs every 30 minutes for four hours and push fluids;-At 11:57 P.M., resident's vital signs have remained within normal limits. Resident wakes when this nurse enters room, asks what medications he/she is taking and takes sips of water. Fluids encouraged each time staff enters room, voices no complaints. Review of the resident's nursing progress notes dated 06/29/25 at 9:19 A.M., showed the resident was awake and alert. Ate breakfast this morning and drank his/her Ensure. He/She answers questions appropriately. Vital signs: blood pressure 156/77, pulse 62 and temperature 36.3 Celsius (97.3 F). During an interview on 07/09/25 at 12:39 P.M., the resident said he/she liked to go outside and was unsure if he/she had any issues related to being outside too long on 06/28/25. He/She did not remember being outside on 06/28/25. 3. Review of the facility follow-up investigation report, for the 06/28/25 Facility Reported Incident