STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265742	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge of Plattsburg	205 E Clay Ave, Plattsburg, MO 64477

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 observation, interview and record review, the facility failed to provide adequate supervision and a safe dining environment for one resident (Resident #1) who sustained burns to the fingers on the right hand, when left un-attended during meal service and was witnessed by Resident #2. This affected one out of four residents sampled. The facility census was 52.On 10/14/25, the Administrator was notified of the past noncompliance which occurred on 10/7/25. On 10/7/25, facility administration was notified of the incident, an investigation immediately began, and corrective action were implemented to include a new policy for meal service for residents who require assistance, and staff training regarding meal service that included staff education that supervision and assistance must be provided to residents when served. The non-compliance was corrected 10/7/25.Review of the facility's Accident and Incident Policy, revised 2017 showed all accident or incident involving residents on the premises will be investigated and reported to the administrator. The nurse supervisor or charge nurse will initiate and document the investigation of the incident with immediate corrective action put into place. All responsible persons will be notified and updated.Review of the facility's Providing Dining Assistance Policy, revised on 10/7/25 showed staff are to assist any resident that cannot feed themselves safely.Review of an all-staff in-service dated 10/7/25 showed the following: Residents that require assistance during meals will not be served until a nursing staff member is present and directly observing/assisting with meal intake. Staff are remined to observe residents who attempt to feed themselves to avoid risk of injury from hot food. Included in this training is educational information about food temperature requirements and also how quickly an injury can happen from handling hot foods. 1. Review of Resident #1's care plan dated, 10/13/25, showed the resident had difficulty expressing needs related to impaired cognition. The resident required staff assistance for all activities of daily living, including being fed at meals by nursing staff.Review of resident's physician order report dated 9/29/25-10/14/25 showed the resident was admitted with a diagnosis of Parkinson's, disorders of peripheral nervous system, and diabetes. Review of the facility's investigation report dated 10/7/25, regarding the resident's burns to fingers on the right hand showed the resident was left unattended at the dining room table with a plate of hot food at breakfast. The resident attempted to feed self with his/her hands and sustained burns resulting in grape-like fluid filled blister to the fingers on the resident's hands. During an observation on 10/14/25 at 11:25 A.M., Resident #1 sat at the dining room table with his/her spouse. The residents' fingers on the right hand were bandaged except the right thumb and right forefinger. During an observation on 10/14/25 at 11:35 A.M., staff placed the resident's plate in front of him/her, which included lasagna, California blend vegetables (green beans, cauliflower, and carrots) and garlic bread. The resident's spouse was assisting the resident to eat. During an interview on 10/14/25 at 12:06 P.M., LPN C said, the resident required nursing assistance when eating and required encouragement at meals. Lids provided for the drinks to reduce spillage, and food was normally not that hot and staff would normally stir the food before starting to assist the resident to eat. Since the resident was burned, CMTs and a CNA are now required to be in the dining room before the passing of any meal trays. During an interview on 10/14/25 at 12:16 P.M., the dietary host said, on the day the resident received the burns, nursing staff were still bringing residents into the dining room while the resident's tray was in front of him/her. The Resident had biscuits and gravy, scrambled eggs, cream of wheat and juice. The dietary host said, she saw the resident's eggs had been touched and there was food on the resident's right hand. The resident's spouse was not there that day to feed the resident. There was no one feeding the resident breakfast. She does not feed residents but observed the resident this day with food on his/her hands. During an interview on 10/11/25 at 12:28 P.M., LPN B said, on 10/7/25 he/she was working in the dining room and was called over to the residents table by CMT A, to assess burns on the resident's right hand. CMT A observed the resident's fingers to be blistered. CMT A then notified RN A to come and look at the resident's hand and fingers, then the physician was also notified. During an interview and observation on 10/14/25 at 12:59 P.M., LPN A provided wound care to the resident's right hand and fingers. He/she observed a blister on the resident's little finger on the right hand and the blister measured at 2cm (centimeter) x 2.5cm and was yellow fluid filled with no drainage. He/she observed a blister measuring 3cm x 4cm with yellow fluid filled blister with no drainage to the ring finger. He/she observed a blister measuring, 1cm x 1cm with intact with fluid and no drainage on the resident's middle finger. Treatment to areas included application of skin prep applied to each finger, let dry, apply gauze and Coban (self- adherent elastic wrap) to each finger. The resident was unaware of treatment being provided. LPN A said since the incident, there now