STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265858	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
E W Thompson Health & Rehabilitation Center	975 Mitchell Road Sedalia, MO 65301

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to meet professional standards of practice when staff failed to document medications as administered for two residents (Resident #1 and Resident #2) and failed to complete treatments as ordered for one resident (Resident #2). The facility census was 59.1. Review of the facility's Administering Medications policy, dated 12/2012, showed staff are directed:-Medications shall be administered in a safe and timely manner, and as prescribed;-If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record (MAR) space provided for that drug and dose;-The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 2. Review of Resident #1's Annual Minimum Data Set (MDS), dated [DATE], a federally mandated assessment tool, showed staff assessed the resident as cognitively intact, a diagnosis of Dementia and prescribed an anticoagulant.Review of the resident's Physician Order Summary (POS), undated, showed an order for Levothyroxine (medication used to treat an underactive thyroid), Eliquis (blood thinner), Tamsulosin (used to treat an enlarged prostate) and Donepezil (used to treat confusion and memory loss).Review of the resident's Medication Administration Record (MAR), dated 02/01/26 through 02/28/26, did not contain documentation staff administered medications as directed for:-Levothyroxine on 02/04/26;-Eliquis, Tamsulosin and Donepezil on 02/15/26; 3. Review of Resident #2's quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact and a diagnosis of heart failure.Review of the resident's POS, undated, showed an order to cleanse the right inner buttock with wound cleanser and pat dry. Apply Chymosin (skin barrier ointment) and zinc to area twice a day and Metoprolol Tartrate (used to treat high blood pressure and chest pain).Review of the resident's MAR, dated 02/01/26 through 02/28/26, did not contain documentation staff administered the resident's medications and did not treatment as directed for:-Chymosin and zinc on 02/03/26, 02/09/26 through 02/13/26, 02/15/26, 02/16/26, and 02/20/26 through 02/28/26;- Metoprolol Tartrate on 02/28/26. 4. During an interview on 03/09/26 at 10:26 A.M., Licensed Practical Nurse (LPN) said staff are directed to document in the resident's MAR after providing a treatment or administering medications. He/She said if a medication or treatment was not completed, staff are required to enter a reason why the task was not completed. During an interview on 03/09/16 at 11:47 A.M., the administrator said staff are directed to document completed treatments and medication administration, or refusal, in the resident's medical record. He/She said the Assistant Director of Nursing (ADON) was responsible to audit the resident medical records at the end of each month. During an interview on 03/09/26 at 11:48 A.M., the Director of Nursing (DON) said staff documented completed treatments and/or medication administration, or if refused, in the resident's medical record. He/She said the ADON was responsible to review the resident's MAR's at the end of each month to ensure the MAR's were completed. During an interview on 03/17/26 at 11:44 A.M., the ADON said once a treatment is completed, or medication is administered, staff should document in the resident's electronic medical records. He/She said he/she and the DON reviewed the MARS and TARS each month to ensure medications administration and treatments were completed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He/She said he/she did not check the February MARS and TARS because he/she was filling in for the MDS Coordinator position, so he/she did not have time to review. #2738619

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to administer nutritional supplements as ordered by the physician for one resident (Resident #1) out of one sampled resident. The facility census was 59.1.Review of Resident #1's Annual Minimum Data Set (MDS), dated [DATE], a federally mandated assessment tool, showed staff assessed the resident as cognitively intact.Review of the resident's Physician Order Summary (POS), undated, showed an order for meal supplement health shakes.Review of the resident's Medication Administration Record (MAR), dated 02/01/26 through 02/28/26, did not contain documentation staff administered the resident's nutritional supplemental health shake as directed on 02/01/26, 02/03/26, 04/05/26, 02/07/26, 02/08/26, 02/09/26, 02/11/26-02/15/26, and 02/19/26.During an interview on 03/09/16 at 11:47 A.M., the administrator said staff are directed to document completed supplemental shakes, or refusal, in the resident's medical record. He/She said if the resident refused supplemental shakes staff should document in the resident's medical record.During an interview on 03/09/26 at 11:48 A.M., the Director of Nursing (DON) said staff document completed medication administration to include supplemental shakes, or if refused, in the resident's medical record. He/She said the Assistant Director of Nursing (ADON) was responsible to review the resident's MAR's at the end of each month to ensure the MAR's were completed. During an interview on 03/17/26 at 11:44 A.M., the ADON said once medication is administered, including a supplemental shake, staff should document in the resident's electronic medical records. He/She said he/she and the DON reviewed the MARS and TARS each month to ensure medications administration and supplemental shakes were completed. He/She said he/she did not check the February MARS and TARS because he/she was filling in for the MDS Coordinator position, so he/she did not have time to review. 2738619