STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A378	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sylvia G Thompson Residence Center, Inc	3333 W Tenth Street 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to review and revise the plan of care to address individualized physical and functional care needs for three residents (Resident #1, #2, and #3) out of four sampled residents. The facility's census was 115.1. Review of the facility's Comprehensive Care Plans Policy, revised 03/2022, showed a comprehensive, person-centered care plan will include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents' condition change. Review showed the policy did not address timeframes for revising a resident's care plan after an injury or change in functional care needs. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 05/29/25, showed staff assessed the resident as cognitively intact, occasional pain, and did not receive non-medication interventions for pain. Review of the resident's progress notes, dated 08/21/25, showed staff documented the resident was observed laying on a warm moist pack during a skin assessment, redness to his/her upper arm and upper back. Family and physician were notified that resident had what appeared to be a burn, received new orders for treatment. Review of the resident's care plan, dated 06/09/25, showed the care plan did not contain direction for the application of warm packs for pain relief, or interventions to address the burns to the resident's left upper arm and upper back. During an interview on 08/26/25 at 12:55 P.M., Registered Nurse (RN) A said he/she was not sure if the resident's care plan had been updated yet regarding the burn and new treatment, but he/she would expect to see new interventions added to the resident's care plan by now. During an interview on 08/26/25 at 2:33 P.M., the Care Plan Coordinator said he/she had not yet updated the resident's care plan to reflect the burn injury or application of hot/cold treatment, because he/she usually updates the care plans on Fridays. 3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment and frequently incontinent of bowel and bladder. Review of the resident's care plan, dated 07/28/25, showed the care plan did not contain direction or interventions to address the resident's bowel incontinence. During an interview on 08/26/25 at 2:33 P.M., the Care Plan Coordinator said the resident is incontinent of bowel and bladder and should have had interventions on his/her care plan to address bowel/functional incontinence, but he/she did not realize he/she had not documented those interventions. 4. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, continent of bowel and bladder, and diagnoses to include constipation. Review of the resident's care plan, dated 07/09/25, showed the care plan did not contain direction or interventions to address the resident's constipation. Review of the resident's Physician's Order Sheet (POS), dated 08/26/25, showed physician orders as followed: -Docusate Sodium 100 milligrams (mg) capsules by mouth, give two capsules twice daily for constipation;-Milk of Magnesia 1200 mg/15 milliliters (ml) suspension, by mouth, give 30 ml daily as needed for constipation, start date 05/23/25; -Polyethylene Glycol Powder 17 grams (gm) mixed in juice or water by mouth, every other day for constipation, start date 07/31/25. During an interview on 08/26/25 at 11:37 A.M., the resident said he/she has issues with constipation and takes medications to help provide relief. The resident said he/she recently started increasing fruits in his/her diet to help provide added relief from constipation.During an interview on 08/26/25 at 2:33 P.M., the Care Plan Coordinator said he/she uses information from the resident's POS, nurses' notes, and the Interdisciplinary Team meetings to add interventions to the resident's care plan, but would have only included interventions for constipation if the resident had triggered or expressed constipation in the seven-day review period of the MDS assessment dated [DATE] 5. During an interview on 08/26/25 at 2:09 P. M., Licensed Practical Nurse (LPN) D said nurses use care plans to help guide each resident's care, and the Care Plan Coordinator is responsible to update the residents' care plans per schedule and with changes regarding specific care needs for the residents. The LPN said interventions to address pain, treatment for injuries, bowel and bladder incontinence and constipation should be included on the residents' care plans if applicable. During an interview on 08/26/25 at 2:33 P.M., the Care Plan Coordinator said he/she is responsible to update the residents care plans quarterly, after an injury/fall, and with significant changes. He/She said he/she usually updates the care plans within a week, usually on Fridays after an injury or change in condition. He/She said he/she was not sure if anyone double checks that the care plans are updated. During an interview on 08/26/25 at 3:39 P.M., the administrator said the Care Plan Coordinator is

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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)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview and record review, facility staff failed to provide appropriate care and services per facility policy to maintain the highest practicable physical and psychosocial well-being for one resident (Resident #1) when staff failed to safely administer a warm pack for pain, which resulted in a burn injury to the resident's left arm and shoulder area. The facility census was 115.1. Review of the facility's Policy and Procedure for Using a Warm and Cool Pack, dated 08/2024, showed if a resident requests a warm or cool pack, one will be provided that will return to room temperature without intervention. This would consist of rice packs, gel packs, or warm/cool cloths that will return to room temperature on their own. Warm packs are not to be microwaved unless manufacturer recommends. Hot water may be utilized only out of facility faucets to ensure temperature is not too hot. Staff should check periodically to see if resident has relief from the issue that requires the use of the pack. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 05/29/25, showed staff assessed the resident as cognitively intact, occasional pain, and did not receive non-medication interventions for pain.Review of the resident's care plan, revised 06/09/25, showed the care plan did not contain interventions to direct staff on how to apply a warm pack to the resident, or how to monitor the resident when a warm pack is applied. Review of the resident's progress notes, dated 08/21/25, showed staff documented the resident was observed laying on a warm moist pack during a skin assessment, redness to his/her upper arm and upper back. Family and physician were notified that resident had what appeared to be a burn, received new orders for treatment.Review of the resident's Physician's Order Sheet, dated 08/21/25, showed a physician order to apply Silvadene one percent (1%) cream (a topical antimicrobial medication used to prevent and treat infection in second and third-degree burns), one application twice per day for burn on left shoulder until healed.Observation on 08/26/25 at 11:47 A.M., showed the resident back of upper arm with a red area, pale-yellow center the size of a quarter and an oblong-shaped reddened area to his/her left shoulder blade.During an interview on 08/26/25 at 11:47 A.M., the resident said he/she asked staff for a hot pack to relive pain and stiffness to his/her left shoulder. The resident said this was not the first time staff had applied a hot pack to his/her shoulder, but this was the first time staff did it the way they did. He/She said the hot pack staff applied to him/her in the past was different and not as hot.During an interview on 08/26/25 at 12:55 P.M., Registered Nurse (RN) A said he/she was the charge nurse assigned to the resident when the incident occurred, but was never notified by the aides or the Certified Medication Technician (CMT) the resident had requested a hot pack, or that one of the aides had placed a hot pack on the resident's shoulder. The RN said he/she was notified of the burn injury during shift report the next day when he/she returned to work. The RN said Certified nursing Assistant (CNA) G also reported to him/her the resident had requested a hot pack the night before, he/she consulted with CMT E, and after CMT E gave him/her directions, he/she heated a wet towel in a plastic bag with water, which initially felt too hot, so he/she poured off some of the water, added cold water to the bag, wrapped the bag in a towel and placed the hot pack on the resident's shoulder.During an interview on 08/26/25 at 3:05 P.M, CMT E said the resident had requested a hot pack and he/she was busy with something else, so he/she asked CNA G to apply the hot pack. The CMT said he/she gave CNA G directions on how to prepare the hot pack but did not direct CNA G on how long to leave the hot pack on the resident. The CMT said he/she should have checked on the resident since he/she had directed CNA G to apply the hot pack to the resident's shoulder, but he/she forgot. The CMT said he/she could not recall if he/she had told the charge nurse that the resident had requested a hot pack for pain so the nurse could follow up with the resident.During an interview on 08/26/25 at 3:19 P.M., the Assistant Director of Nursing (ADON) said CNAs can administer warm packs to a cognitive resident, but after consulting with the nurse so the nurse can further assess the resident's need/request for the warm pack, and the CMT or nurse to follow up with the resident. The ADON said staff should monitor a resident within 15 minutes if they apply a warm/cold pack to a resident's skin. During an interview on 08/26/25 at 3:57 P.M., Nursing Assistant (NA) F said he/she was training with CNA G when the incident occurred. The NA said CNA G placed a washcloth with warm water in a plastic bag and heated the bag in the microwave for about 15 seconds. The NA said he/she mentioned to CNA G that the bag was probably too hot, and CNA G wrapped the bag into a towel and placed it on the resident's shoulder. The NA said he/she found out the next day the resident had sustained burns to his/her shoulder, and he/she has not received any in-services regarding how to use a warm pack since the incident. During an interview on 08/26/25 at 5:32 P.M., Licensed Practical nurse (LPN)