

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26A378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Sylvia G Thompson Residence Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>48982</p> <p>Based on observation, interview, and record review, facility staff failed to verify medications to the Medication Administrator Record (MAR) for two (Resident #90 and #50) of three sampled residents. The facility census was 116.</p> <p>1. Review of the facility's policy titled Administering Medications, revised April 2019, showed:</p> <ul style="list-style-type: none"> -Medications are administered according to prescriber orders; -Verify the resident's identity before giving medication by checking photo attached to the medical record; -Check the medication three times to verify the right resident, right medication, right dose, right time, and right route of administration before giving the medication; -The individual administering the medication initials the MAR after giving each medication. <p>2. Observation on 01/21/25 at 12:00 P.M., showed Licensed Practical Nurse (LPN) C drew up Novolin Insulin (a medication used to control blood sugars) for Resident #90 and did not check the MAR to ensure he/she administered the proper dosage. Observation showed LPN C looked at a cheat sheet that hung on the medication room cabinet to know how much insulin to administer.</p> <p>During an interview on 01/21/25 at 12:15 P.M., LPN C said the nursing administration updates the cheat sheet for staff to use to administer insulin instead of using the MAR. LPN C said he/she then goes back later and signs the MAR. LPN C said if the orders change for a resident the administration is responsible to update the cheat sheet for the staff and post it.</p> <p>3. Observation on 01/22/25 at 11:10 A.M., showed Registered Nurse (RN) R administered Humalog Insulin to Resident # 50 and did not check the MAR to ensure he/she administered the proper dosage. Observation showed RN R looked at a cheat sheet on the blood glucose carrier to know how much insulin to administer.</p> <p>During an interview on 01/22/25 at 11:15 A.M., RN R said staff are given cheat sheets for insulin to make it faster. RN R said he/she is responsible to update the cheat sheet with any new orders but he/she is not sure what happens if he/she is not working.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During an interview on 01/22/25 at 1:15 P.M., the Director of Nursing (DON) said staff are expected to compare the MAR to the medication prior to administering it. The DON said staff should not use a cheat sheet to give medications as there is a potential for a new order to be given and a medication error would be made.</p> <p>During an interview on 01/22/25 at 1:45 P.M., the Administrator said he/she knew staff used a cheat sheet to give certain medications but should compare medications to the MAR before administering.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424</p> <p>Based on observation, interview, and record review, facility staff failed to provide safe mechanical transfers for two residents (Resident #51, and #39). Facility staff failed to safely store hazardous materials in three shower rooms and one storage area and failed to ensure medications were safely stored. The facility census was 116.</p> <p>1. Review of the facility's Using a Mechanical Lifting Machine policy, dated July 2017, showed staff were directed:</p> <ul style="list-style-type: none"> -Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility; -Clear an unobstructed path for the lift machine. <p>Review of the mechanical lift operating instructions, dated 2018, showed the legs of the lift must be opened to the widest position when transferring a resident.</p> <p>2. Review of Resident #51's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/27/24, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> -Severe Cognitive impairment; -Transfer as total dependence. <p>Observation on 01/20/25 at 10:32 A.M., showed Certified Nurse Aid (CNA) F and Nurse Aid (NA) G transferred the resident from bed to the wheelchair. Observation showed CNA F operated the lift while NA G supported the resident. Staff lifted the resident off the bed, the CNA closed the legs of the lift, backed away from the bed, pivoted towards the wheelchair with the legs of the lift fully closed. The CNA then opened the legs to clear the wheelchair and lowered the resident into the wheelchair.</p> <p>During an interview on 01/20/25 at 10:41 A.M., CNA F said he/she closed the legs of the lift for balance and was trained to close them when turning.</p> <p>3. Review of Resident #39's quarterly MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> - Cognitively intact; -Transfer total dependence. <p>Observation on 01/21/25 at 10:45 A.M., showed CNA H and CNA I transferred the resident from bed to a wheelchair with a mechanical lift. CNA H operated the lift and CNA I supported the resident. CNA H lifted the resident off the bed, pulled the lift away from the bed and pivoted towards the wheelchair with the mechanical lift legs closed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/21/25 at 11:00 A.M., CNA H said he/she does not open the legs of the lift during mechanical transfer because there is not enough room for the lift. He/She said it was safe not to open the lift legs.</p> <p>4. During an interview on 01/22/25 at 1:18 P.M., the Director of Nursing (DON) said staff should transfer residents with the lift legs open to the widest position for stability. The DON said staff are trained to use the lift this way for resident safety. He/She said they were ultimately responsible with ensuring staff used the lift correctly.</p> <p>During an interview on 01/22/25 at 1:20 P.M., the administrator said the lift legs should be open to the wide position for stability. The administrator said if the legs are not open the lift is not stable and could injure a resident.</p> <p>5. Review of the facility's policy's showed the facility did not provide a hazardous material storage policy.</p> <p>6. Observation on 01/20/25 at 11:32 A.M., showed the 200 hall shower room door open with a unlocked cabinet contained a bottle of aftershave, and a bottle of peroxide multi-disinfectant. Observation showed residents and staff passed by the door.</p> <p>Observation on 01/21/25 at 12:50 P.M., showed the memory care unit shower room near room [ROOM NUMBER] unlocked and a cart contained two disposable razors.</p> <p>Observation on 01/21/25 at 12:53 P.M., showed the memory care unit common area lower cabinet not locked. The cabinets contained one spray bottle of disinfectant.</p> <p>Observation on 01/21/25 at 12:55 P.M., showed the memory care unit shower room near room [ROOM NUMBER] unlocked and contained a one gallon container of hand sanitizer gel floor.</p> <p>Observation on 01/21/25 at 3:30 P.M., showed the 100 hall shower room door open and a resident in a wheelchair left the room. Observation showed staff were not present. Observation showed the shower room contained an unlocked cabinet which contained a bottle of heavy duty acidic cleaner, a bottle of disinfectant cleaner, and an open pack of disposable razors. Observation showed multiple staff walked by the shower room.</p> <p>During an interview on 01/21/25 at 12:55 P.M., CNA K said razors should not be left in the shower rooms. CNA K said cleaning chemicals should not be stored in the common area cabinets. CNA K said all aides were responsible for ensuring hazardous items were kept away from residents. CNA K said he/she did not know the razors and cleaning materials were not secured.</p> <p>During an interview on 01/21/25 at 1:00 P.M., NA L said chemicals should not be left unsecured in common area cabinets. NA L said he/she did not know the chemicals were in the cabinet. NA L said the hand sanitizer gel was in the shower the day prior but he/she did not know who put it there. NA L said he/she did not think about the hand sanitizer as a safety issue since it was there already. NA L said he/she left the cart with the razors in the shower room. NA L said he/she had to leave the unit earlier and forgot to secure the cart.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/22/25 at 9:35 A.M., CNA Q said hazardous materials should be in a locked area. The CNA said the shower rooms have cabinets that lock. CNA G said residents could be poisoned or injured in some way with the cabinets being left unlocked.</p> <p>During an interview on 01/22/25 at 9:42 A.M., RN R said residents should not have access to chemicals or other hazardous materials. The RN said these hazards should be locked up to prevent injury to the residents.</p> <p>During an interview on 01/22/25 at 9:47 A.M., RN J said the shower room cabinets should be locked when not in use and no staff present. He/She said a resident could ingest the chemicals and be injured.</p> <p>During an interview on 01/22/25 at 1:18 P.M., the DON said the shower room cabinets should be locked to prevent injury to residents when not in use.</p> <p>During an interview on 01/22/25 at 1:22 P.M., the administrator said leaving cabinets and other hazardous materials unlocked could cause a resident to be injured.</p> <p>7. Review of the facility's policy titled Administering Medications, revised 04/2019, showed:</p> <ul style="list-style-type: none"> -The Director of Nursing (DON) supervises and directs all staff on administering medications and related functions; -The expiration date on the medication label is checked prior to opening or administering; -When opening a multi-dose container, the date opened is recorded on the container; -The medication cart is to be kept closed and locked when out of sight of the medication aide or nurse; -No medications are to be kept on top of the cart. <p>8. Observation on 01/21/25 at 7:44 A.M., showed nursing station two medication cart in the dining room with 11 bottles which contained medication on top of the cart unattended and residents nearby.</p> <p>Observation on 01/21/25 at 7:51 A.M., showed Certified Medication Technician (CMT) D prepared medications for a resident, walked away from nurse's station two medication cart with 11 bottles of medications on top of the cart, unlocked and unattended.</p> <p>Observation on 01/21/25 at 8:50 A.M., showed nurse's station two medication cart in the dining room with 11 bottles which contained medication on top of the cart unattended and residents nearby.</p> <p>Observation on 01/22/25 at 7:30 A.M., showed nurse's station two medication cart in the dining room with nine bottles which contained medication on top of the cart unattended and residents nearby.</p> <p>Observation on 01/22/25 at 8:53 A.M., showed nurse's station two medication cart in the dining room with nine bottles which contained medication on top of the cart unattended and residents nearby.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/22/25 at 9:30 A.M., CMT D said it is acceptable to leave over the counter medications on top of his/her medication cart. CMT D said he/she did not think about a resident potentially getting the medications and taking them. CMT D said he/she should always lock his/her cart when not working in it and he/she forgot.</p> <p>9. Observation on 01/21/25 at 8:12 A.M., showed the nurse's station one medication cart in the dining room with 14 bottles which contained medication on top of the cart unattended and residents nearby.</p> <p>Observation on 01/21/25 at 9:50 A.M., showed the nurse's station one medication cart in the dining room with two bottles of medication on top of the cart, unattended and Resident #80 grabbed at the cart.</p> <p>Observation on 01/22/25 at 7:35 A.M., showed the nurse's station one medication cart in the dining room with 11 bottles of medication, four insulin pens, and two syringes of insulin on top of the cart, unattended and residents nearby.</p> <p>During an interview on 01/21/25 at 9:56 A.M., CMT E said he/she is responsible for the medication cart. CMT E said medication carts should not be left unattended and medications should not be left on top of the cart. CMT E said this could result in a resident taking medications and cause potential harm. CMT E said he/she did leave medications on top of his/her cart and should not have.</p> <p>10. During an interview on 01/22/25 at 1:15 P.M., the DON said staff are expected to keep medications locked up when not being administered. The DON said staff should not keep medications on top of the medication cart and walk away from it. The DON said medication or treatment carts should not be unlocked or unattended. The DON said this is done to ensure resident safety.</p> <p>During an interview on 01/22/25 at 1:45 P.M., the administrator said staff are expected to keep medications locked up when not being administered, and staff should not keep medications on top of their carts. The administrator said medication or treatment carts should not be unlocked or unattended. The administrator said this is to ensure resident safety.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48982</p> <p>Based on observation, interview, and record review, facility staff failed to ensure a medication error rate of less than five percent (%). Out of 41 opportunities observed, three errors occurred, resulting in a 7.32% error rate, which affected two residents (Resident #45, and #5) out of 10 sampled residents. The facility census was 116.</p> <p>Review of the American Academy of Allergy Asthma and Immunology recommendations titled Tips for Administering Eye Drops, dated 08/2010, showed close the eyelids and apply pressure for one to two minutes over the point where the eyelid meets the nose (nasolacrimal duct) after administering eye drops.</p> <p>1. Review of the facility's policy titled Administering Medications, revised 04/2019, showed:</p> <ul style="list-style-type: none"> -Medications are administered according to prescriber orders; -Medication errors are documented, reported, and reviewed by the Quality Assurance Performance Improvement (QAPI) team; -The individual administering the medications: <p>2. Review of Resident #45 Physician's Order Sheet (POS), dated 01/21/24, showed:</p> <ul style="list-style-type: none"> -Memantine (a medication for dementia) 10 milligrams (mg) 1 tablet by mouth; -Dorzolamidine HCL/Timolol (a medication used to treat glaucoma and eye conditions that cause high pressure in the eye) 2 percent (%)-0.5% 1 drop each eye. <p>Observation on 01/21/25 at 7:57 A.M., showed Certified Medication Technician (CMT) D prepared medications for Resident #45. Observation showed CMT D crushed the resident's medications per orders, and administered the crushed medications. Observation showed the resident spit a whole pill out on the dining room table and CMT D picked the pill up and threw it away. Observation showed CMT D did not attempt to re-administer the medication. Observation showed CMT D administered Dorzolamide HCL/Timolol 2%/0.5% (a medication used to treat glaucoma) eye drops to the resident and did not hold the lacrimal duct after administration.</p> <p>During an interview on 01/22/25 at 9:30 A.M., CMT D said he/she did not know he/she should have held the lacrimal duct after he/she administered eye drops. CMT D said this could be considered a medication error as the eye drops may not absorb completely. CMT D said he/she should have made a second attempt to administer the medication that Resident #45 spit out. CMT D said it would be a medication error for not attempting to give it again the proper way.</p> <p>3. Review of Resident #5's POS, dated 01/21/25, showed an order for Artificial tears one drop in each eye.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 01/21/25 at 8:13 A.M., showed CMT E administered Artificial tears to Resident #5 and did not hold the lacrimal duct after administration.</p> <p>During an interview on 01/22/25 at 9:10 A.M., CMT E said he/she should have held the lacrimal duct when administering the eye drops. CMT E said this would be considered a medication error as the eye drops may not absorb completely.</p> <p>4. During an interview on 01/22/25 at 1:15 P.M., the Director of Nursing (DON) said if a resident spits a medication out that should have been crushed staff are expected to crush the medication and offer it again. She said if staff do not do this it would be considered a medication error. The DON said the proper way to administer eye drops is to hold the lacrimal duct after administration, he/she said if staff don't do this it would be considered a medication error.</p> <p>During an interview on 01/22/25 at 1:45 P.M., the Administrator said if a resident spits a medication out that should have been crushed staff are expected to crush the medication and offer it again. She said if staff do not do this it would be considered a medication error. The Administrator said the proper way to administer eye drops is to hold the lacrimal duct after administration, he/she said if staff don't do this it would be considered a medication error.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48982</p> <p>Based on observation, interview, and record review, facility staff failed to store medications in a safe and effective manner in two of two medication rooms and failed to discard expired medications in one two medication carts. The Facility census was 116.</p> <p>1. Review of the facility's policy titled Controlled Drug Policy and Procedure, revised 08/2024, showed a separate compartment for controlled drugs is provided in a locked cabinet inside the medication room or locked medication cart. The compartment has a special lock and key, and must be kept locked at all times.</p> <p>2. Observation on 01/21/25 at 10:00 A.M., showed the Nurse's station one's medication room contained an unlocked refrigerator. Observation showed two opened bottles of liquid Ativan (a controlled drug). Observation showed the unlocked narcotic cabinet contained one opened four opened bottles of liquid morphine.</p> <p>Observation on 01/21/25 at 11:59 A.M., showed (Licensed Practical Nurse) LPN C unlocked the nurses's station one medication room, propped the door open and walked away from the open medication room. Observation showed the unlocked refrigerator in the medication room contained two bottles of liquid Ativan. Observation showed the unlocked narcotic cabinet in the medication room contained four bottles of opened liquid morphine. Observation showed the medication room sat with the door propped open, unlocked, and unattended for 10 minutes until LPN C returned to close the door.</p> <p>During an interview on 01/21/25 at 12:15 P.M., LPN C said he/she should not have left the medication door propped open for resident safety and to prevent medications being taken. LPN C said all medications should be kept under lock unless staff are preparing them. LPN C said narcotics should be kept under a double lock and he/she just forgot to lock the cabinet. LPN C said the refrigerator does not have a lock on it, but it should since it contained Ativan.</p> <p>3. Observation on 01/21/25 at 9:00 A.M., showed nurse's station two's medication room contained an unlocked refrigerator. Observation showed one opened and undated vial of Tuberculosis (TB) solution (a medication used to test for TB), one opened bottle of probiotic with an expiration date of 10/24, and one opened bottle of liquid Ativan.</p> <p>Observation on 01/22/25 at 8:47 A.M., showed nurse's station two's medication room refrigerator sat unlocked and contained one opened bottle of liquid Ativan.</p> <p>During an interview on 01/21/25 at 9:00 A.M., LPN B said he/she did not know the refrigerator in the medication room had a bottle of Ativan in it. The LPN said Ativan is a narcotic and it should be kept under a double lock, and the refrigerator should have a lock on it to prevent discrepancies.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/21/25 at 9:30 A.M., Certified Medication Technician (CMT) D said all narcotics should be kept under a double lock. CMT D said he/she knew there was not a lock on the refrigerator in the nurse's station two's medication room and that it contained Ativan. CMT D said the facility changed the refrigerator out a few months ago and he/she has not seen a lock on it since. CMT D said he/she did not know if it had been reported and he/she had not reported it.</p> <p>During an interview on 01/21/25 at 10:20 A.M., the Director of Nursing (DON) said he/she narcotics should be stored under a double lock and he/she did not know this had not been happening.</p> <p>During an interview on 01/21/25 at 10:22 A.M., the Administrator said he/she was not aware staff were not storing narcotics under double lock. The Administrator said the refrigerators and cabinets that contain narcotics should be locked inside the medication rooms.</p> <p>4. Review of the facility's policy titled Administering Medications, revised 04/2019, showed:</p> <ul style="list-style-type: none"> -The Director of Nursing (DON) supervises and directs all staff on administering medications and related functions; -The expiration date on the medication label is checked prior to opening or administering; -When opening a multi-dose container, the date opened is recorded on the container; <p>5. Observation on 01/21/25 at 9:10 A.M., showed the nurse's station two medication cart contained:</p> <ul style="list-style-type: none"> -One opened bottle of Geri-lax (a medication used as a laxative) as a stock medication with an expiration date of 06/24 and an open date of 12/15/24; -One opened bottle of ear wax drops with no resident name and an expiration date of 07/24; -One opened bottle of ear ache drops with no resident name, an expiration date of 08/24 and an open date of 10/14/24; -One opened box of Benadryl 25 mg as a stock medication with an expiration date of 08/24; -One opened bottle of Geri-tussin (a medication used for cough) as a stock medication with an expiration date of 12/24. <p>During an interview on 01/21/25 at 9:00 A.M., LPN B said licensed staff who pass medications are responsible to ensure medications are not expired and administered to residents. LPN B said expired medications should be removed from the supply and destroyed. LPN B said staff should check every medication before they open it to ensure it is not expired.</p> <p>During an interview on 01/21/25 at 9:30 A.M., CMT D said he/she is responsible for the nurses's station two medication cart. CMT D said it is the responsibility of the licensed staff giving medications to check for expiration dates and if a medication is expired it should be removed and destroyed. CMT D said staff should check the expiration date before they open a new medication. CMT D said he/she should do a better job at checking for expired medications but he/she gets busy and doesn't have time.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Sylvia G Thompson Residence Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 3333 W Tenth Street Sedalia, MO 65301	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/21/25 at 12:15 P.M., LPN C said all staff who administer medication are responsible to check for expiration dates. LPN C said staff should remove any expired meds and destroy them, he/she said they should not be administered to a resident. LPN C said the staff person who opens a new medication is responsible to date the medication and check the expiration date.</p> <p>6. During an interview on 01/22/25 at 1:15 P.M., the DON said staff should date medications when opened, and should check expiration dates. The DON said all staff who administer medications are responsible for checking expirations dates, and discarding expired medications. The DON said expired medications should not be administered to residents. The DON said he/she expects staff to keep medications locked up when not being administered. The DON said the medication room door should not be propped open, and all narcotics including Ativan and Morphine, should be stored under a double lock. The DON said this is done to ensure resident safety and to prevent discrepancies. The DON said he/she did not know there were not locks on the refrigerators in the medication rooms but there should be since they contain Ativan.</p> <p>During an interview on 01/22/25 at 1:45 P.M., the administrator said staff are expected to check expiration dates before administering medications, and should not be administering expired medications. The administrator said all staff who administer medications are responsible for monitoring for expired medications and discarding when appropriate. The administrator said the medication room door should not be propped open, and all narcotics such as Morphine and Ativan should be kept under a double lock. The administrator said he/she did not know there were not locks on the refrigerators in the medication rooms but there should be since they contain Ativan. The Administrator said this is to ensure resident safety and to prevent discrepancies.</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>45564</p> <p>Based on observation, interview and record review, the facility staff failed to provide each resident with a nourishing, palatable, well-balanced diet to meet their daily nutritional and special dietary needs, when staff failed to provide portions as directed in standardized recipes. This affected all residents who received their meals from the facility's kitchen. The facility census was 116.</p> <p>1. Review of the facility's standardized menu for 01/20/25 (Week 4 - Day 23), showed staff were directed to serve the residents eight ounces of beef goulash and eight ounces of tossed salad.</p> <p>Observation on 01/20/25 at 12:52 P.M., showed [NAME] M served the residents one, #6 (5.33 ounces) scoop of goulash (2.66 ounces less than directed) and a four-ounce spoodle of salad (four ounces less than directed).</p> <p>Observation on 1/20/25 at 1:08 P.M., showed Dietary Aide (DA) O served a #6 scoop of goulash (2.66 ounces less than directed and pre-made salads from the kitchen which were four ounces (four ounces less than directed).</p> <p>During an interview on 01/20/25 at 12:52 P.M., [NAME] M said he/she was the evening cook and the day shift cook placed the serving utensils for the noon meal. [NAME] M said he/she did not check the serving utensils to ensure they matched the menu so he/she did not realize he/she was not serving the correct portions.</p> <p>During an interview on 01/20/25 at 1:22 P.M., [NAME] N said he/she was responsible for pulling correct utensils for the noon meal service. [NAME] N said another staff member handed him/her the salad spoodle but he/she did not check it. [NAME] N said he/she just completed training and did not check the menu for correct serving sizes. [NAME] N said he/she was not sure where to find correct portion sizes.</p> <p>2. Review of the facility's standardized menu for 01/21/25 (Week 4 - Day 24), showed staff were to serve the residents four ounces of cubed potatoes with breakfast.</p> <p>Observation on 01/21/25 at 8:05 A.M., showed DA O served the station two residents a #12 scoop (2.66 ounces) of cubed potatoes (1.33 ounces less than directed).</p> <p>During an interview on 01/20/25 at 1:10 P.M., DA O said the cooks send the serving utensils to station two along with the meal cart. DA O said salads were prepared in the kitchen and delivered on a tray with the meal cart.</p> <p>During an interview on 01/22/25 at 10:00 A.M., [NAME] P said he/she was responsible for providing breakfast utensils for the station two dietary aide. [NAME] P said he/she pulled the scoop for the breakfast meal but he/she pulled the wrong size. [NAME] P said he/she uses the scoop chart and standardized recipes to determine which utensils to pull.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/20/25 at 1:05 P.M., the Dietary Manager (DM) said he/she had been working evenings and training the night cook so he/she had not been keeping up with the day shift cook's training. The DM said he/she was not aware the day shift cook did not know where to find correct portion sizes.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>40424</p> <p>Based on interview and record review, facility staff failed to electronically submit to Centers for Medicare and Medicaid Services (CMS), a complete and accurate direct care staffing information to the Payroll Based Journal (PBJ) data from July 1, 2024 through September 30, 2024. The facility census was 116.</p> <p>1. Review of the facility policy titled, Reporting Direct Staffing Information (Payroll-Based Journal), Revised August 2022, showed:</p> <p>-Complete and accurate direct care staffing information is reported electronically to CMS through the PBJ system in a uniform format specified by CMS;</p> <p>-Direct care staffing information is submitted on the schedule specified by CMS, but no less frequently than quarterly;</p> <p>-Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. Dates are as follows:</p> <p>--Fiscal Quarter 1: Date Range October 1-December 31: submission deadline February 14;</p> <p>--Fiscal Quarter 2: Date Range January 1-March 31: submission deadline May 15;</p> <p>--Fiscal Quarter 3: Date Range April 1-June 30: submission deadline February 14;</p> <p>--Fiscal Quarter 4: Date Range July 1-September 30: submission deadline November 14.</p> <p>2. Review of the facility's CMS PBJ Staffing Data Report, dated January 2, 2025, did not contain a report for the period of July 1, 2024 through September 30, 2024.</p> <p>During an interview on 01/22/24 at 8:46 A.M., Human Resources (HR) said it is his/her responsibility to ensure the PBJ report is submitted timely. He/She is aware the facility's PBJ reports were not filed timely. He/She said the facility hired a new payroll management company and they have had issues with their payroll information uploading to CMS correctly. He/She said he/she and the board members have been working with the new payroll management company each quarter to try and fix the uploading errors.</p> <p>During an interview on 01/22/25 at 9:00 A.M., the administrator said HR is responsible for submitting the PBJ reports. He/She said he/she did know the facility had not submitted the PBJ reports timely/accurately. He/She said HR has had issues since they switched payroll management companies. He/She said the system had not allowed them to upload to CMS with the correct data and they are working to get the errors corrected.</p> <p>47193</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48982</p> <p>Based on observation, interview, and record review, facility staff failed to follow infection control practices during medication administration for five (Resident #109, #45, #110, #5, & #120) out of 24 sampled residents. The facility census was 116.</p> <p>1. Review of the facility's policy titled Administering Medications, revised 04/2019, showed staff are directed to follow facility infection control procedures (hand washing, antiseptic technique, gloves, etc.) for the administration of medications.</p> <p>Review of the facility's policy titled Handwashing and Hand Hygiene, revised 08/2019, showed:</p> <ul style="list-style-type: none"> -All staff shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other staff, resident, or visitors; -Use an alcohol-based had rub for the following situations; <ul style="list-style-type: none"> -Before and after coming in contact with a resident; -Before preparing or handling medications; -After contact with objects and/or medical equipment in the vicinity of the resident; -After removing gloves. <p>2. Observation on 01/21/25 at 7:45 A.M., showed Certified Medication Technician (CMT) D prepared medications for Resident #109. Observation showed CMT D dropped an Aspirin on top of the medication cart and used his/her bare hand to pick the medication up and put it in the cup. Observation showed CMT D administered the Aspirin to the resident.</p> <p>Observation on 01/21/25 at 7:57 A.M., showed CMT D prepared medications for Resident #45. Observation showed CMT D dropped a medication on the floor, picked it up and threw it in the trash, did not wash his/her hands or apply gloves and administered the residents eye drops.</p> <p>During an interview on 01/22/25 at 9:30 A.M., CMT D said he/she should wear gloves to administer eye drops to residents. CMT D said he/she did not realize he/she forgot to wear gloves until after administering the eye drops. CMT D said he/she should not touch a resident's medication with his/her bare hands. CMT D said he/she should have washed his/her hands after picking medication up off the floor.</p> <p>3. Observation on 01/21/25 at 8:13 A.M., showed CMT E prepared medications for Resident #110. Observation showed CMT E dropped a Vitamin D 3 on the medication cart. Observation showed CMT E used his/her bare hands to pick the medication up and put it in the medication cup. Observation showed CMT E administered the medication to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/22/25 at 9:10 A.M., CMT E said staff should wear gloves to touch resident's pills to prevent cross contamination and spreading of germs.</p> <p>4. Review of the facility's policy titled Instillation of Eye Drops, revised 01/2014, showed staff are directed to put on gloves before administering eye drops.</p> <p>Observation on 01/21/25 at 8:13 A.M., showed CMT E administered Artificial tears (an eye lubricant) to Resident #5. Observation showed CMT E did not wear gloves to administer the medication.</p> <p>During an interview on 01/22/25 at 9:10 A.M., CMT E said he/she should have worn gloves to administer eye drops to a resident.</p> <p>5. Observation on 01/21/25 at 9:30 A.M., showed CMT D completed a narcotic count of the nurse station two medication cart. Observation showed CMT D did not perform hand hygiene, counted a bottle of Oxycodone (pain medication) 5/325 milligrams (mg) for Resident #120, and touched the pills with his/her bare hands. Observation showed CMT D put the medication back in the bottle for resident use.</p> <p>During an interview on 01/22/25 at 9:30 A.M., CMT D said not washing his/her hands caused cross-contamination and spreading of germs. CMT D said he/she did not think about washing his/her hands at the time.</p> <p>6. During an interview on 01/22/25 at 1:15 P.M., the Director of Nursing (DON) said staff should not pick something up off the floor and then administer medications to the resident without washing their hands. The DON said this is cross contamination and can cause infections to spread. The DON said staff are expected to wear gloves when giving eye medications as standard precautions and to prevent cross contamination or possible infection risks. The DON said staff should wear gloves to touch a resident's medication and not use their bare hands. The DON said this helps prevent the spread of germs. The DON said the glucometer should be placed on a barrier once sanitized to prevent contamination. The DON said if staff do not use a barrier after sanitizing the glucometer it could spread germs from the surface to the resident. The DON said staff should not put a dirty glucometer in the carrier as this causes contamination.</p> <p>During an interview on 01/22/25 at 1:45 P.M., the Administrator said staff should not pick something up off the floor and then administer medications to the resident without washing his/her hands as this causes cross contamination and can cause infection to spread. The Administrator said staff are expected to wear gloves when giving eye medications as standard precautions and to prevent cross contamination or possible infection risks. The Administrator said staff should wear gloves to touch a resident's medication and not use their bare hands. The Administrator said if staff do not use a barrier after sanitizing the glucometer it could cause a spread of germs from the surface to the resident. The Administrator said staff should not put a dirty glucometer in the carrier as this causes contamination.</p>		