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	10/09/2025

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to follow their Facility Assessment to ensure the facility staffed enough staff to meet the needs of the residents. Staff failed to provide a sufficient number of direct care staff members to ensure call lights were answered in timely manner. The facility census was 112. 1. Review of the facility assessment tool, dated 08/28/25, showed: -Average census of 117 residents;-Goal staffing is one to eight ratio for Certified Nursing Assistants (CNAs), the day-to-day average is one to ten for CNAs;-Days: Five Registered Nurses (RNs), two Licensed Practical Nurses (LPNs), and 17 CNAs;-Evenings: One RN, one LPN, and 14 CNAs;-Nights: Two LPNs and eight CNAs;-Weekend days: One RN, one LPN, and other direct care hours remain the same.2. Review of the facility census sheet, dated 08/30/25, showed the facility census at 117.Review of the employee schedule, dated 08/30/25, showed: -Eight CNAs on evening shift;-Seven CNAs on night shift.3. Review of the facility census sheet, dated 08/31/25, showed the facility census at 117.Review of the employee schedule, dated 08/3/25, showed: -Nine CNAs on day shift;-Nine CNAs on evening shift;-Six CNAs on night shift.4. Review of the facility census sheet, dated 09/06/25, showed the facility census at 117.Review of the employee schedule, dated 09/06/25, showed: -One RN on day shift;-Eight CNAs on evening shift.5. Review of the facility census sheet, dated 09/07/25, showed the facility census at 117Review of the employee schedule, dated 09/07/25, showed one LPN and nine CNAs on evening shift scheduled.6. Review of the facility census sheet, dated 09/13/25, showed the facility census at 118.Review of the employee schedule, dated 09/13/25, showed: -11 CNAs on day shift;-Seven CNAs on evening shift;-Six CNAs on night shift.7. Review of the facility census sheet, dated 09/20/25, showed the facility census at 117.Review of the employee schedule, dated 09/20/25, showed: -Nine CNAs on evening shift;-One LPN on night shift.8. Review of the facility census sheet, dated 09/21/25, showed the facility census at 117Review of the employee schedule, dated 09/21/25, showed: -Seven CNAs on evening shift;-One LPN and seven CNAs on night shift.9. Review of the facility census sheet, dated 09/27/25, showed the facility census at 117.Review of the employee schedule, dated 09/27/25, showed: -11 CNAs on day shift;-Nine CNAs on evening shift;-One LPN and seven CNA's on night shift.10. Review of the facility census sheet, dated 09/28/25, showed the facility census at 117.Review of the employee schedule, dated 09/28/25, showed: -One LPN and five on evening shift;-Six CNAs on night shift.During an interview on 10/9/25 at 4:05 P.M., the Director of Nursing (DON) said they staff one charge nurse, one CMT and four to five CMT's on each unit on day shift. He/She said they have three units. He/She said for the weekends they staff two nurse, three CMT's and the same number of aides. He/She said they have plenty of staff scheduled, but their issue is having no shows and call ins. He/She said they have incentives in place to try and encourage staff to show up to shifts and they have administrative staff come work the shifts when needed.During an interview on 10/9/25 at 4:07 P.M., the administrator said they use their facility assessment as a goal for how many staff they should have on the floor. He/She said they do not always staff according to the facility assessment. He/She said they have plenty of staff on payroll and scheduled but that they do not always show up to work their shifts. He/She said when that (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	happens the DON, himself/herself, or other administrative staff with work the floor.11. Review of the facility's policy titled, Answering the Call Light, dated September 2022, showed the purpose is to ensure timely responses to the resident's requests and needs, and staff are directed to answer the resident call system immediately. The policy did not contain direction for who may answer the call light.12. Review of the daily nursing staff assignment sheet, dated 10/02/25, showed:-Day shift: 29 CNA/CMT;-Evening shift: 13 CNA/CMT.Review of the facility's wireless call light report, dated 10/02/25 showed: -At 5:27 A.M., room [ROOM NUMBER] with call light response time of 30 minutes;-At 5:45 A.M., room [ROOM NUMBER] with call light response time of 51 minutes;-At 6:23 A.M., room [ROOM NUMBER]'s bathroom with call light response time of 43 minutes;-At 6:41 A.M., room [ROOM NUMBER] with call light response time of 44 minutes;-At 7:04 A.M., room [ROOM NUMBER] with call light response time of 37 minutes;-At 7:14 P.M., room [ROOM NUMBER] with call light response time of 31 minutes.13. Review of the daily nursing staff assignment sheet, dated 10/03/25, showed:-Day shift: 19 CNA/CMT;-Evening shift: 11 CNA/CMT.Review of the facility's wireless call light report, dated 10/03/25 showed: -At 11:41 A.M., room [ROOM NUMBER]'s bathroom with call light response time of 36 minutes;-At 5:30 P.M., room [ROOM NUMBER] with call light response time of 1 hour and 21 minutes;-At 7:34 P.M., room [ROOM NUMBER]'s bathroom with call light response time of 32 minutes;-At 7:38 P.M., room [ROOM NUMBER] with call light response time of 44 minutes;-At 7:54 P.M., room [ROOM NUMBER] with call light response time of 33 minutes. 14. Review of the daily nursing staff assignment sheet, dated 10/04/25, showed:-Day shift: 14 CNA/CMT;-Evening shift: 11 CNA/CMT.Review of the facility's wireless call light report, dated 10/04/25 showed: -At 6:44 A.M., room [ROOM NUMBER] with call light response time of 2 hours and 59 minutes;-At 6:55 A.M., room [ROOM NUMBER] with call light response time of 1 hour and 13 minutes;-At 7:29 A.M., room [ROOM NUMBER] with call light response time of 36 minutes;-At 7:36 A.M., room [ROOM NUMBER]'s bathroom with call light response time of 2 hours and 8 minutes;-At 8:57 A.M., room [ROOM NUMBER] with call light response time of 40 minutes;-At 12:33 P.M., room [ROOM NUMBER] with call light response time of 31 minutes;-At 4:20 P.M., room [ROOM NUMBER] with call light response time of 1 hour and 9 minutes;-At 5:47 P.M., room [ROOM NUMBER] with call light response time of 56 minutes;-At 6:07 P.M., room [ROOM NUMBER] with call light response time of 34 minutes;-At 7:45 P.M., room [ROOM NUMBER] with call light response time of 1 hour and 4 minutes;-At 7:50 P.M., room [ROOM NUMBER] with call light response time of 55 minutes.15. Review of the daily nursing staff assignment sheet, dated 10/05/25, showed:-Day shift: 15 CNA/CMT;-Evening shift: 12 CNA/CMT.Review of the facility's wireless call light report, dated 10/05/25 showed: -At 1:13 P.M., room [ROOM NUMBER] with call light response time of 31 minutes;-At 7:11 P.M., room [ROOM NUMBER] with call light response time of 40 minutes;-At 8:06 P.M., room [ROOM NUMBER] with call light response time of 30 minutes.16. Review of the daily nursing staff assignment sheet, dated 10/06/25, showed:-Day shift: 26 CNA/CMT;-Evening shift: 11 CNA/CMT.Review of the facility's wireless call light report, dated 10/06/25 showed: -At 1:43 P.M., room [ROOM NUMBER] with call light response time of 1 hour and 42 minutes;-At 1:48 P.M., room [ROOM NUMBER]'s bathroom with call light response time of 1 hour and 49 minutes;-At 2:23 P.M., room [ROOM NUMBER] with call light response time of 1 hour and 12 minutes;-At 2:28 P.M., room [ROOM NUMBER]'s bathroom with call light response time of 1 hour and 7 minutes;-At 2:39 P.M., room [ROOM NUMBER] with call light response time of 59 minutes;-At 3:00 P.M., room [ROOM NUMBER] with call light response 37 minutes;-At 3:58 P.M., room [ROOM NUMBER] with call light response time of 53 minutes;-At 4:13 P.M., room [ROOM NUMBER] with call light response time of 55 minutes;-At 4:25 P.M., room [ROOM NUMBER] with call light response time of 44 minutes;-At 4:27 P.M., room [ROOM NUMBER] with call light response time of 45 minutes;-At 4:31 P.M., Nurse's Station two women's bathroom with call light response time of 40 minutes;-At 6:02 P.M., room [ROOM NUMBER] with call light response time of 37 minutes;-At 7:57 P.M., room [ROOM NUMBER] with call light response time of 33 minutes.17. During an interview on 10/06/25 at 11:32 A.M., Resident #111 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	said he/she needs help from staff to transfer and to use the bathroom, but staff sometimes takes up to 30 minutes to respond to his/her call light which sometimes causes him/her to have bladder accidents and require him/her to change his/her brief. During an interview on 10/06/25 at 11:40 A.M., Resident #28 said he/she needs help from staff with toileting, and sometimes staff takes over 30 minutes to answer his/her call light which has caused him/her to have bladder accidents which he/she does not like because he/she does not ask for much.During an interview on 10/06/25 at 12:02 P.M., Resident #44 said he/she often waits over 30 minutes to an hour for staff to respond to his/her call light and ends up having bladder accidents because of the long wait for help. During an interview on 10/06/25 at 1:27 P.M., Resident #26 said he/she doesn't think there is enough staff to assist because it can take over 30 minutes for staff to answer his/her call light during the evenings. The resident said he/she now eats dinner in his/her room to avoid having to wait a very long time for staff to assist him/her back to his/her room from the dining room after meals.During an interview on 10/07/25 at 9:27 A.M., Resident #38 said staffing is an issue. He/She said he/she often waits longer than 20 to 30 minutes for staff to answer his/her call light often causing him/her to wet himself/herself. The resident said he/she sometimes wonder if the call lights are working because of how long it takes for someone to respond. During an interview on 10/08/25 at 1:38 P.M., Resident #81 said there isn't enough staff, and staff often tells him/her there is only one person on the hall, so it takes them longer to respond to his/her call light. The resident said he/she waited over an hour more than once the past few days for staff to answer his/her call light, which caused him/her to have a bowel movement on himself/herself and staff had to take him/her to the shower room to get cleaned up and showered. He/She said it's not a good feeling to have to go on yourself because they don't have the help to help you when you need it.During an interview on 10/09/25 8:20 A.M., Resident #37 said he/she sometimes wait for up to an hour for staff to answer his/her room or bathroom call light and it makes him/her feel like he/she is nothing and that staff doesn't care. The resident said when he/she gets tired of waiting, he/she thinks about walking back to his/her bed by himself/herself but is scared he/she may fall and hurt himself/herself, so he/she just sits there and wait till staff decides to show up.During an interview on 10/09/25 at 1:06 P.M., Nurse Aid (NA) I said staff are expected to answer call lights within two to five minutes and 30 minutes or longer is a long unacceptable time for a call light to go unanswered. He/She said staff should not leave a resident in the bathroom unattended other than to gather supplies or get assistance. He/She said if a resident's room or bathroom call light goes unanswered for longer than 30 minutes, the resident may get tired of waiting and attempt to transfer or have an accident. During an interview on 10/09/25 at 1:10 P.M., RN C said staff are expected to respond to a resident's call light within five minutes. RN C said 30 minutes or longer for a call light to go unanswered is unacceptable, but it seems to happen mostly on the evening shift because there aren't as many staff working due to regular staff call-ins. RN C said the nursing staff checks the computer at the nurses' stations to see which call light is on and staff are expected to respond to the light that has been on the longest (at the top of the list) first. During an interview on 10/9/25 at 4:05 P.M., the Director of Nursing (DON) said anything over 20 minutes is considered a concern for call light times. He/She said they look over the call light response report and investigate the call light times to figure out why there is long call light times. He/She said he/she was not aware of call light times over an hour long, but they would have to investigate it to determine the cause.During an interview on 10/9/25 at 4:07 P.M., the Administrator said he/she considers anything longer than 20 min is too long. He/She said he/she takes the report for the call light times and investigate why call lights were taking so long and they address those issues based off those findings. He/She said he/she saw the call light report showed multiple call lights going off longer than 30 minutes and some over 2 hours. He/She would have to investigate before he/she could determine the reasoning for that and if it was truly that long. He/She said staff must be at the nurse station to hear the call lights go off and see what room number pops up on the screen. He/She said they do not carry pagers or have lights that go off in the hallways. He/She said it lights up green on the screen at the nurse's station and turns red after 20 minutes. Complaint # 2631904

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview facility staff failed to ensure two of three ice machines, used to supply ice to residents, drained through an air gap to prevent cross-contamination. Facility staff failed to ensure one ice machine was free of materials to prevent ice contamination. The facility census was 112.1. Observation on 10/08/25, during the Life Safety Code tour showed:-the ice machine located in the clean utility room contained two small white plastic tubes which drained from the rear of the ice machine into a larger white plastic floor drain and did not contain an air gap. Observation showed the white plastic above the ice storage bin contained a black speckled substance;-the nurse station 2 dining room ice machine contained a black drain hose which ran into a white plastic drain and did not contain an air gap.During an interview on 10/09/25 at 11:35 A.M., the Safety Coordinator said the facility's contracted vendor was responsible for cleaning the ice machines, but he/she did not know how often. The safety coordinator said maintenance staff were responsible for maintaining facility plumbing but he/she did not know about the air gap requirement.During an interview on 10/09/25 at 12:50 P.M., the administrator said maintenance staff were responsible for the ice machines. The administrator said he/she was familiar with ice machine air gap requirements, but he/she did not know the two machines did not have air gaps. The administrator said he/she was not aware of the black material in the ice machine.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to meet professional standards of care when they failed to document they administered treatments for three residents (Resident #46, #110, and #112) of 28 sampled resident treatments. The facility census was 112.1. Review of the facility's policy titled, Wound Care, revised October 2010, showed the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The following information is be recorded in the resident's medical record:-The type of wound care given;-The date and time the wound care was given;-If the resident refused the treatment and the reason(s) why;-Staff are directed to notify the supervisor is the resident refuses the wound care. 2. Review of Resident #46's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/08/25, showed staff assessed the resident as:-Severe cognitive impairment;-Rejection of care not exhibited;-At risk of Ulcers/injuries;-Surgical wound.Review of the resident's Physician Order Sheet (POS), dated 09/10/25, showed an order for apply wet to dry sterile dressing with Dakins, secure with dry dressing twice per day at 9:00 A.M. and, 9:00 P.M., to left buttock. Review of the resident's Treatment Administration Record (TAR), dated 09/25, showed the record did not contain documentation staff provided wound treatment as ordered on 09/10/25, 09/12/25, 09/14/25, 09/16/25, 09/21/25, 09/23/25, 09/24/25, 09/26/25- 09/29/25. Review of the resident POS, dated 10/25, showed an order for apply wet to dry sterile dressing with Dakins, secure with dry dressing twice per day at 9:00 A.M. and, 9:00 P.M., to left buttock. Review of the resident's TAR, dated 10/25, showed the record did not contain documentation staff provided wound treatment as ordered on 10/03/25, 10/04/25, 10/05/25, and 10/08/25.3. Review of Resident #110's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Severe cognitive impairment;-Rejection of care not exhibited;-One stage 2 (a partial-thickness skin loss involving the epidermis and possibly the dermis) pressure ulcer and one stage 4 (the most server type of pressure sore, characterized by full-thickness tissue loss and exposure of underlying structures such as bone, muscle, or tendons) pressure ulcer.Review of the resident POS, dated 09/25, showed a wound treatment order to coccyx: Cleanse with wound cleanser, pat dry. Sprinkle Pixie (powder medication used in wound healing) dust to wound, cover with Calcium Alginate (a water-insoluble, gelatinous, cream-colored substance that can be created through the addition of aqueous calcium chloride to aqueous sodium alginate) and border foam dressing daily. Review of the resident's TAR, dated 09/25, showed the record did not contain documentation staff provided wound treatment as ordered on 09/05/25- 09/07/25 and 09/17/25-09/30/25.Review of the resident POS, dated 10/25, showed an order for wound treatment to coccyx: Cleanse with wound cleanser, pat dry. Sprinkle Pixie dust to wound, cover with Calcium Alginate and border foam dressing daily. Review of the resident's TAR, dated 10/25, showed the record did not contain documentation staff provided wound treatment as ordered on 10/03/25, 10/05/25, and 10/06/25.During an interview on 10/09/25 at 3:30 P.M., Registered Nurse (RN) V said he/she does most of the treatments in evening. RN V said when treatments are done, staff are expected to sign off on the TAR. The RN said if he/she does not do the treatment then they don't sign off on it. The RN said if the treatment does not get done, they can pass it on to next shift. RN V said he/she does not know why the treatments for those residents would not have been done.4. Review of Resident #112's annual MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment. Review of the resident's POS, dated 10/25, showed physician orders directed staff to change oxygen tubing, nasal cannula, and humidifier one time per week on Friday's 3:00-11:00 P.M. shift and cleanse the resident buttocks with normal saline, pat dry, apply calmoseptine (topical medication used to treat skin irritations) with A and D ointment (barrier) three times a day at 7:00 A.M. to 3:00 P.M., 3:00 P.M. to 11:00 P.M., and 11:00 P.M., to 7:00 A.M., until resolved, start 10/02/25. Review of the resident's TAR, dated 09/25, showed the record did not contain documentation staff changed the resident's oxygen tubing, nasal cannula, and humidifier on (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/12/25.Review of the resident's TAR, dated 10/25, showed the record did not contain documentation staff changed the resident's oxygen tubing, nasal cannula, and humidifier on 10/03/25.Review of the resident's TAR, dated 10/25, showed the record did not contain documentation staff provided the treatment to the resident's buttock on the evening shift for 10/03/25, 10/04/25, 10/05/25, on the night shift on 10/06/25, and on the day shift for 10/08/25. During an interview on 10/09/25 at 1:39 P.M., RN C said staff are expected to sign the residents' TAR after each treatment is administered to show it was completed. During an interview on 10/09/25 at 4:30 P.M., the Director of Nursing (DON) said the expectation is that staff document treatments on the TAR as they are done. The DON said he/she was not aware of there were holes in the TARs showing missed treatments. During an interview on 10/09/25 at 4:34 P.M., the administrator said staff are to document treatments on the TAR. The administrator was not aware of the undocumented treatments on the residents TARs but does not think the treatments are not being done. The administrator said she believes the staff just forgot to sign off on it.

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to provide a safe mechanical lift transfer for two residents (Resident #21 and #90) when staff failed to open the legs of the mechanical lift during transfers and failed to position the resident's wheelchair to prevent bumping the mechanical lift during the transfer. The facility census was 112. 1. Review of the facility's policy titled, Safe Lifting and Movement of Residents, dated July 2017, showed the following:-In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents;-Staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices;-Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques;-Safe lifting and movement of residents is part of an overall facility employee health and safety program which provides training on safety, ergonomics and proper use of equipment. 2. Review of Resident #21's Quarterly minimum data set (MDS), a federally mandated assessment tool, dated 10/08/25, showed staff assessed the resident as:-Severely impaired cognition;-Diagnosis of heart failure, neuropathy (damage or dysfunction of the peripheral nerves), and hemiplegia (the loss of the ability to move one side of the body);-Dependent on staff for transfers;Observation on 10/08/25 at 9:05 A.M., showed Certified Nurse Aid (CNA) T and Nurse Aid (NA) U attached the resident's sling to the mechanical lift. CNA T raised the resident from his/her wheelchair without the mechanical lift legs open and rolled the mechanical lift without the legs open towards the resident's bed.During an interview on 10/09/25 at 12:05 P.M., CNA T said he/she should have had the legs of the mechanical lift spread open while transferring the resident. The CNA said he/she just forgot to spread the legs open when transferring the resident. 3. Review of Resident #90's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-Diagnosis of heart failure, diabetes, anxiety disorder, depression, and spinal stenosis of the lumbar region;-Dependent on staff for transfers.Observation on 10/07/25 at 11:55 A.M., showed CNA T and NA J attached the resident's sling to the mechanical lift. CNA T raised the resident from his/her bed and rolled the mechanical lift with the legs open away from the bed. NA J asked CNA T to close the legs of the mechanical lift so he/she can get the residents wheelchair positioned. CNA T then closed the legs of the mechanical lift. NA J attempted to maneuver the resident's wheelchair around the mechanical lift, bumped and shook the mechanical lift with the resident suspended in the air, and was unable to get the wheelchair around the mechanical lift. NA J then asked CNA T to open the legs of the mechanical lift. Observation showed CNA T opened the mechanical lift legs, NA J attempted to maneuver the resident's wheelchair around the mechanical lift, bumped and shook the mechanical lift with the resident suspended in the air, and was unable to get the wheelchair around the mechanical lift. NA J asked CNA T to close the legs of the mechanical lift, NA J then maneuvered the resident's wheelchair around the mechanical lift, placed the wheelchair sideways over the closed legs of the mechanical lift, and lowered the resident into his/her wheelchair. During an interview on 10/08/25 at 9:30 A.M., the resident said he/she has a general fear of being transferred with a mechanical lift due to previous experiences and said the transfer from yesterday made him/her nervous. During an interview on 10/09/25 at 12:05 P.M., CNA T said he/she should have not spread the legs of the mechanical lift open and should have had them closed to get the residents wheelchair positioned sideways over the mechanical lift legs. The CNA said because he/she had the legs opened, NA J was not able to get the residents wheelchair positioned and said he/she realizes the residents transfer was not smooth. The CNA said he/she just started working at the facility a few weeks ago and was not trained or shown by facility staff how to transfer the resident due to his/her larger wheelchair. The CNA said after he/she helped with transferring the (continued on next page)

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Sylvia G Thompson Residence Center, Inc	3333 W Tenth Street Sedalia, MO 65301

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident, NA J explained that the legs of the mechanical lift must be closed in order to get the residents larger wheelchair positioned sideways across the closed legs and to lower the resident into the wheelchair.During an interview on 10/09/25 at 1:40 P.M., NA J said staff must keep the mechanical lift legs closed to get the residents wheelchair in position due to the larger size of the chair. The NA said he/she would open the mechanical lift legs for regular sized wheelchairs but will keep them closed for the resident's larger wheelchair and for some of the residents using a Broda chair (specialized wheelchair or seating system designed for long-term sitting comfort and therapeutic positioning) within the facility. NA J said he/she was trained by facility staff to keep the mechanical lift legs closed and to position the resident's wheelchair sideways across the closed legs when transferring the resident. NA J said he/she realizes he/she bumped the mechanical lift during the resident's transfer, but said if they would have had the legs closed from the start, the transfer would have been smoother. During an interview on 10/09/25 at 2:13 P.M., Registered Nurse (RN) C said he/she would expect for staff to have the mechanical lift legs spread open when transferring a resident, regardless of the resident's type of chair. The RN said the resident is heavy as well, so it is even more important to have the mechanical lift legs spread open while transferring the resident to help with balance. The RN said staff should not bump the mechanical lift with the wheelchair while the resident is suspended in the air. During an interview on 10/09/25 at 4:11 P.M., the Director of Nursing (DON) said he/she would expect for staff to have the mechanical lift legs spread open when transferring all residents and for staff to not bump the mechanical lift while the resident is being transferred. During an interview on 10/09/25 at 4:13 P.M., the Administrator said he/she would expect for staff to have the mechanical lift legs spread open when transferring all residents and for staff to not bump the mechanical lift while the resident is being transferred. The Administrator said he/she believes that the therapy department had trained staff on how to transfer the resident due to the larger wheelchair and said he/she does not think therapy trained staff to keep the mechanical lift legs closed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to assess residents for the use of bed rails on a quarterly basis for six residents (Resident #2, #3, #10, #11, #29, and #112) of 28 sampled residents. The facility census was 112. 1. Review of the facility's policy titled, Bed Safety and Bed Rails, dated August 2022, showed the use of bed rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, and resident assessment.2. Review of Resident #2's Quarterly minimum data (MDS), a federally mandated assessment tool, dated 09/26/25, showed staff assessed the resident as follows:-Severe cognitive impairment;-Required substantial/maximal assistance with toileting, showering, personal hygiene; -Bed rails not used as a restraint in bed.Review of the resident's medical record showed the record did not contain a quarterly side rail assessment.Observation on 10/07/25 at 1:20 P.M., showed the resident in bed with bilateral side rails in the upright position.Observation on 10/08/25 at 8:11 AM., showed the resident in bed with bilateral side rails in the upright position. During an interview on 10/08/25 at 3:03 P.M., the MDS Coordinator said the last side rail assessment he/she completed for the resident was on 06/13/25, and he/she did not complete a quarterly side rail assessment for the resident in September.3. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely impaired cognition and bed rails not used as a restraint.Review of the resident's medical record showed the medical record did not contain a quarterly bed rail assessment in July 2025.Observation on 10/06/25 at 1:32 P.M., showed the resident in bed with one quarter length bed rail in the upright position.Observation on 10/07/25 at 8:59 A.M., showed the resident in bed with one quarter length bed rail in the upright position.4. Review of Resident #10's Quarterly MDS, dated [DATE], showed staff assessed as cognitively intact and bed rails not used as a restraint.Review of the resident's medical record showed the medical record did not contain quarterly bed rail assessments for May 2025 and August 2025. Observation on 10/07/25 at 9:07 A.M., showed the resident in bed with one quarter length bed rail in the upright position. Observation on 10/08/25 at 9:30 A.M., showed the resident in bed with one quarter length bed rail in the upright position.5. Review of Resident #11's Significant change MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Dependent on staff for toileting, showers, and ability to roll in bed;-Bed rails not used as a restraint in bed.Review of the resident's medical record showed the record did not contain a quarterly side rail assessment.Observation on 10/07/2025 at 10:29 A.M. showed the resident in bed with bilateral quarter rails in the upright position. Observation on 10/08/25 at 2:05 P.M., showed the resident in bed with bilateral quarter rails in the upright position.Observation on 10/09/25 at 11:00 A.M., showed the resident in bed with bilateral quarter rails in the upright position.During an interview on 10/08/25 at 3:03 P.M., the MDS Coordinator said the last side rail assessment he/she completed for the resident was on 05/05/25, and he/she did not complete a quarterly side rail assessment for the resident in August.6. Review of Resident #29's annual MDS, dated [DATE], showed staff assessed the resident as follows: -Moderate cognitive impairment;-Required setup from staff to roll left and right in bed, and partial/moderate assistance with transfers from chair/bed-to-chair;-Bed rails not used as restraint in bed.Review of the resident's care plan, dated 08/06/25, showed the resident uses quarter bed rails on his/her bed to aid in repositioning and bed mobility, and to evaluate risks and benefits of using devices.Review of the resident's medical record showed the record did not contain a quarterly side rail assessment.Observation on 10/06/25 at 2:02 P.M., showed the resident in bed with bilateral side rails in the upright position.Observation on 10/07/25 at 10:05 AM., showed the resident in bed with his/her legs hung loose off the left side of the bed, and bilateral side rails in the upright position. During an (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 10/08/25 at 3:03 P.M., the MDS Coordinator said the last side rail assessment he/she completed for the resident was on 02/17/25, and he/she did not complete a quarterly side rail assessment for the resident in May or August. 7. Review of Resident #112's annual MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Required partial/moderate assistance to roll left and right in bed, and dependent with transfers from chair/bed-to-chair;-Bed rails used daily as restraint in bed.Review of the resident's care plan, dated 07/22/25, showed the resident used bed rails as a restraint, and to evaluate risks and benefits of using devices.Review of the resident's medical record showed the record did not contain a quarterly side rail assessment.Observation on 10/07/25 at 9:56 A.M., showed the resident in bed with bilateral side rails in the upright position.Observation on 10/08/25 at 8:02 A.M., showed the resident in bed with bilateral side rails in the upright position.During an interview on 10/08/25 at 3:03 P.M., the MDS Coordinator said the last side rail assessment he/she completed for the resident was on 04/18/25, and he/she did not complete a quarterly side rail assessment for the resident in July. 8. During an interview on 10/08/25 at 3:03 P.M., the MDS Coordinator said he/she is responsible to complete the quarterly side rail assessments for all the residents with their MDS assessments. The MDS Coordinator said he/she did not complete some of the quarterly side rail assessments due to being busy, and said he/she was not sure if anyone double checks the quarterly side rail assessments are completed. During an interview on 10/09/25 at 1:39 P.M., Registered Nurse (RN) C said the MDS Coordinator is responsible to complete the residents' side rail assessments quarterly along when he/she completes the MDS assessments.During an interview on 10/09/25 at 4:11 P.M., the Director of Nursing (DON) said he/she expects for side rail assessments to be completed quarterly. During an interview on 10/09/25 at 4:15 P.M., the Administrator said he/she expects for side rail assessments to be completed quarterly and said he/she was not aware the side rail assessments were not being completed quarterly.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, facility staff failed to ensure Nurse Aide's ((NA) NA H, NA J, NA P, NA Q, and NA S) of 24 completed the nurse aide training program within four months of his/her employment in the facility. The census was 112.1.Review of the facility's Nurse Aide Qualifications and Training Requirements policy, revised 08/2022, showed nursing assistants failing to successfully complete the required training program within the first four (4) months of their date of employment may be terminated from employment or may be reassigned to non-nursing related services.2. Review of NA H's CNA report, showed a hire date of 03/24/25. Review showed the NA's file did not contain documentation the NA completed a nurse aide training program.3 Review of NA J's CNA report, showed a hire date of 04/28/25. Review showed the NA's file did not contain documentation the NA completed a nurse aide training program.During an interview on 10/17/25 at 10:40 A.M., NA J said he/she started back with the facility in April. He/She has taken the classes online through the facility but has yet to take the test. He/She said he/she has not taken the test because he/she is trying to study more before taking it. He/She said he/she has yet to schedule the test.4 Review of NA P's CNA report, showed a hire date of 02/14/25. Review showed the NA's file did not contain documentation the NA completed a nurse aide training program.5 Review of NA Q's CNA report, showed a hire date of 03/12/25. Review showed the NA's file did not contain documentation the NA completed a nurse aide training program.6. Review of NA S's CNA report, showed a hire date of 05/21/24. Review showed the NA's file did not contain documentation the NA completed a nurse aide training program.7. During an interview on 10/9/25 at 9:48 A.M., the Administrator said he/she is responsible for ensuring that new hired have completed the CNA training within the 4 months. He/She said he/she has a few aides that are outstanding on time frames. He/She said that his/her staff have gone through the classes and have just not passed the test. He/She said the instructor they use offers online and in person classes, but no one is passing the test. He/She said he/she was not aware that the aides had to complete the training and be certified by the 4 months, he/she said he/she thought they just had to have the education done in that time frame.During an interview on 10/9/25 at 4:05 P.M., the Director of Nursing (DON) said the Administrator is in charge of the nurse aide training and scheduling. He/She does not handle hiring or education and it not sure what the required time frames are for ensure aides have completed education and are certified.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, facility staff failed to ensure a medication error rate of less than five percent (5%) out of 25 opportunities observed, nine errors occurred, resulting in a 36% error rate, which affected two residents (Resident #48 and #62) out of seven sampled residents. The facility's census was 112.1. Review of the facility's policy titled, Administering Medications, revised April 2019, showed staff: -Medications are administered in a safe and timely manner, and as prescribed;-Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders);-The individual administering the medication checks the label THREE times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication;-Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training.Review of the facility's Medication Pass times, provided by the administrator upon entrance, showed medications are administered at scheduled timeframes. 2. Review of Resident #48's Physician's Order Sheet (POS), dated October 2025, showed:-Spironolactone (to treat high blood pressure) 25 milligrams (mg) by mouth daily at 8:00 A.M.;-Memantine HCL (to treat dementia) 10 mg by mouth twice daily at 8:00 A.M., and 8:00 P.M.;-Torsemide (to treat high blood pressure) 20 mg by mouth daily at 8:00 A.M.;-Aspirin (to prevent a heart attack) 81 mg by mouth daily at 8:00 A.M.; -Omeprazole (to treat heartburn) 20 mg by mouth daily at 8:00 A.M.;-Potassium Chloride Extended Release (to treat low potassium levels) 10 milliequivalent (mEq) daily at 8:00 A.M; -Budesonide inhalation suspension (to treat shortness of breath) 0.5 mg/2 milliliter (ml), one vial via nebulizer twice daily at 7:00 A.M., and 5:00 P.M.;-Arformoterol Tartrate (to treat Chronic obstructive pulmonary disease (COPD)) 15 microgram (mcg) /2 ml nebulization, one vial via nebulizer twice daily at 7:00 A.M., and 5:00 P.M.Observation on 10/09/2025 at 10:24 A.M., showed Certified Medication Technician (CMT) A administered Spironolactone, Memantine, Torsemide, Aspirin, Omeprazole, and Potassium medications to the resident one hour and twenty-four minutes after the ordered administration time.Observation on 10/09/2025 at 10:26 A.M., showed CMT A administered Budesonide and Arformoterol breathing treatments to the resident two hours and twenty-six minutes after the ordered administration time.During an interview on 10/09/25 at 10:24 A.M., CMT A said staff were allowed an hour before and after the schedule medication time to administer the resident's morning medications. CMT A said he/she administered the resident's medications late and would be considered a medication error, which could result in the resident being given another dose of the same medications too close and cause issues. He/She said he/she would notify the charge nurse of the late medication administration error. 3. Review of Resident #62's POS, dated October 2025, showed an order for Lidocaine (treatment for pain) 5% patch (two patches) daily at 8:00 A.M., apply to lower back and hip for pain.Observation on 10/06/25 at 11:24 A.M., showed CMT B applied one Lidocaine four percent (4%) patch to the resident's lower back, and one lidocaine 4% patch to the resident's right hip. The CMT administered the medication two hours and twenty-four minutes after the ordered administration time. During an interview on 10/08/25 at 1:43 P.M., CMT B said he/she administered the resident's pain medication late. He/She said he/she did not verify the correct medication dosage and administered the wrong dose of the lidocaine patches to the resident. The CMT said the late medication administration and wrong dose were both considered a medication error, and he/she would notify the charge nurse per facility policy for follow up. 4. During an interview on 10/09/25 at 9:05 A.M., Registered Nurse (RN) C said staff are allotted two hours before and after the scheduled medication administration time to administer the morning medications. He/She said late medications and wrong dose are considered medication errors, and the CMTs are expected to notify the charge nurse of any medication errors, and the nurse to follow up with the physician and per facility policy. During an interview on 10/09/25 at 4:05 P.M. the Director of Nursing (DON) said staff are allotted two hours before and after the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled administration time to administer routine morning medications, so any medications administered outside the allotted time are late. He/She said if staff administer the wrong dose or administer medications late, it is considered a medication error, and the nurse should be notified to follow up per policy. During an interview on 10/09/25 at 4:10 P.M., the administrator said if staff administer the wrong dose or late medications, it is considered a medication error. He/She said the CMTs are expected to notify the nurse of late medications or other medication error and the nurse to follow up with the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to label and store medications in a safe and effective manner in one of two sampled medication storage rooms and one of two sampled medication carts. Staff failed to ensure medications were properly stored during medication administration to residents. The facility census was 112.1. Review of the facility's policy titled, Storage of Medication, revised 11/2020, showed:-The facility stores all drugs and biologicals in a safe, secure, and orderly manner;-Drug containers that have missing, incomplete, or incorrect labels are returned to the pharmacy for proper labeling before storing;-Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed;-Schedule II-V (two to five) controlled medications are stored in separately locked, permanently affixed compartments.Review of the facility's policy titled, Administering Medications, revised 04/2019, showed when opening a multi-dose container, the date opened is recorded on the container, and insulin pens are clearly labeled with the resident's name or other identifying information. 2. Observation on 09/06/25 at 10:04 A.M., showed nursing station two's medication storage room contained: -One Lantus insulin (medication to lower blood sugar) a multi-dose vial opened and undated; -One Humalog insulin vial opened and undated; -One Admelog insulin vial opened and undated; -One Tresiba insulin pen opened and undated; -One Humalog insulin pen opened and undated;-58 Tramadol (a schedule IV-controlled medication used to treat pain) 50 milligram (mg) tablets on the countertop next to the sink. Observation on 10/06/25 at 10:25 A.M., showed the memory care unit medication cart contained one Novolog insulin pen without a resident's name, opened and undated, and one bottle of Tums Smoothies Extra Strength (ES) 750 mg tablets, opened, unlabeled, with an expiration date of 10/2024.During an interview on 10/06/25 at 10:16 A.M., Certified Medication Technician (CMT) W said controlled medications should be stored behind two locks until they are administered to a resident or destroyed and should not be left on the counter to ensure proper storage and safety. CMT W said only nurses and CMTs have access to the medication storage room and he/she did not know who removed the Tramadol tablets from the medication cart and left them improperly stored on the counter. CMT W said the nurses mainly administer insulin medication to residents, but any CMT or nurse who opens an insulin pen or vial should ensure a resident's name is on the insulin and label the medication with the opened date and expiration date. During an interview on 10/06/25 at 10:32 A.M., CMT X said the CMTs are responsible to check the medication carts for expired medications every couple of weeks and remove expired medications from the medication carts, so he/she was not sure why the expired Tums were still inside the cart. CMT X said insulin pens should be labeled with the resident's name, and either the CMT or nurse who opens the insulin pen should label the pen with the opened date and expiration date before they place the pen inside the medication cart for storage. During an interview on 10/09/25 at 9:05 A.M., Registered Nurse (RN) C said nurses and CMTs should ensure controlled medications are stored behind two locks and not left on the countertop in the medication storage room. RN C said the nurse or CMT who opens the insulin medication should ensure the insulin pen or vial has a resident's name and label the insulin with the opened and expiration date. RN C said prior to each medication administration to a resident, the nurse or CMT should check the medication's expiration date and remove and discard the medication if it is expired. RN C said the CMTs are responsible to routinely check and remove expired medications from the medication carts, so there should not be any expired medications from a year ago inside the cart. RN C said he/she was not sure if anyone double checks expired meds are removed from the medication carts. During an interview on 10/09/25 at 4:05 P.M. the Director of Nursing (DON) said nurses and CMTs should ensure controlled medications are stored behind two locks until administered (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or discarded and should not be left on the countertop to limit access to the medications. The DON said when a nurse or CMT opens an insulin medication, he/she is expected to ensure the insulin vial or pen has a resident's name and label the medication with the opened and expiration dates. The DON said there should not be any medications in the carts that have expired over a year because the CMTs are expected to remove expired medications from the carts daily, and one of the senior CMTs who works in the office double checks the medication carts and medication storage rooms once per month for expired medications.During an interview on 10/09/25 at 4:10 P.M., the administrator said the nurses and CMTs should ensure controlled medications are stored behind two locks. The administrator said he/she expects staff to ensure insulin pens and vials have a resident's name from the pharmacy, and when the nurse or CMT opens the insulin pen or vial, he/she should label the medication with the opened and expiration dates. He/She said the clinical nurse manager is responsible to double check that medications are properly labeled and stored inside the medication carts and medication storage rooms monthly.3. Review of the facility's policy titled, Administering Medications, revised 04/2019, showed during administration of medications, the medication cart is kept closed and locked when out of site of the medication nurse or aide, and no medications are kept on top of the cart. 4. Observation on 10/08/25 at 12:19 P.M., showed a medication cart in nursing station two's dining room with two opened insulin pens, three insulin syringe needles pre-filled with medication, in partially opened individual packaging, unattended and residents nearby.Observation on 10/09/25 at 8:42 A.M., showed CMT A walked away from the medication cart in nursing station one's dining room to administer medications to a resident. CMT A left one cup with approximately six to eight unidentified medications, and six bottles of over the counter (stock) medications unattended on top of the medication cart in the dining room, as several residents and staff members walked by the medication cart.Observation on 10/09/25 at 10:24 A.M., showed CMT A entered room [ROOM NUMBER] to administer medications to a resident, and left a bottle of aspirin 81 mg tablets unattended on top of the medication cart in the hallway, as several staff and residents transitioned the hallway pass the cart.During an interview on 10/08/25 at 12:20 P.M., CMT W said the nurse placed the insulin pens and needles on top of the medication cart. CMT W said he/she stepped away from the medication cart to administer medications to a resident in the dining room and should not have left the medications unattended on top of the cart because someone could have taken the medications. During an interview on 10/09/25 at 8:43 A.M., CMT A said staff should not leave medications unattended on top of the medication cart to ensure proper storage and prevent someone from taking them. CMT A said he/she should not have left the medications unattended on the medication cart and was not sure why he/she did.During an interview on 10/09/25 at 9:05 A.M., RN C said staff should not leave any medications unattended on top of the medication cart for safety and proper storage. RN C said he/she accidentally left the insulin pens and needles on top of the cart to assist a resident with meal set-up and should have ensured the medications were stored properly inside the cart or the medication storage room. During an interview on 10/09/25 at 4:05 P.M. the DON said he/she expects staff to lock medications inside the medication cart or medication storage room for proper storage, and staff should not leave any medications unattended on top of the medication carts. During an interview on 10/09/25 at 4:10 P.M., the administrator said staff should not leave any medications unattended on top of the medication carts and should ensure medications are properly stored inside the medication cart or medication storage room. Complaint # 2631904