

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  26E256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/29/2026
NAME OF PROVIDER OR SUPPLIER  Johnson County Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  122 East Market Street Warrensburg, MO 64093	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to implement Enhanced Barrier Protection (EBP-an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) for three out of three residents (Residents #5, #6, and #7) sampled for infection control with wounds. The facility census was 72 residents. Review of the facility policy enhanced Barrier Precautions dated 2025 showed:-The EBP approach recommended gown and glove use for certain residents during specific high-contact resident care activities.-EBP are indicated for residents with any of the following:--Certain infections.--Wounds and/or indwelling medical devices.--Wounds generally included chronic wounds such as pressure ulcers (localized damage to the skin and/or underlying soft tissue, usually over a bony prominence, resulting from prolonged pressure alone or in combination with shear/friction), diabetic foot ulcers (an open sore or wound, typically located on the bottom of the foot, that occurs in individuals with diabetes (a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin)), venous stasis ulcers (wounds on your skin that develop because of problems with blood circulation).--Indwelling medical devices such as central lines (flexible tube that is inserted into a vein use them to give medicine, fluids, blood, or nutrition), urinary catheters (a flexible tube used to empty the bladder and collect urine in a drainage bag), feeding tubes (a flexible medical device inserted into the gastrointestinal tract to deliver liquid nutrition, fluids, and medication directly to the stomach or small intestine), and tracheostomies (surgically created hole, in the windpipe that allows air to pass into the windpipe to help with breathing when the usual way of breathing is blocked or reduced).-For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities:--dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care, and wound care (any skin opening requiring a dressing) Review of the Centers for Disease Control and Prevention website on 1/28/26 showed:-Facility staff should use Enhanced Barrier Precautions for residents with residents with certain conditions.-Everyone entering the room of these residents must clean their hands before entering and when leaving the resident's room.-Providers and staff must wear gloves and a gown for the following high-contact resident care activities for the residents that require EBP:--Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting.--Device care of use of central lines, urinary catheters, feeding tubes, and tracheostomies.--Wound care for any skin opening requiring a dressing. 1. Review of Resident #5's admission record printed 1/30/26 showed the resident:-admitted to the facility on [DATE].-Had diabetes, a skin infection, and non-pressure chronic ulcer of his/her left foot. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 12/29/25 showed the resident was cognitively intact and had a diabetic foot ulcer and a wound infection.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan dated 1/9/26 showed:-The resident had skin impairment related to diabetes.-The resident had a chronic wound. Review of the resident's Treatment Administration Record (TAR) dated January 2026 showed a wound treatment order dated 10/30/25 to clean the wound to the resident's left, great toe, pat dry, apply Iodoflex (a sterile, antimicrobial, non-adhesive pad dressing used for chronic, exuding, and infected wounds. It removes debris and exudate (any fluid that has been forced out of the tissues or its capillaries because of inflammation or injury) while releasing iodine to kill bacteria) to wound, apply dressing one time a day every other day on even days. Review of the resident's wound care provider note dated 1/27/26 showed:-The resident had diabetes.-The resident had a chronic left great toe wound.-The resident had been treated with Intravenous (IV) antibiotics in the past for chronic osteomyelitis (an infection in the bone).-The resident saw a surgeon who recommended amputation of the resident's left great toe but the resident declined.-The diabetic wound on the resident's left great toe was acquired 7/1/20.-The measurements were 0.5 centimeters (cm) length x 0.3 cm width x 0.1 cm deep.-The wound was described as a grade one (a superficial wound, meaning the skin is broken, but the ulcer is shallow) diabetic ulcer, small amount of serosanguineous exudate (containing blood and watery drainage) that was red and brown in color, has slough (necrotic/avascular tissue in the process of separating from the viable portions of the body), has a large amount of granulation (any soft pink fleshy projections that form during the healing process in a wound that does not heal by first intention) that was pale pink, and had a small amount of necrotic (dead) tissue that is adherent slough. Observation and interview during wound care with the Director of Nursing (DON) on 1/28/26 at 11:23 A.M. showed:-There were no EHB signs or Personal Protective Equipment (PPE-equipment such as gloves, gowns, masks, respirators, and face shields, that serve as a barrier against infectious materials, protecting both workers and patients) outside the resident's room.-The DON provided wound care on the resident's great toe on his/her left foot.-The DON used gloves and completed hand hygiene during the wound care.-The DON did not wear a gown during wound care.-The DON said they had not talked about EBP at the facility.-The DON said they had not used EBP at the facility. 2. Review of Resident #6's admission Record printed 1/28/26 showed the resident:-admitted to the facility on [DATE].-Had a diagnosis of diabetes. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident:-Moderately cognitively impaired.-Diagnosis of diabetes.-Treatments included the application of nonsurgical dressings other than to feet.-Treatments included the application of ointments/medications other than to feet. Review of the resident's care plan dated 1/9/26 showed:-The resident had a diagnosis of diabetes.-The resident had an infection of his/her left, great toe. Review of the resident's TAR dated January 2026 showed:-A physician's order dated 12/24/25-1/22/26 to clean the resident's left, lower extremity wound with wound cleanser, apply calcium alginate (a highly absorbent dressing), cover with foam dressing (highly absorbent wound cover designed to manage moderate-to-heavy exudate while maintaining a moist, protected healing environment) one time a day.-A physician's order dated 1/23/26 to cleanse the resident's left lower extremity wound with wound cleanser, apply calcium alginate cut to size of wound bed, and cover with foam dressing daily until resolved. Review of the resident's skin observation tool dated 1/19/26 showed the resident had abrasions to his/her right and left knee that were both 1.0 cm in length and 1.0. cm in width and 0.0 cm in depth. Review of the resident's skin observation tool dated 1/26/26 showed the resident had a vascular wound to his/her left lower leg that measured 0.5 cm in length and 0.5 cm in width and 0.0 cm in depth. Observation and interview on 1/28/26 at 11:33 A.M. showed:-There were no EHB signs or PPE outside the resident's room.-The resident had dressings on his/her left and right shin.-The DON said they had not talked about EBP at the facility.-The DON</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>said they had not used EBP at the facility. 3. Review of Resident #7's admission Record printed on 1/28/26 showed:-The resident admitted to the facility on [DATE].-The resident had an open wound on his/her left foot and osteomyelitis. Review of the resident's care plan dated 9/4/25 showed:-The resident was at risk for infection related to a wound on his/her foot.-The resident had actual impairment to skin integrity related to a chronic foot wound. Review of the resident's significant change MDS dated [DATE] showed the following staff assessment of the resident:-Cognitively intact.-Had an open lesion(s) on his/her foot.-Had the application of dressings to his/her feet. Review of the resident's TAR dated January 2026 showed:-A physician's order to clean his/her left plantar (a thick, fibrous band of tissue running along the bottom of the foot, connecting the heel bone to the toes) area with wound cleanser, apply A&amp;D ointment to dry areas, apply foam dressing and kerlex (woven gauze that is non-adhesive used to wrap wounds) daily.-A physician's order dated 9/19/24 to cleanse the right foot plantar with wound cleanser, apply foam dressing and kerlex one time a day.-A physician's order dated 10/17/25 to cut Calcium Alginate (a highly absorbent dressing) to wound bed size and apply to wound on right foot daily for open area. Review of the resident's skin observation tool dated 1/24/26 showed the resident had:-A callous on the bottom of his/her left foot that measured 1.0 cm length x 1.0 cm with x 0.0 depth.-A chronic wound on the bottom of his/her right foot that measured 5.0 cm length x 4.0 cm width and 1.0 cm depth. Observation and interview on 1/28/26 at 11:40 AM showed:-There were no EHB signs or PPE outside the resident's room.-The DON said:-The resident had wounds on the bottom of both his/her feet.-They had not talked about EBP at the facility.-They have not used EBP at the facility.-The resident had socks on his/her feet and didn't want to take them off. 4. During an interview on 1/28/26 at 10:10 A.M., Certified Medication Technician A said: -He/She hardly ever saw any of the nurses use gloves when doing wound treatments.-He/She saw nurses doing wound treatments without a gown on.-He/She didn't even know where the gowns were. During an interview on 1/28/26 at 11:23 A.M., the DON said:-They had not talked about EBP at the facility.-They have not used EBP at the facility for any residents. During an interview on 1/28/26 at 12:10 P.M., the Administrator said they had not been doing EBP and he/she did not think they had an EBP policy. During an interview on 1/28/26 at 12:22 P.M., the Infection Preventionist said he/she had never heard of EBP prior to today. During an interview on 1/28/26 at 12:35 P.M., Licensed Practical Nurse (LPN) A said:-The facility administration had not told them to use EBP.-He/She had only been wearing gloves during wound treatments.-He/She had not worn gowns when doing wound treatments. 2692293</p>		