STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265409	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gideon Care Center	300 Lunbeck Gideon, MO 63848

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodations to meet the needs of residents by not replacing an oxygen concentrator for one resident (Resident #18) out of 16 sampled residents and by not adjusting a dining table to an adequate level during meal consumption for one resident (Resident #31) out of 16 sampled residents and one resident (Resident #42) outside the sample. The facility failed to place a call light within reach for one resident (Resident #54) outside the sample. The facility census was 62.Review of the facility's policy titled, Accommodation of Needs, dated November 2025, showed:- The resident has the right to reside and receive services in the facility reasonable of their needs and preferences;- The resident's individual needs and preferences are accommodated to the extent possible by the facility and staff, except when the health and safety of the individual or other residents would be endangered;- The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis;- To accommodate individual resident needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility;- Staff are trained and expected to assist the residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with the resident's wishes. For example:a. interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication, and maintain dignity;b. arranging call lights, assistive devices, toiletries, and personal items so they are in easy reach of the resident, and;c. maintaining hearing aids, glasses, and other adaptive devices for residents. 1. Review of Resident #18's medical record showed:- admitted on [DATE];- Diagnoses of pneumonia (an infection that inflames the air sacs in one or both lungs), chronic respiratory failure (a condition in which the blood doesn't have enough oxygen), hypoxia (an oxygen deficiency), anxiety disorder (persistent worry and fear about everyday situations), and chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of the resident's March 2025 Physician Order Sheet (POS), showed: - An order for oxygen per nasal cannula (NC - a tube delivering oxygen to a person's nose) at 4 liters (L) per minute every shift related to COPD, dated 07/18/25;- An order to clean the nebulizer (a medical device that converts liquid medication into a fine mist for inhalation directly into the lungs) machine per the facility policy, change the nebulizer tubing, place in a zip lock bag with the date/initials, dated 08/20/25;- An order to clean the oxygen concentrator per the facility policy, change the NC, place in the bag, and date/initial every day shift, and every Sunday for maintenance, dated 08/20/25. Review of the resident's Care Plan, revised 09/20/25, showed:- Oxygen therapy;- Change the oxygen tubing per the policy;- Monitor for signs and symptoms of respiratory distress and report to the Medical Director;- Chronically dependent on 4 L oxygen via NC continuous and as needed;- Monitor oxygen levels as needed. Observations on 03/16/26 of the resident showed:- At 11:12 A.M., the resident lay in bed with the NC and the oxygen concentrator in use at 4 L and his/her oxygen concentrator made a loud continuous beeping sound. A note attached on the back of the resident's oxygen concentrator showed the tubing changed, dated 03/15/26;- At (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for him/her to reach the food served. He/She had never mentioned the table height to anyone. During an interview on 03/19/26 at 10:46 A.M., Certified Nurse Assistant (CNA) J said he/she had not noticed the tables, however the tables looked too tall for some of the residents. The tables looked like they had adjustments that could be made at the bottom of the legs of the tables. During an interview on 03/19/26 at 10:50 A.M., the DON said she would expect the accommodations of the residents to be met. She had never noticed the tables being too high or the residents sitting too low, however she would investigate the positioning of the resident's chair and table. During an interview on 03/19/26 at 11:15 A.M., the Administrator said the tables were standard height and she did not see a problem with the heights of the dining room tables. She had not had any complaints from the residents. 3. Review of Resident #54's medical record showed:- admitted on [DATE];- Diagnoses of type II diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), chronic kidney failure, dementia, and COPD. Review of the resident's Care Plan, revised 11/21/25, showed:- Needs staff assistance with activities of daily living (ADLs);- Maximum assist with toileting and transfers;- Fall risk: ensure call light is within reach and encourage resident to use for assistance as needed;- Resident needs prompt response to all requests for assistance. Observation on 03/16/26 at 8:37 A.M., and 10:38 A.M., showed:- Resident #54 lay in bed and the call light lay on the floor out of reach of the resident. During an interview on 03/16/26 at 10:39 A.M., the resident said he/she used his/her call light for staff assistance and to go to the restroom. During an interview on 03/16/26 at 1:54 P.M., CNA A said call lights should always be within reach of the resident. During an interview on 03/16/26 at 2:04 P.M., LPN C said call lights should always be within reach of the resident. During an interview on 03/17/26 at 8:36 A.M., CNA B said call lights should always be within reach of the resident. During an interview on 03/19/26 at 10:16 A.M., the DON said call lights should always be within reach of the resident. During an interview on 03/19/26 at 10:31 A.M., the Administrator said call lights should always be within reach of the resident.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) to the resident and/or the resident's representative in writing at least two calendar days before discharge from skilled services. This notice informs the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting the financial liability for those services. This practice affected one resident (Resident #8) out of three sampled residents. The facility census was 62.Review of the facility's policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, dated September 2024, showed:- A resident (who is a Medicare beneficiary) is informed in advance and in writing when Medicare payment denial or change in coverage is likely;- Written notices of the likelihood of Medicare payment denial are provided to the resident/beneficiary:a. as soon as the facility makes the assessment that Medicare payment certainly or probably will not be made and before the item or service is furnished;b. far enough in advance of an event (e.g., receiving a medical service) so that the beneficiary can make a rational, informed decision without undue pressure; and the resident/beneficiary receiving the notice must: be able to read, understand, act on his/her rights, and comprehend the notice; be issued the written notice in a manner that allows her/him to comprehend the contents of the written notice; and be afforded the verbal or written assistance in other languages to assist in understanding the notice;- Written notices are provided in person to the beneficiary when possible. A copy of the notice is provided to the beneficiary (or authorized representative) immediately after the notice is signed;- The facility will issue a SNF ABN CMS Form 10055 to any Medicare (Fee for Service) resident prior to providing care that Medicare usually covers but may not pay for under the current circumstance because the care is not medically necessary or considered custodial;- The SNF ABN provides information to the resident so that he or she can decide whether to get the care that may not be paid for by Medicare and assume financial responsibility;- The SNF ABN is only issued if the resident/beneficiary intends to continue services, and the facility believes the services may not be covered under Medicare;- The facility issues a SNF ABN for the following triggering events:a. Initiation - if the facility believes Medicare will not pay for extended care items or services that a physician has ordered, a SNF ABN is issued to the beneficiary before those non-covered extended care items or services are furnished to the beneficiary;b. Reduction - if the facility proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF ABN is issued to the beneficiary before items or services to the beneficiary are reduced;c. Termination - if the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered, the SNF ABN is issued to the beneficiary before such extended care items or services are terminated. Review of Resident #8's medical record showed:- The resident discharged from skilled Medicare services on 01/24/26, and remained in the facility;- No documentation the resident and/or the representative received a SNF ABN;- The facility failed to provide the SNF ABN form to the resident and/or the representative at least two calendar days before the skilled Medicare services ended. During an interview on 03/18/26 at 2:46 P.M., the Administrator said she assumed a SNF ABN was not provided and signed because she could not find one. The facility had several Social Services Designees and it must have been missed.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, the facility staff failed to post the required daily nurse staffing information which included the total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, in a prominent location readily accessible to residents and visitors for three out of four days. The facility census was 62. Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, dated August 2022, showed:- The facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents;- Within two hours of the beginning of each shift, the number of licensed nurses (Registered Nurses (RN), Licensed Practical Nurse (LPN), and Licensed Vocational Nurse (LVN) and number of unlicensed nursing personnel Certified Nurse Assistant (CNA) and Nurse Assistant (NA) directly responsible for resident care is posted in a prominent location (accessible to resident and visitors) and in a clear and readable format;- Within two hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location designated by the Administrator. Observations on 03/16/26 at 4:15 P.M., 03/17/26 at 4:10 P.M., and 03/18/26 at 8:05 A.M., of the facility's Staff Posting Sheet, located on a window across from the nurse's station showed:-The facility did not post the required daily nurse staffing information for 03/16/26, 03/17/26, and 03/18/26. During an interview on 03/18/26 at 7:50 A.M., LPN D said each shift was responsible for filling out the staffing sheet with the hours worked and the staff worked. During an interview on 03/19/26 at 10:48 A.M, the Director of Nursing (DON) said she would expect each nurse on each shift to completely fill out the staffing sheet as soon as they arrived for their shift. She expected the staffing sheet to include the staff hours worked and the hours totaled for each shift. During an interview on 03/29/26 at 12:03 P.M., the Administrator said the nurses should be filling out the staffing sheet completely with the actual staff worked and the total hours worked.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to implement procedures to ensure medications were accurately documented, disposed of, and reconciled for two residents (Residents #34 and #37) out of 16 sampled residents. The facility census was 62.Review of the facility's policy titled, Controlled Substances, revised November 2022, showed:- Controlled substances are separately locked in permanently affixed compartments;- The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the following:- Records of personal access and usage;- Medication administration records;- Declining inventory, destruction, waste, and return to pharmacy records;- The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the Director of Nursing (DON) services;- The DON documents irreconcilable discrepancies in a report to the Administrator. 1. Observation of the medication refrigerator for the 300 Hall medication room on 03/18/26 at 10:10 A.M., showed: - An unlocked narcotic lock box in the refrigerator with two opened bottles of lorazepam (an anti-anxiety medication) for Residents #34 and #37;- Resident #34's opened bottle of lorazepam 2 milligrams (mg)/milliliter (ml) with 16 ml remained;- Resident #37's opened bottle of lorazepam 2mg/ml with 18 ml remained. Review of the Narcotic Count Log for the medication refrigerator for the 300 Hall medication room on 03/18/26 at 10:27 A.M., showed: - For Resident #34, one bottle of lorazepam 2mg/ml with 20 ml remained with the last dose administered on 02/04/26;- For Resident #37, one bottle of lorazepam 2mg/ml with 22.5 ml remained with the last dose administered on 03/17/26. During an interview on 03/18/26 at 10:33 A.M., the Director of Nursing said nurses should lock the narcotic lock box before returning it to the refrigerator anytime it was opened to count narcotic medications. She was unaware the narcotic count was off and would expect staff to let him/her know immediately when the count was off. If a resident refused a dose of a narcotic, a waste form should be filled out, but staff did not fill them out like they should. She had no follow up process for refusals or wasting of medications. During an interview on 03/18/26 at 10:34 A.M., Licensed Practical Nurse (LPN) D said he/she counted the narcotics with Registered Nurse (RN) G at shift change and they did know the count was off for Resident #34 and Resident #37, but he/she had not let the DON know yet because he/she had not had a chance. He/She was unsure why the count was off. LPN D said he/she normally locked the narcotic lock box back but must have forgotten to after counting. 2. Observation of the Nurses Medication Cart on 03/18/26 at 10:55 A.M., showed:- One bottle of morphine (a narcotic pain medication) 100 mg/5 ml with 20 ml remained for Resident #34. Review of the Narcotic Count Log for the Nurses Medication Cart on 03/18/26 at 10:57 A.M., showed: - For Resident #34 one bottle of morphine 100 mg/5 ml with 26 ml remained, with last dose administered on 03/17/26. During an interview on 03/19/26 at 10:56 A.M., the Administrator said she would expect staff to be reconciling medications every shift or whenever the narcotic keys change ownership. She would expect staff to let the DON know immediately of any reconciliation discrepancies, and for the DON to follow the policy. She said the narcotic lock box should be locked back after opening it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow Enhanced Barrier Precautions (EBP) and failed to follow infection control practices for wound care for one resident (Resident #32) out of two sampled residents. The facility census was 62.Review of the facility's policy titled, Enhanced Barrier Precautions, last revised March 2024, showed: - EBPs are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents;- EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply;- Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room);- Personal protective equipment (PPE) is changed before caring for another resident;- Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: wound care (any skin opening requiring a dressing);- EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization;- Wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds);- Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. Review of the facility's policy titled, Wound Care, last revised October 2010, showed:- Steps in the Procedure: Use no-touch technique. Use sterile tongue blades or applicators to remove ointments and creams from their containers;- Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply the dressing. 1. Review of Resident #32's medical record showed;- An admission date of 01/09/25;- Diagnoses of type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood), acquired absence of the right leg above the knee, hypertension (high blood pressure), anxiety (feelings of dread, fear, and or uneasiness), and depression (persistent sadness, loss of interest in activities, and low energy). Review of the resident's Physician Order Sheet (POS), dated March 2026, showed:- An order to cleanse the left posterior (the back or rear) lateral (to the side) calf wound with wound cleanser and pat dry. Apply a thin layer of gentamicin (an antibiotic) 0.1% ointment to the wound bed and cover with a 4x4 gauze (a type of dressing), and wrap with kerlix (a type of dressing), and tape to secure, three times a day, dated 03/16/26;- An order to cleanse the left medial (middle) superior (above or higher) leg wound with wound cleanser and pat dry, apply skin prep to the surrounding tissue. Apply a thin layer of gentamicin 0.1% ointment to the wound bed, cover with a 4x4 gauze, wrap with kerlix, and tape to secure, three times a day, dated 03/12/26. Observation of the resident's wound care on 03/17/26 at 2:52 P.M., showed:- EBP supplies affixed to the outside of the resident door;- No EBP signage on the outside of the resident door;- Licensed Practical Nurse (LPN) C put on a gown and entered the resident room, performed hand hygiene, and put on gloves;- LPN C removed the soiled dressing from the left leg, did not perform hand hygiene, and changed gloves;- LPN C cleaned the left medial superior leg wound with gauze soaked with normal saline (NS - a sterile solution designed to match the salt concentration of human blood and body fluids), did not perform hand hygiene, and changed gloves;- LPN C cleaned the left posterior lateral calf wound with gauze soaked with NS, did not perform hand hygiene, and changed gloves;- LPN C did not use a no-touch technique and applied the gentamicin ointment with a gloved finger to the left medial superior leg wound, did not perform hand hygiene, and did not change gloves;- LPN C did not use a no-touch technique and applied the gentamicin ointment with a gloved finger to the left posterior lateral calf wound, did not perform hand hygiene, and did not change gloves; - LPN C applied the gauze, the gauze wrap, the tape, and did not date and initial the dressing to the left lower leg. Observation of the resident's wound care on 03/18/26 at 8:45 A.M., showed: - EBP supplies affixed to outside of resident door;- No EBP signage on the outside of the resident door;- LPN D did not put on a gown, performed hand hygiene, put on gloves, and entered the resident room;- LPN D removed the dressing, cleaned the left leg wounds, performed hand hygiene, changed gloves, did not use a no-touch technique and applied the gentamicin (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ointment with a gloved finger to left medial superior leg wound, did not perform hand hygiene, and did not change gloves;- LPN D did not use a no-touch technique and applied the gentamicin ointment with a gloved finger to left posterior lateral calf wound, did not perform hand hygiene, and did not change gloves;- LPN D did not perform hand hygiene, changed gloves, applied the gauze, the gauze wrap, the tape, and did not date and initial the dressing to the left lower leg. Observation of the resident's wound care on 03/19/26 at 9:08 A.M., showed:- EBP supplies affixed to outside of resident door;- No EBP signage on the outside of the resident door;- Registered Nurse (RN) E put on a gown and entered the resident room, performed hand hygiene, and put on gloves;- RN E removed the soiled dressing from the left lower leg, did not perform hand hygiene, and changed gloves;- RN E cleaned the left medial superior leg wound with gauze soaked with NS, did not perform hand hygiene, and changed gloves;- RN E cleaned the lateral wound with gauze soaked with NS, did not perform hand hygiene, and changed gloves;- RN E completed the wound care treatments as ordered to the left leg wounds. During an interview on 03/16/26 at 11:25 A.M., Certified Medical Technician (CMT) F said the supplies outside of Resident #32's door were for staff to put on while providing care because he/she had a wound. During an interview on 03/17/26 at 2:50 P.M., LPN C said the supplies outside of Resident #32's door was to protect staff from any bacteria that might be in the resident's wound. During an interview on 03/18/26 at 11:04 A.M., LPN D said the supplies outside of the resident's room was for EBP, because Resident #32 had wounds. He/She forgot to put a gown on this morning during wound care. During an interview on 03/19/26 at 9:21 A.M., RN E said EBP was something new and it was for residents with wounds or tubes but didn't apply to catheters. During an interview on 3/19/26 at 11:02 A.M., the Director of Nursing (DON) said during wound care, she expected staff to put on a gown and gloves before entering a resident's room and to perform hand hygiene after every glove change. Her expectation of staff while providing wound care and applying ointments or creams would be to use a cotton-tipped applicator or a tongue depressor for each wound to prevent contamination of the wounds. During an interview on 03/19/26 at 11:30 A.M., the Administrator said she expected staff to follow the EBP for residents with wounds by putting on a gown and gloves before entering the resident room to provide care. When applying creams or ointments to wounds, she would expect staff to use a cotton-tipped applicator for each application.