

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2024
NAME OF PROVIDER OR SUPPLIER Medicalodges Nevada		STREET ADDRESS, CITY, STATE, ZIP CODE 1210 West Ashland Nevada, MO 64772	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534</p> <p>Based on interview and record review, the facility failed to ensure all allegations of abuse and neglect were reported immediately to facility management and to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required two-hour time frame when staff failed to immediately report an allegation of employee to resident abuse of involving three residents (Resident #1, #2 and #3). The facility census was 31.</p> <p>The Administrator was notified on the morning of 12/17/24 of the Past Non-Compliance which occurred on 12/15/24 between 3:00 A.M. and 5:00 A.M. The accused certified nurse aide was suspended on 12/17/24. Staff assessed both residents for injuries and none were found. On 12/17/24, in-service of all staff was started. Staff began the full investigation on 12/17/24 and completed interviews on 12/17/24. The facility implemented monitoring, including once a week for four weeks or as needed for psychosocial support. The noncompliance was corrected on 12/17/24.</p> <p>Review of the facility's policy titled, Abuse, Neglect, and Exploitation, revised 10/2022, showed the following:</p> <ul style="list-style-type: none"> -The resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. It is the policy of Medicalodges, Inc., to treat each resident with respect, kindness, dignity and care, to keep them free from abuse and neglect and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect; -All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source are to be reported immediately to the Administrator and/or their designated representative, the appropriate state agency and when applicable, law enforcement, not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury. <p>1. Review of Resident #1's face sheet (resident information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included cerebral palsy (a group of disorders that affect a person's ability to move, maintain balance, and control posture), muscle weakness, and depression. <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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's annual Minimum Data Set (MDS - federally mandated assessment tool completed by facility staff), dated 12/05/24, showed the following:</p> <ul style="list-style-type: none"> -The resident was cognitively intact; -The resident used a wheelchair to ambulate; -The resident was dependent on others for assistance in completing the Activities of Daily Living (ADL's - dressing, grooming, bathing, eating, and toileting). <p>Review of the resident's care plan, updated 12/18/24, showed the following:</p> <ul style="list-style-type: none"> -The resident yells out at night because he/she is hungry; -The resident frequently screams. Staff to redirect him/her to use his/her words; -The resident needed to develop a trusting, therapeutic relationship with others; -Allow the resident to express his/her emotions without judgement or criticism; -The resident needed staff to follow up on his/her needs and concerns in a timely manner. <p>2. Review of Resident #2's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included major depressive disorder (mood disorder that is characterized by a low mood and negative emotions), muscle weakness, and dementia (a general term for a number of neurological conditions that cause a decline in cognitive abilities). <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -The resident had severe cognitive impairment; -The resident was dependent on others for assistance in completing his/her ADL's, -The resident used a wheelchair to ambulate; -The resident was dependent on others to push his/her wheelchair. <p>Review of the resident's care plan, updated 12/18/24, showed the following:</p> <ul style="list-style-type: none"> -The resident needed staff to wheel him/her around his/her home. The resident was unable to do so on his/her own; -Monitor the residents verbal and nonverbal cues for pain. <p>3. Review of the facility's Investigation Summary, dated 12/17/24, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The Administrator was notified on 12/17/24, at 8:30 A.M., of an allegation of employee to resident verbal and physical abuse, that had occurred on 12/16/24 between 3:00 A.M. and 5:00 A.M.;</p> <p>-The staff reported the allegations of abuse to DHSS on 12/17/24 at 9:21 A.M.</p> <p>Review of a written statement, dated 12/17/24, showed Certified Nurse Aide (CNA) E noted the following:</p> <p>-On 12/15/24, at around 3:30 A.M., the CNA heard Resident #1 screaming and then heard a staff tell the resident to Shut-up! You are fine!</p> <p>-On 12/15/24, at around 4:40 A.M., Resident #2 was yelling for help and CNA F came up behind the resident in a wheelchair, grabbed the wheelchair, and roughly began pushed the resident forward hard enough to cause the resident's legs to bend back under the wheelchair.</p> <p>-CNA F then walked over to Resident #3 and without saying anything, ripped the blankets off of the resident. The resident began screaming. The CNA sid hey, I'm chaingng you! and yanked the resident's brief down being rough with the resident. The resident was continued to scream.</p> <p>4. Review of DHSS's intake information dated 12/17/24, at 9:33 A.M., showed the facility self-reported a verbal allegation of abuse by a CNA.</p> <p>5. During an interview on 12/23/24, at 1:29 A.M., CNA A said the following:</p> <p>-If he/she witnessed, or if a resident reported, any abuse or neglect to him/her, he/she would immediately report the allegations to the charge nurse;</p> <p>-The state required allegations of abuse and neglect to be reported to the state within two hours;</p> <p>-Before moving a resident in a wheelchair staff should make sure the resident's feet were on the foot pedals and the resident's arms were in their lap;</p> <p>-Verbal abuse was considered abuse and should be reported to the state.</p> <p>6. During an interview on 12/23/24, at 1:37 A.M., CNA B said the following:</p> <p>-If a resident reported abuse or neglect to him/her CNA B would report it to the charge nurse;</p> <p>-The state required allegations of abuse and neglect to be reported to the state with in two hours;</p> <p>-Prior to pushing a resident in a wheelchair staff should make sure the resident's feet are on the foot pedals and the resident's arm/hands are on their lap;</p> <p>-If a resident does not have pedals on their wheelchair staff should not push that resident.</p> <p>7. During an interview on 12/23/24, at 1:40 A.M., CNA C said the following:</p> <p>-All allegations of abuse and neglect should be reported to the charge nurse immediately;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The state required all allegations of abuse and neglect to be reported within two hours;</p> <p>-The residents should not be pushed in a wheelchair that did not have foot pedals;</p> <p>-The resident's feet should be on the foot pedals prior to pushing;</p> <p>-The resident should be sitting all the way to the back of the wheelchair;</p> <p>-Being rough with a resident and telling a resident to shut up was abuse and should be reported to upper management.</p> <p>8. During an interview on 12/23/24, at 10:36 A.M., CNA E said the following:</p> <p>-If he/she witnessed any abuse towards a resident he/she would report it immediately to the charge nurse;</p> <p>-The state required all allegations of abuse and/or neglect to be reported within two hours;</p> <p>-On 12/15/24, around 3:00 A.M., Resident #1 had yelled for help and CNA F responded by saying Shut up, you're fine.</p> <p>-CNA E did not feel that what CNA F said to the resident was appropriate;</p> <p>-The same night CNA F walked up behind Resident #2's wheelchair and started pushing it. CNA F did not make sure the resident's feet were on the foot pedals. Resident #2 started screaming because his/her leg was being bent as his/her foot was on the ground while CNA F was pushing the wheelchair;</p> <p>-CNA E did not tell the charge nurse working about CNA F telling Resident #1 to shut up or about CNA F pushing Resident #2 in the wheelchair roughly;</p> <p>-CNA E contacted the Administrator two days after the incidents with CNA F to report his/her concerns.</p> <p>9. During an interview on 12/23/24, at 1:45 A.M., Licensed Practical Nurse (LPN) D said the following:</p> <p>-LPN D would report all allegations of abuse and neglect to the Director of Nursing (DON) and the Administrator;</p> <p>-The Administrator should start an investigation and report the allegations to the responsible state agency within two hours;</p> <p>-Staff are trained in the proper way to assist residents in wheelchairs;</p> <p>-The resident's feet should be on the foot pedals of the wheelchair prior to moving the wheelchair;</p> <p>-No staff reported to him/her that CNA F verbally or physically abused or was rough with a resident;</p> <p>(continued on next page)</p>		

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