STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to ensure staff treated all residents with dignity and respect when the staff failed to provide a dignity bag for a catheter (a sterile tube inserted into the bladder to drain urine) bag for three residents (Resident #40, #10, and #16), failed to knock before entering the room of one resident (Resident #41), and when staff stood over three residents (Resident #33, #23, and #24) when assisting the residents with a meal. The facility census was 45. Review of the facility's policy titled State and Federal Regulation, dated 10/2019, showed the following information: -A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Review of facility policy titled Your Rights and Protections as a Nursing Home Resident, undated, showed the following: -The resident had the right to be treated with dignity and respect, as well as make his/her own schedule and participate in the activities he/she chooses; -The resident has the right to proper privacy, property, and living arrangements. 1. Review of Resident #40's face sheet (resident's information at first glance) showed the following information: -admitted [DATE]; -Diagnoses included urinary tract infection and neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal, or nerve problems). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 05/02/24, showed the following information: (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
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Dependent on staff for toileting; -Indwelling catheter. -Diagnoses included neurogenic bladder (lack of bladder control due to brain, spinal, or nerve problems). Review of the resident's care plan, last revised on 01/31/24, showed the resident had a Foley catheter related to neurogenic bladder. (Staff did not care plan regarding the use of dignity bags.) Observation on 06/10/24, at 11:00 A.M., showed the resident in his/her room with the door open. The resident sat in the wheelchair facing the window. A catheter bag was attached to the back of the wheelchair with yellow urine visible from the hallway. There was no dignity bag in place over the catheter bag. Observation on 06/11/24, at 9:17 A.M., showed the resident walked up and down 200 hall with therapy staff. A catheter bag hung underneath the resident's wheelchair with yellow urine visible. There was no dignity bag in place over the catheter bag. Observation and interview on 06/11/24, at 11:10 A.M., showed the resident in his/her room with door open, catheter bag hung from the back of wheelchair. Yellow urine visible from the hallway. Resident said the catheter bag should be inside of a dignity bag. The therapy staff often take it out to allow for full extension of his/her lower extremities during therapy. Observation on 06/11/24, at 12:26 P.M., the resident sat at dining room table, catheter bag draining visible yellow urine hung on the back of the wheelchair, dignity bag hung beside the catheter bag. 41787 2. Review of Resident #10's face sheet, showed the following information: -admitted [DATE]; -Diagnoses included malignant neoplasm (cancer) of bladder, neuromuscular dysfunction of bladder (loss of bladder control, inability to empty bladder), and hemiplegia and hemiparesis (paralysis of one side of the body) following cerebrovascular disease (stroke) affecting left non-dominant side. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Indwelling catheter; -Dependent on staff for toileting hygiene, personal hygiene, showering, and dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, last revised on 06/03/24, showed the showing information: -Required staff assistance with activities of daily living (ADL) related to physical limitations; -Required one staff assistance for dressing and personal care. (Staff did not care plan related to the use of catheter and dignity bags.) Observation on 06/10/24, at 12:35 P.M., showed the resident in an electric wheelchair in the dining room. His/her catheter bag layed on the footrest of electric wheelchair between his/her feet with the cloudy yellow urine visible in the bag. The catheter bag was not covered with a dignity bag. Observation on 06/11/24, at 11:05 A.M., showed the resident in his/her room in an electric wheelchair with television on. The catheter bag laid flat on the foot pedals of the electric wheelchair between the resident's feet, not covered by a dignity bag, with cloudy yellow urine visible from hallway. Observation 06/11/24, at 12:43 P.M., showed the resident in the dining room. The catheter bag completely on the foot pedal of electric wheelchair between resident's feet and was not covered with a dignity bag with cloudy yellow urine visible. During an interview on 06/11/24, at 2:00 P.M., the resident said that he/she had not had a blue cover over the catheter bag for some time. He/she said no one seems to know where to find them. He/she would prefer to have the bag covered when in common areas. Observation on 06/12/24, at 12:20 P.M., showed the resident in an electric wheelchair in the dining room. His/her catheter bag was setting on the footrest of electric wheelchair between his/her fee with cloudy yellow urine visible in the bag. Observation on 06/13/24, at 9:30 A.M., showed the resident was his/her room in the electric wheelchair, resting with eyes closed. The catheter bag was setting on the wheelchair pedals with no dignity cover and cloudy yellow urine visible from hall. 3. Review of Resident #16's face sheet, showed the following information: -admitted on [DATE]; -Diagnosis included multiple sclerosis (chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue) and neuromuscular dysfunction of bladder. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Cognitively intact; -Indwelling catheter; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for toileting hygiene, personal hygiene, showering, and dressing. Review of the resident's care plan, last revised on 02/26/24, showed the showing information: -Required staff assistance with ADL's related to physical limitations secondary to primary diagnosis of MS; -Required assistance of one staff for dressing and personal cares; -Resident had suprapubic catheter (a catheter surgically inserted through the abdomen into the bladder) related to neurogenic bladder; (Staff did not care plan related to the use of a dignity bag.) Observation on 06/10/24, at 12:35 P.M., showed the resident in his/her electric wheelchair in the dining room. The catheter bag was hanging on the back side of her wheelchair with no dignity bag in place with clear yellow urine in the bag. Observation 06/11/24, at 12:42 P.M., showed the resident's catheter bag only partially covered by a dignity bag hanging on the left side of the wheelchair off the arm of wheelchair with clear yellow urine visible in the bag. During interview and observation on 06/12/24, at 10:10 A.M., the resident rested in bed, fully dressed, with catheter laying on the bed. The resident said that staff went to get the lift to get him/her out of bed. The resident said he/she preferred to have the catheter bag in a blue cover, he/she did not want everyone else to see the catheter. Observation on 06/13/24, at 9:40 A.M., the resident was resting in bed with eyes closed. The catheter bag was hanging on the lower left side bed rail with no dignity bag and yellow urine visible from hallway. 4. During an interview on 06/12/24, at 10:03 A.M., Nurse Aide (NA) A said catheter bags should always have a dignity bag on them. 5. During an interview on 06/13/24, at 9:50 A.M., NA H said some residents' catheter bags had privacy bag when in common areas, but in the resident rooms the catheter bags just hang on the bed rail. 6. During an interview on 06/12/24, at 12:31 P.M., Licensed Practical Nurse (LPN) B said staff must keep catheter bags inside a dignity bag to protect the resident's privacy. 7. During an interview on 06/14/24, at 11:26 A.M., the Director of Nursing (DON) said catheter bags should be covered with dignity bag, at all times, especially in common areas. 8. During an interview on 06/14/24, at 1:24 P.M., the Administrator said the staff realized on Tuesday that they did not have any dignity bags. Catheter bags should be covered with a dignity bag, at all times. 9. Review of Resident #41's face sheet showed the following information: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admitted [DATE]; -Diagnoses included chronic heart failure (CHF - a condition in which the heart can't pump enough blood to the body's other organs), squamous cell carcinoma (cancer that begins in the outer layer of skin), obstructive and reflux uropathy (urine cannot drain through the urinary tract, may back up into the kidneys), neuromuscular dysfunction of bladder (loss of bladder control, inability to empty bladder), and residual schizophrenia (subtype of schizophrenia in which the individual has suffered an episode of schizophrenia but there are no longer any delusions, hallucinations, disorganized speech or behavior). Review of resident's admission MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Used a wheelchair for mobility; -Had an indwelling catheter; -Always continent of bowel. Observation on 06/13/24, at 2:38 P.M., showed the following: -Certified Medication Technician (CMT) K in the resident's room to perform catheter care; -The resident's room door was closed; -The resident and the CMT were in the bathroom with door partially open for catheter care and medication application; -A laundry assistant walked into the room without knocking and proceeded past the bathroom door to hang up clothing and then left the room; -A staff opened outside door and then closed the door without knocking; -The Administrator and maintenance staff opened the bedroom door without knocking to check on the call light; -The resident said well, bring in the whole baseball team and their friends. During an interview on 06/14/24, at 8:45 A.M., NA A said that staff should knock before entering a resident room. During an interview on 06/14/24, at 9:20 A.M., CMT K said that staff should not enter a resident room without knocking or requesting entrance from the resident. During an interview on 06/14/24, at 4:15 P.M., Registered Nurse (RN) D said that staff should always knock before entering a resident room, they should announce self and wait for response. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/14/24, at 10:50 A.M., the DON said that staff should always knock and announce themselves before entering resident room. During an interview on 06/14/24, at 1:24 P.M., the Administrator said that resident have the right to privacy, staff knock before entering. 31464 10. Review showed the facility did not provide a policy pertaining to meal assistance. Observation on 06/14/24, at 7:56 A.M., showed NA W stood over Resident #33 and Resident #23 to assist them with bites of food and offer them drinks. Observation on 06/14/24, at 7:59 A.M., showed CNA R stood over Resident #24 to offer him/her bites of food and then Resident #23 to give him/her a drink. During an interview on 06/14/24, at 3:55 P.M., CNA P said that staff should assist residents with food and offer drinks between bites. Staff should help at the resident's pace and should be seated next to resident, making eye contact, and should be involved with the resident. He/she said if staff stand over the resident, it could be seen as posturing. During an interview on 06/14/24, at 4:15 P.M., RN D said staff should interact with residents when assisting with meals. They should ask the resident what they want first, give them a bite, and offer them a drink. Staff sitting next to the resident is the best option. During an interview on 06/14/24, at 10:53 A.M., the DON said staff should sit down next to a resident to feed them or cue them to feed themselves. During an interview on 06/14/24, beginning at 1:24 P.M., the Administrator said staff should sit down next to a resident while assisting them to eat. They should interact directly with the resident and not rush them to eat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 31464 Based on interview and record review, the facility failed follow their abuse prevention policy when staff failed to request a criminal background check (CBC) and complete a Nurse Aide (NA) Registry check to ensure staff did not have a Federal Indicator (a marker given to a potential employee who has committed abuse, neglect, or misappropriation of property against residents) prohibiting them to work in a certified facility prior to one staff member's (Housekeeping S) contact with residents. A sample of 10 employees was reviewed in a facility with a census of 45. Review of the facility's policy entitled Abuse, Neglect and Exploitation, undated, showed the following: -All new employees will be investigated prior to employment for a previous history of abuse, neglect, or exploitation; -All non-licensed employees shall have a criminal background check as required by law and may be periodically checked; -Results of background checks will be maintained in the employee's personnel file; -All employees are hired on a probationary basis pending the result of their background check. Review of the facility's Business Office Checklist for pre-hire procedures showed the following: -Submit (request for) criminal background check and print off results; -Check state NA Registry and print off results. 1. Review of Housekeeping S' personnel file showed the following; -Hire date of 05/11/23; -Staff did not document a CBC request; -Staff did not document a NA Registry check. During interviews on 06/14/24, at 8:15 A.M. and 10:35 A.M., the Business Office Manager (BOM) said the following: -He/she used an electronic system, including a checklist, to ensure all background checks and other information were obtained prior to hiring a new employee; -The request for a CBC is submitted and the results are printed out for the personnel file; -He/she should check the NA Registry for all new hires and print out a copy of the results for the personnel file. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she was not able to locate copies of either a CBC or NA Registry check for the housekeeper. During an interview on 06/14/24, at 10:53 A.M., the interim Director of Nursing (DON) said facility staff should request the CBC and check the NA Registry prior to a new employee beginning their orientation. During interviews on 06/14/24, at 7:50 A.M. and 9:00 A.M., the Adminstrator said the following: -The facility did not have a specific written policy regarding CBC and NA Registry checks. Their policy was to follow the regulations; -The BOM should ensure all steps are completed on the checklist regarding background checks; -Staff should print out documentation showing the results of the CBC and NA Registry check prior to hiring an employee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on interview and record review, the facility failed to complete the required Preadmission Screening and Resident Review (PASARR - a two level tool used to screen each resident in a nursing facility for a mental disorder or intellectual disability prior to admission) prior to or upon admission to the facility and after changes in condition for one resident (Resident #8), out of five sampled residents, to ensure the resident received appropriate care and services. The facility census was 45. Review showed the facility did not provide a policy or procedure addressing completion of PASARR forms. 1. Review of Resident #8's face sheet (brief information sheet about the resident) showed the following information: -admitted [DATE]; -Diagnoses included bipolar disorder (onset date of 01/10/20), major depressive disorder, mild intellectual disabilities (slower in all areas of conceptual development and social and daily living skills), and impulse disorder. Review of the resident's care plan, last reviewed 08/25/20, showed the following: -The resident had mood/behavior and psychosocial (pertaining to the influence of social factors on an individual's mind or behavior, and to the interrelation of behavioral and social factors) problems; -The resident could be manipulative, passive/aggressive, and attention seeking at times; -The resident was at risk for aggression towards others related to maladaptive mood and behavior. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument, completed by facility staff), dated 05/23/24, showed the following information: -Most recent readmitted [DATE]; -Cognitively intact; -Diagnoses included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), depression, bipolar disease (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), renal insufficiency (poor function of the kidneys that may be due to a reduction in blood-flow to the kidneys caused by renal artery disease), and mild intellectual disabilities; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Taking antipsychotic medications (used to treat psychosis (collection of symptoms that affect ability to tell what is real and what is not)) on a routine basis. Review of resident's DA-124 A/B PASARR form (used to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 07/16/08, showed the following information: -Diagnoses included anxiety and depression; -Potential problem areas included aggression with intermittent combativeness; -Level one screening criteria for serious mental illness showed resident showed signs or symptoms of major mental disorder and diagnosed with depressive disorder; -Dementia was not the primary reason for nursing facility placement; -The person had serious problems in level of functioning in the last six months; -The person did not have intensive psychiatric treatment in the past two years; -Special admission category when a level 2 screening was indicated: -The persons condition qualified him/her for special admission category of respite care (stays of not more than thirty days to provide relief for in-home caregivers); -No Level 2 information provided. Review of the resident's medical record showed staff did not notify the state agency, or re-complete the PASARR screening when the resident's stay extend the 30-day respite. Review of the resident's medical record hosed staff did not complete a new PASARR screening after the resident had changes in condition in 2020, with new diagnosis, and in 2022, with psychiatric hospital stay During an interview on 06/11/24, at 2:00 P.M., the Social Services Director (SSD) was unable to locate any a level 2 form for the resident, or any other information related to PASARR for the resident. She had not been in the position long and was unsure of when another form needed completed. During an interview on 06/11/24, at 4:00 P.M., the Administrator said the resident went out to psychiatric hospital stay in 2022. She was unsure if another form was completed at that time due to change in condition. She could not locate a completed level 2 form. She was unsure if another form should have been completed due to the respite status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 31464 Based on observation, interview, and record review, the facility failed to ensure an qualified individual was designated as the activities program director. The facility census was 45. Review showed the facility did not provide a policy pertaining to the activity program or requirements of the program director. 1. Review of the facility's current staff listing, provided on 06/10/24, showed no individual listed as an activities program director. Review of the facility's staffing schedules for the months of May 2024 and June 2024 showed no individual scheduled to lead activities. Observation on 06/10/24, at 3:10 P.M., showed six to eight residents in the dining room area playing Bingo. A resident was calling the numbers. No staff was present. Observations on 06/11/24, at 10:15 A.M., showed Certified Nursing Assistant (CNA)/Staffing Coordinator M lead approximately six to eight residents in exercising/dancing to music played in the central lobby/living area. During an interview on 06/11/24, at 11:00 A.M., CNA/Staffing Coordinator M said he/she tried to help by leading activities when he/she was available. The facility did not currently have a full-time activity director. Review of Resident #33's care plan, last updated 05/01/24, showed the following: -Resident would like to engage in activities in his/her home; -Resident would like to attend activities throughout the week; -Resident enjoyed Bingo, especially if grand kids are present. Resident enjoyed music and live entertainment. Staff to invite resident to social gatherings and parties. Staff to provide resident with an activity calendar and encourage resident to attend activities. Staff to visit and provide one on one activities throughout the week. During an interview on 06/10/24, at 3:18 P.M., Resident #33's family member said the facility did not currently have an activity director. He/she said the residents no longer received one-on-one interaction for any activity and many of the residents appeared to be bored. The resident just sat in his/her room most of the time in between meals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/14/24, at 10:53 A.M., the Director of Nursing (DON) said the facility did not currently have a designated activities program director. The former activities director had changed positions and was now a certified medication technician (CMT). Other staff members directed some activities as they had time to do so, including playing music for listening or exercise sessions. There was currently no one-on-one activity being done. The DON said some residents had recently complained about being bored. The facility was trying to hire a new activities program director. During an interview on 06/14/24, at 1:24 P.M., the Administrator said the facility did not currently have a designated activities program director. The former director had changed positions two to three weeks prior. Department heads and volunteers (usually hospice staff) were trying to lead some activities, based on a calendar/schedule set up previously, while the facility was advertising to hire a new director. Current staffing did not allow for consistency in doing one-on-one activities with residents who did not attend group activities. MO00237558 MO00237588

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on interview and record review, the facility failed to provide care per standard of practice when the facility failed to complete ordered labs/x-rays for two residents (Resident #26 and #29) resulting in a possible delay in care and when staff failed to provide restorative therapy for one resident (Resident #33). The facility census was 45. Review showed the facility did not provide a policy or procedure related to following physician orders for laboratory or diagnostic imaging. 1. Review of Resident #26's face sheet showed the following information: -admitted [DATE]; -Diagnoses included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) with agitation, fibromyalgia (chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), Raynaud's syndrome (causes some areas of the body - such as fingers and toes - to feel numb and cold in response to cold temperatures or stress) without gangrene (dead tissue caused by an infection or lack of blood flow), hypertension (high blood pressure), and hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone - can disrupt such things as heart rate, body temperature, and all aspects of metabolism). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility), dated 05/09/24, showed the following: -Severe cognitive impairment; -Dependent on staff for toileting hygiene, showering, dressing, putting on/taking off footwear, personal hygiene, and transfers; -Use of wheelchair for mobility; -Frequently incontinent of bowel and bladder. Review of the resident's care plan, reviewed 05/17/24, showed the following: -Required staff assistance with activities of daily living (ADL) related to physical limitations; -Resident will have ADL needs met as exhibited by neat, clean and odor free appearance daily through next review. Review of the resident's nursing progress notes showed the staff documented the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/08/24, at 10:09 P.M., the resident had been lethargic and sleepy all evening. He/she did sit up and ate the evening meal in his/her room and later got up and ate a snack. He/she took medications without difficulty. Verapamil (high blood pressure medication) was held due to low blood pressure. Staff notified the physician and received new order for straight catheter (a flexible tube inserted through a narrow opening into a body cavity) urinalysis, complete blood count (CBC - lab), and complete metabolic panel (CMP - lab); -On 06/12/24, at 3:03 P.M., therapy stated they were not able to ambulate with resident because he/she was short of breath and unable to stand without assistance because of severe pain noted in the resident's left side, which therapy said had been going on for days. The resident admitted to left sided pain rated 4 out of 10. Staff administered Tylenol and resident was transported to emergency room (ER) by facility staff. Staff notified family and physician; -On 06/12/24, at 6:47 P.M., the resident returned via facility vehicle with new order for antibiotics for urinary tract infection (UTI). Review of resident's medical record showed staff did not enter the labs ordered by the physician or completion of the labs ordered on 06/08/24. During an interview on 06/13/24, at 12:20 P.M., Licensed Practical Nurse (LPN) I/Medical Records said he/she did not know why the labs on the resident were not done on 06/08/24. He/she found it during the morning clinical excellence meeting on Tuesday, 06/11/23, at 8:00 A.M. that the labs for Saturday, 06/08/24, were not entered or drawn. He/she did not know why the order was not entered at the time it was found. The resident was sent to the hospital on 06/12/23. During an interview on 06/14/24, at 10:50 A.M., the Director of Nursing (DON) said she was unsure why the order for the resident did not get completed until sent to the hospital multiple days later. During an interview on 06/14/24, at 1:24 P.M., the Administrator said on 06/10/24 the nurse was notified the lab orders for the resident needed completed. The next day, she told the nurse that the labs needed to be done that day, but it did not get done and the resident was sent to the hospital on 06/12/24. 2. Review of Resident #29's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), dementia, pain, repeated falls, fibromyalgia, and restless leg syndrome (condition characterized by a nearly irresistible urge to move the legs, typically in the evenings). Review of the resident's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Dependent on staff for toileting hygiene, showering, dressing, and personal hygiene; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Use of wheelchair for mobility; -Use of pain medication routinely. Review of resident's care plan, last reviewed 05/25/24, showed the following: -Required staff assistance with ADLs related to physical limitations; -If had pain may require more assistance with completing ADLs; -At risk for falls and/or injury related to history of falls; -Staff should complete labs as indicated; -Staff should notify family of falls and injury; -Staff should notify physician of injuries; -Resident had pain; -Staff should give pain medications as ordered and monitor for effectiveness; -Staff should monitor for non-verbal cues of pain. Review of resident's progress note dated 05/24/24, at 3:09 P.M., showed the resident was seen by the physician for monthly rounds. The resident complained of pain in his/her hips. The physician ordered an x-ray of bilateral hips. No other orders of concerns noted. Review of the resident's physician orders sheet, dated 05/01/24 through 06/14/24, showed staff did not enter an order for bilateral hip x-rays. Review of the resident's medical record showed no results for bilateral hip x-rays. During an interview on 06/14/24, at 10:39 A.M., LPN I said he/she was unable to locate any results for the resident related to hip x-rays that were ordered on 05/24/24. He/she did not know why the x-ray order was not completed. During an interview on 06/14/24, at 10:50 A.M., the DON said usually, the mobile order company is able to come out the same day the order is sent to them. This should have been addressed much sooner for the resident. During an interview on 06/14/24, at 1:24 P.M., the Administrator said she was unsure why the hip x-rays for the resident were not completed as ordered on 05/24/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During interviews on 06/13/24, at 12:20 P.M., and on 06/14/24, at 10:39 A.M., LPN I/Medical Records said that when the nurse receives lab orders, they should enter the labs into the physician orders, complete a lab requisition form, and put the pink part of the form in the medical records box. He/she monitored and ensured that the labs results are received and uploaded to the computer. The lab comes several times per week. On the weekend, or other times when labs are needed sooner, the nurses are able to draw the lab, and someone can take to the laboratory. All staff nurses can and should put in x-ray orders and lab orders when received from the physician. He/she entered the routine monthly lab orders. 4. During an interview on 06/14/24, at 10:50 A.M., the DON said that either the charge nurse or LPN I/Medical Records should put in any and all orders received from the physician or other providers. Typically, the charge nurse puts in the orders that were received by phone or fax. Any lab and x-ray orders should be entered immediately after received from the provider. Labs should be done on the shift it is ordered, especially a urinalysis test should be done as soon as possible. A urinalysis ordered on a Saturday should not wait until Monday or later to be completed. Staff should get someone to take it to the hospital lab as soon as possible. 5. During an interview on 06/14/24, at 1:24 P.M., the Administrator said that all nurses can and should put lab and x-ray orders they receive into the EMR system, then any new order has to be reviewed by medical records. Staff follow up with all changes with clinical excellence meeting every day. The clinical excellence morning meeting team reviews all new orders for the previous 24 hours. The nursing staff should be following what is in the physician orders. The nurses should act on the received orders. The nurse should fill out the requisition form for the lab or x-ray and ensure that it was completed. She follows up with nurses every day and tell them everything that that needs follow up at that time. She said that there was no policy related to physician orders, they follow regulation guidelines. 6. Review showed the facility did not provide a policy pertaining to restorative nursing. Review of Resident #33's face sheet showed the following information: -admitted [DATE]; -Diagnoses included Parkinsonism (neurologic disorder affecting movement, often including tremors), dementia with Lewy bodies (characterized by changes in sleep, behavior, cognition, movement, and regulation of automatic bodily functions), type 2 diabetes, chronic obstructive pulmonary disease (COPD - breathing disorder), post-traumatic stress disorder (PTSD - difficulty recovering after experiencing or witnessing a terrifying event), convulsions, heart disease, sleep apnea (breathing disorder while sleeping), depression, high blood pressure, gastro-esophageal reflux disease (GERD - stomach acid backs up into the esophagus), muscle weakness, chronic pain, and need for assistance with personal care. Review of the resident's care plan, updated 05/01/24, showed the following: -On 05/05/23, resident needed assistance of two staff and a gait belt for transfers and the use of the sit-to-stand lift as a safety back up; -On 05/05/23, resident needed staff to wheel resident around home; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 05/09/23, resident had limitations on the right side of the body; -On 01/30/24, resident to be discharged from skilled physical therapy and transitioned to restorative aide program one to three times per week; Review of the resident's therapy form entitled Communication with Restorative Nursing, dated 01/23/24, showed the following information: -Date of Discharge: 01/26/24 (Occupational Therapy; OT); 01/30/24 (Physical Therapy; PT); -Patient's status at time of discharge: Maximum to total dependence for all activities of daily living (ADLs). Sit to stand lift for all transfers (use Hoyer mechanical lift as needed); -Recommendations to restorative nursing three to five times per week with bilateral upper and bilateral lower extremities stretching, two-person assist with sit-to-stands with transfer pole, 1-2 each and three times per week use toilet with sit-to-stand lift. Follow-up screening in two months; -Signed by OT. Review of the resident's care plan, updated 05/01/24, showed on 04/03/24, goal that resident will improve or maintain level of functioning. During an interview on 06/14/24, at 7:50 A.M., the Administrator said there was only one restorative entry note in the resident's chart, a therapy order, dated 08/2023 for continued restorative nursing therapy. During an interview on 06/11/24, at 3:18 P.M., the resident's family member said the facility was not consistent with staffing and care. The restorative nurse aide (RNA) got pulled to work the floor fairly often, so no restorative therapy was being done to help maintain/improve the resident's strength. The resident had declined in his/her ability to bear weight on his/her legs. During an interview on 06/14/24, at 8:55 A.M., with Certified Physical Therapy Assistant/Licensed (CPTA/L) X and Certified Occupational Therapy Assistant/Licensed (COTA/L) Y said they both are part time and were not sure if either of them had worked with the resident. They explained the process of evaluating and providing therapy for residents and the process of discharging a resident with recommendation orders to restorative nursing. They said staff should have followed the restorative recommendations/orders given by therapy to maintain the resident's strength. CPTA X and COTA Y said they did a post-therapy screening two months after therapy discharge and no recommendations or changes were made to the restorative orders. Staff should have continued with the plan. During an interview on 06/14/24, at 8:45 A.M., CNA/RNA N said the resident did have an order from the therapy department, dated 08/23/23, for restorative nursing therapy for core strengthening. However, he/she had not been able to work with the resident on restorative due to being pulled to work the floor as an aide. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/14/24, at 10:53 A.M., the Director of Nursing (DON) said the resident needed therapy or exercises to strengthen his/her weaker side, to allow him better weight-bearing. He/she said CNA/RNA N had not been able to work with the resident on restorative therapy, because the RNA had been needed to work the floor as an aide, in between transporting residents to appointments. The DON said there was only one RNA progress note dated 08/23/23. During an interview on 06/14/24, beginning at 1:24 P.M., the Administrator said the physical therapy (PT) department recommends restorative nursing if they feel it would benefit the resident upon discharge from skilled PT. They communicate the need to the nursing staff/restorative nurse, who assigns the restorative therapy to the RNA or other staff. CNA/RNA N also does transportation and has had to work the floor often for the past six to eight months. He/she has not been able to do restorative therapy with the resident. MO00237558 41787

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, record review, and interview, the facility failed to provide care to all pressure ulcers per standards of practice when the facility failed to have a system in place to ensure timely implementation of new wound care orders, to ensure timely physician notification of wounds, and to document and track wound timely and completely for one resident (Resident #40). A sample of 15 residents was reviewed in the facility with a census of 45. Review of the facility's policy titled, Wound Prevention and Management, revised 12/2018, showed the following information: -All residents will be assessed in the first four hours of admission using the Braden Scale (a standardized tool used in health care to assess a patients risk of developing pressure ulcers or pressure injuries) to determine the risk for skin breakdown. Residents will be reassessed quarterly and with any identified significant change; -The facility will develop a system to review all residents at risk on a weekly basis; -The facility will review all residents with wounds weekly ; -The Director of Nursing (DON) or designee will be responsible for monitoring all wounds on a weekly basis using the skin condition assessment on the electronic medical record system; -The plan of care will address problems, goals, and interventions directed towards prevention of pressure ulcers and/or skin integrity concerns identified; -Referrals to wound care specialists as needed; -Physician will be notified when wounds show no signs of healing or show decline to evaluate current treatment and/or need for new treatment. Review showed the facility did not provide a policy or procedure regarding following physician orders for wounds. 1. Review of Resident #40's face sheet (first glance look at resident's information) showed the following information: -admitted [DATE]; -Diagnoses include urinary tract infection, high blood pressure, diabetes, and pain. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/02/24, showed the following information: -Cognitively intact; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required substantial to maximum assistance from staff for lower body dressing, showering, and personal hygiene; -Required partial to moderate assistance with mobility; -At risk for developing pressure ulcers; -Required pressure reducing device for bed and chair; -No pressure, arterial (a wound on the lower leg caused by poor circulation), venous (a wound on the leg or ankle caused by abnormal or damaged veins), or diabetic wounds documented. Review of the resident's weekly skin assessment, dated 05/04/24, showed staff did not document any skin impairment for the resident. During an interview on 06/12/24, at 10:03 A.M., Nursing Assistant (NA) A said he/she saw the resident's skin daily. There was no skin issue when he/she put the resident to bed on 05/06/24, but the next morning, on 05/07/24, during a shower he/she saw an area to the resident's left second toe. It did not appear open at the time, but was very red and angry. He/she told the charge nurse (Licensed Practical Nurse (LPN) B) immediately. He/she said this should be documented in the resident's progress notes. LPN B told him/her that the podiatrist would be there soon, and they would go from there. The resident wore ted hose during this time and staff believed that could have been caused some pressure to the area, so those were discontinued. Review of the resident's progress notes, dated 05/07/24, showed staff did not document regarding the conversation between NA A and LPN B's and the identified area on the resident's toe. Review of resident's podiatry visit note, dated 05/07/24, showed the following information: -Resident seen at request of staff. Resident seen for at risk foot care, chronic conditions, painful toenails, and development of new ulceration located on left second toe. Resident said the second toe ulceration had developed over the past one to two weeks. The resident said the pain was mild and denied any purulence (consisting of, containing, or discharging pus), or drainage; -Wound located on left second toe measured 0.4 centimeters (cm) x 0.3 cm x 0.2 cm. The podiatrist noted the wound type as pressure; -Pre-debridement assessment showed 75% red granulation, 0% slough (yellow to white colored dead cells in the wound bed), eschar (a tan to black tissue that sheds or falls off from the skin), and epithelial tissue (thin tissue forming the outer layer of the body's surface), and 25% fibrous tissue. The resident's bone was not visible. Exudates (drainage) amount was light and serous (clear to yellow fluid) with no odor. The peri-wound (skin surrounding wound) was hyperkeratotic (a thickened tissue); -Post-debridement assessment showed 100% granulation tissue with bone not visible, exudates light and serous, no odor, and peri-wound clear; -Wet to dry dressing applied; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-New orders included if the wound was wet, dress wound with betadine (an aqueous solution that kills germs promptly) and dry compressive dressing daily. If the wound is dry, dress with triple antibiotic cream and dry compressive dressing daily. Resident to follow up in two to three months with podiatry. Resident should be monitored by the wound care team and should be seeing a vascular specialist for workups. Review of the resident's Physician Order Sheet (POS) showed staff did not add the the podiatrists orders to the order sheet. Review of the resident's care plan showed the staff did not update the care plan with the new wound or the orders from the podiatrist. During an interview on 06/11/24, at 11:06 A.M., the resident said he/she was seen on 05/07/24 by the podiatrist. The podiatrist found a red spot on his/her left second toe. The facility staff started treating it several days later. He/she doesn't believe the wound had showed much improvement, until a referral was put in for wound care clinic. Review of the resident's progress note dated 05/11/24, at 12:51 P.M., showed the following information: -LPN B documented a therapist came to him/her asking if he/she could look at the resident's toe. The resident was seen by the podiatrist recently and the therapist saw a band-aid in place. LPN B assessed that second toe to left foot was swollen and extremely red. Skin was peeling between the toes. The ulcer had a white center with red surrounding tissue and drainage present. New order written for wound to be cleansed with wound cleanser, pat dry, apply calcium alginate (a non adhesive, non-woven wound dressing made from alginate, a natural polymer derived from brown seaweed), to wound bed, and cover with band-aid daily. Staff sent fax to physician. Staff noted possible need for antibiotics. (Staff did not document regarding the resident's toe prior to 05/11/24.) Review of the resident's May 2024 Treatment Administration Record (TAR) showed the following information: -An order, dated 05/12/24, to cleanse second toe of left foot with wound cleanser, pat dry, apply calcium alginate to wound bed, and cover with band-aid daily. Staff documented the wound care was completed as ordered on 05/12/24 through 05/14/24; -An order, dated 05/15/24, to cleanse second toe of left foot with wound cleanser, apply Santyl (prescription ointment used to remove damaged tissue), then calcium alginate, and cover with band-aid daily. Staff documented the wound care was completed as ordered on 05/15/24 through 05/16/24. (Staff did not document the podiatrist's wound care orders, or wound treatment prior to 05/12/24.) Review of the resident's care plan, revised 05/17/24, showed the following information: -At risk for skin break down; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide weekly skin assessments per protocol and report any changes to the physician; -Pressure relieving devices for bed and chair; -Wound on left second toe measured 1.0 cm by 1.2 cm. The wound treatment included to cleanse the wound with wound cleanser, pat dry, apply calcium alginate, cover with band-aid, and change daily. Physician placed resident on Levaquin (a fluroquinolone antibiotic that fights bacteria in the body) 500 mg daily for 10 days (05/14/24 to 05/24/24) and ordered referral to wound care clinic. Review of the resident's May 2024 TAR showed the following information: -An order, dated 05/17/24, to cleanse second toe of left foot with wound cleanser, pat dry, apply Santyl to wound bed, cover with calcium alginate, place 2 x 2 gauze over calcium alginate, and secure in place with coban (self adhesive wrap) daily; -Staff documented wound care was completed as ordered on 05/17/24 through 05/21/24. Review of the resident's progress note, dated 05/21/24, showed agreement with wound care clinic signed. Consent and other referral paperwork given to LPN I to be sent to wound care clinic. Review of the resident's May 2024 TAR showed staff documented wound care was completed on 05/22/24 through 05/25/24. Review of the resident's progress notes showed the following information: -On 05/24/24, resident completed antibiotic treatment of Levaquin. Upon assessment of the wound, the toe still had redness and drainage. The wound bed was white. The resident felt he/she needs another round of antibiotics with a different antibiotic as he/she does not feel the Levaquin helped control and eliminate the infection; -On 05/25/24, the wound not showing signs of improvement. Physician at the facility yesterday and it was decided to wait to see what the wound care clinic suggested. No new orders for continuation of current antibiotic, or new antibiotic received. Physician did not provide new treatment orders. Resident's toe remains very painful when touched. Review of the resident's May 2024 TAR showed staff documented wound care completed on 05/26/24 and 05/27/24. Review of the resident's progress notes showed the following information: -On 05/28/24, resident was seen by wound care clinic. A wound culture was obtained and the facility will receive the results after the wound care clinic evaluates them. Resident will be seen every Tuesday by wound care clinic. Clinic provider ordered new treatment of cleanse with hypochlorous acid (a chlorine oxoacid with formula HOCl, a weak and unstable acid, it is the active form of chlorine in water), pat dry, apply Santyl to wound bed, apply calcium alginate, cover with gauze and secure with tape. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound care clinic provider's Wound Assessment Report, dated 05/28/24, showed the following information: -Per resident and LPN I, wound initially appeared as intact pink tissue as a result of wearing ill fitting shoes while ambulating. Resident was seen by podiatry on 05/07/24 and wound was cleansed and covered. Facility nurse said the staff were not aware of a wound and did not receive podiatry notes until several days later. By 05/16/24, the wound was full thickness; -The ulcer has mixed etiology including pressure and diabetic; -Wound measurements show 1.3 cm x 1.4 cm x 0.2 cm; -[NAME] grade three ([NAME] scale is a widely accepted wound classification system that assesses the severity of diabetic foot ulcers) indicating full thickness with infection. Wound may have cellulitis (infection in the skin), abscess (pocket of puss) formation, presence of infected tissue, and/or osteomyelitis (inflammation of the bone caused by infection); -New orders provided to cleanse wound with hypochlorous acid, apply Santyl nickel thick to entire wound bed, apply calcium alginate to wound bed, cover with bordered gauze, and change daily; -Wound culture obtained. Review of the resident's May 2024 POS and May 2024 TAR showed staff did not not add the new orders from the wound clinic that included the hypochlorous acid. Review of the resident's May 2024 TAR showed staff documented the wound care order from 05/17/24 was completed 05/29/24 though 05/31/24. Review of the resident's progress notes showed the following information: -On 05/31/24, the physician ordered linzelid (an antibiotic used to treat bacterial infections); -On 06/01/24, resident started antibiotic therapy monitoring for Bactrim DS (a combination of two antibiotics that's used to treat a wide variety of infections) and gentamicin (an antibiotic used to treat bacterial infections). -On 06/02/24, the wound remained red, painful to touch, drained, and had a white center; -On 06/03/24, the toe remained extremely red; -On 06/04/24, the toe remained extremely red. Review of the resident's wound care clinic Assessment Report, dated 06/04/24, showed the following information: -Wound healing had stopped and decision to start oral antibiotics made. Education provided regarding dressings and proper offloading; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Rounded with LPN I, new tendon exposed to wound, peri-wound continues to appear red and swollen, but slightly improved from last week. Provider wanted to perform debridement, but resident was not medicated prior to visit; -New orders for left foot X-ray to rule out any underlying issues due to new exposed underlying tissue. Also recommend arterial ultrasound and ABI's (ankle brachial test, used to identify peripheral artery disease (a condition of narrow arteries that reduces blood flow to the limbs)) to left lower extremity, as resident wound benefit from compression therapy. Culture results reviewed from 05/28/24 visit and Bactrim DS and gentamycin cream ordered for seven days. Review of the resident's progress notes showed the following information: -On 06/06/24, the resident remained on antibiotics; -On 06/07/24, the toe remained red and the wound bed still had some slough; -On 06/08/24, some maceration to the wound with remaining tenderness and redness; -On 06/09/24, showed the toe remained tender. Review of wound care clinic Wound Assessment Report, dated 06/11/24, showed the following information: -Provider rounded with LPN I. LPN I said he/she had not yet scheduled imaging that was ordered last week, but will on this date. Resident continued to have exposed tendon and devitalized (dead) tissue to wound bed. Firm edema (swelling) to both legs. Provider wanted to perform debridement, but resident was not medicated prior to visit. Recommended changing primary dressing to hydroferra blue (moist dressing that manages exudates and provides antibacterial protection) and will decrease treatment to every other day. Educated nurse and resident on updated treatment plan. Reinforced teaching on use of grip socks and the need for elevation. Review of the resident's progress notes showed the following information: -On 06/12/24, the toe remains red and tender; -On 06/13/24, redness continued to be present. Review of the resident's POS showed staff did not transcribe the new order for hydoferra blue and reduction in treatment. Review of the resident's x-ray results, dated 06/12/24, showed the following information: -Bony erosion (loss of bone from disease process) and haziness of fat planes with patchy sclerosis (inflammatory cells seen infiltrating tissues with patches of tissue hardening) seen along distal phalanx(bone at the end) of second metatarsal (toe) with soft tissue swelling likely representing osteomyelitis (infection of the bone). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/12/24, at 12:29 P.M., showed Registered Nurse (RN) D and NA A in the shower room with the resident. The resident sat in the shower chair with a blanket covering him/her. RN D said the wound care company had changed the treatment for the resident's toe, but was not sure if the facility had gotten the supplies yet. RN D's assessment of the wound showed a deep purple peri-wound. Wound appeared to be slough tissue. LPN B entered the shower room and performed the treatment including gentamycin. The new ordered treatment was not performed. RN D said to LPN B that the treatment was changed to hydroferra blue. LPN B said he/she was not aware. Review of the resident's progress note, dated 06/13/24, showed the provider came earlier in the evening for X-rays of left foot. Findings included osteomyelitis. Staff faxed the results to the resident's primary care provider. During interviews on 06/12/24, at 2:35 P.M. and 4:26 P.M., LPN I said the following: -Resident had been walking with therapy since the end of April and his/her shoes were believed to have been causing pressure to the toe; -The podiatrist saw the resident on 05/07/24 and had placed a corn cushion on the area. The podiatrist did not make the facility aware of a wound. He/She found out by RN D reporting it to him/her the wound to her around 05/14/24; -He/she went and assessed it and the physician started the resident on Levaquin on 05/14/24; -The physician has told the staff to do whatever they thought would be good, as far as treatment; -LPN B also reported it to her. LPN B said the resident had a red area a few days prior RN D reporting it. When LPN B reported it to him/her, he/she did go assess it. It was red and was entirely slough, no odor, and had drainage present. Nothing was on the wound at that time. The nurses did clean it and he/she thought they covered it, but they weren't successful at getting the physician for orders at the time; -No treatment was initiated until RN D made his/her report; -Wounds are his/her responsibility, so he/she should have contacted the physician him/herself, but sometimes the staff nurses do it; -He/she rounds with the wound care clinic and is aware of new orders right then. He/She is responsible for putting new orders in, but sometimes puts them in a little bit later. This is because he/she doesn't want to enter the orders until the medication has arrived; -He/she had not put the new order for hydroferra blue in because they don't have the hydroferra blue yet. Santyl and calcium alginate should be the current order and the gentamycin should be over with by now; -He/She was aware of having some trouble getting Santyl from the pharmacy and it looks like it's been discontinued by LPN B, but that's what the staff should be doing; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She said the facility also did not order the coban, because he/she didn't think it was needed since the resident is so swollen. During an interview on 06/12/24, at 5:15 P.M., LPN I said she told LPN B to discontinue to Santyl because insurance wouldn't cover it. He/She said he/she put the gentamycin order in and it was ordered when the Bactrim was ordered. They both were ordered based off the wound culture results, but isn't sure when the gentamycin should have been discontinued. He/She is not sure if it was supposed to be layered with Santyl or what exactly they should be doing. During an interview on 06/13/24, at 9:30 A.M., LPN I said he/she asked for clarification on the gentamycin. It was ordered for seven days, so should be discontinued and the staff should be using Santyl. He/she needed to update the orders. During an interview on 06/12/24, at 12:31 P.M., LPN B said the following: -When an aide sees a new skin concern, they should report it to the nurses. The nurses should assess the wound; -After assessing the wound, the nurses take that information to LPN I and staff then discuss appropriate treatment. Staff also determine rather there should be a referral for the wound care clinic; -Staff then initiate treatment instantly and the resident's physician gets notified; -He/she assumed the resident's wound was caused by pressure; -LPN B originally said the wound was found around 05/12/24, but recalled that NA A had found it in the shower and reported it to him/her. That should be documented on a skin assessment. On that day, 05/07/24, the podiatrist was coming, so LPN B told NA A that and they would go from there; -After the podiatrist saw the resident, it was seen that he had put a little sponge on the wound; -LPN B did not go assess the wound; -He/she assumed LPN I had received new orders. He/she was not sure when LPN I got the reports from the podiatrist, but the podiatrist didn't say anything to anyone about his/her assessment; -On that weekend, 05/11/24, the therapy staff told LPN B about a band-aid on the resident's toe. He/she went to assess it and it was open with slough at that time. LPN B then discussed it with the medical record staff and determined treatment, wound care clinic referral, notified the physician, and initiated treatment. He/she put in a skin note was done that very day; -The nurses decide what course of treatment to take and then the physician usually writes it off if he/she thinks it's good; -LPN I does the weekly monitoring and measurements of the wounds. During an interview on 06/12/24, at 4:16 P.M., LPN B said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN I rounds with the wound care clinic and received those reports; -If there are new orders, LPN I should input that; -The floor nurses aren't aware of what treatment to do unless LPN I puts it into the system. He/She sometimes doesn't put the order in until the supplies come in though; -The physician is okay with staff starting a simple treatment before getting a hold of him/her; -He/She did not do a skin note because he/she is not allowed to stage it. He/she made LPN I aware, the following Monday 05/14/24. During an interview on 06/12/24, at 5:12 P.M., LPN B said LPN I told him/her to discontinue to Santyl due to insurance not paying for it. They did have Santyl for the resident at a time, but have been out for a while. During an interview on 06/14/24, at 9:35 A.M., RN D said he/she believes the gentamycin order had been discontinued for the resident. He/she believed he/she was supposed to use Santyl and calcium alginate daily. He/she was not sure if the physician order sheet reflected that currently. During an interview on 06/14/24, at 9:51 A.M., the resident's Primary Care Provider said he has known the resident for [AGE] years and had previously treated the resident with an infected finger wound. He/she saw the resident at the end of April 2024 and there was no wound there at that time. The facility staff reach him by fax/email/telephone. He couldn't recall the specifics as to when the facility contacted him or what they said regarding the wound or recommended treatment. He said there are no standing orders for wound care. All orders should be individualized. Not notifying him about the wound could cause an infection, however he places that blame on the podiatrist as that was that physician's responsibility to initiate care. His expectation of the staff if a new skin concern is report it to him immediately and assess the wound. He also expects any other physicians involved in the resident's care to call/fax him as well. He believes that staff should have followed up with the resident and podiatrist within two to three days if the wound did not look better post debridement. The staff should also have had the wound covered the entire time. He does not believe that treating with wound treatments and/or antibiotics sooner could of prevented the infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/14/24, at 10:06 A.M., the resident's Podiatrist said he is a mobile podiatrist and the first time he came to the facility was 05/07/24. At that time the resident was on his list to be seen. While assessing him/her he saw an area of eschar on his/her left second toe. The resident was a high risk due to his/her decreased circulation and edema. He/She had a contracted hammertoe (a curled toe due to a bend in the middle of the toe joint) on the same toe which he believed pressure such as a shoe rubbing against that could have caused the wound. He debrided the area of eschar and seen the wound underneath. There were no signs of infection at this time. After debridement, he applied antibiotic cream, and covered the area with gauze as well as an offloading bandage. He talked with the resident and discussed with him/her to continue to wearing sandals verses shoes, as the shoes were causing a great deal of pressure to his/her toe. He also discussed his wound care orders and recommendations (vascular studies, keep wound covered, and get with physician in a timely manner) with the staff at the facility. He could not recall the staff members name, but believes the contact person is the social services. After that, he also sent a fax to the facility. The facility reported to him there was an issue in receiving the initial fax and requested a second fax on 05/14/24. During an interview on 06/14/24, at 10:53 A.M., the Wound Care Clinic Nurse Practitioner said he/she first saw the resident on 05/28/24. At that time, he/she cultured the wound him/herself as it looked infected. On 5/29/24, he/she reported to LPN I that she ordered linzeloid. On 5/31/23, the facility reached out to her and told her that the resident was private pay and could not afford the linzeloid and at that time he/she ordered Bactrim DS. On 06/03/24, the facility got a hold of him/her to clarify the Bactrim dosage and frequency as they were not giving it correctly. They were giving one-tab verses two. He/She also ordered gentamycin at the same time as Bactrim. The facility did not implement the gentamycin. He/she knows this because on his/her 06/04/24 visit, LPN I told her it hadn't been put in the system yet. He/She said she stressed the importance of following orders. Santyl was never discontinued, they were supposed to layer the Santyl and gentamycin. He/She also ordered arterial ultrasounds, ABI's and none of those had been ordered by that time either. LPN I again told her she just hadn't gotten around to putting the orders again. He/She again stressed the importance of following through with orders. During an interview on 06/14/24, at 11:26 A.M., the Director of Nursing (DON) said when a new skin concern is found, it should be reported to the nurse, assessed, and the physician should be contacted for treatment. Orders should be entered and followed through with immediately. She was not aware that the wound was found and reported seven days prior to treatment initiation. During an interview on 06/14/24, at 1:24 P.M., the Administrator said if a staff member noticed something with a resident's skin, that staff should report it directly to the nurse. The nurse should go down to the resident and do an assessment, enter findings into the computer, initiate a treatment, and contact the physician. When the nurse puts that note in, it will also let LPN I know, as he/she oversees all the wounds. Nurses know they are not to change a treatment, except LPN I. LPN I was supposed to enter all orders from the wound care clinic and any orders for diagnostics or labs. Any orders should be followed through with immediately. She was not aware that the wound was found and reported seven days prior to treatment initiation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50185 Based on observation, interview, and record review, the facility failed to ensure an environment as free of accident hazards as possible when staff transferred one resident (Resident #39), who was non-weight bearing, with a gait belt. The facility census was 45. Review showed the facility did not provide a policy regarding transferring residents, gait belt use, or mechanical lift use. Review of the American Nurse Journal, titled Gait Belts 101, dated 05/03/19, showed the following information: -Before using a gait belt, conduct a mobility assessment which includes four elements - cognition, strength, balance, and endurance. If the patient passes to mobility test, still address any concern that a knee might buckle, a patient could become dizzy, or something could go wrong; -After the belt is properly secured, ensure that the patient's feet are placed flat on the floor (no dangling feet); -Be passive and careful not to grab the gait belt to pull the patient up to stand. A gait belt is used to steady a patient and is not a lifting device; -Always use an underhand grip on the gait belt; -Hand positioning for hands on assistance includes one hand on the gait belt in the front and one hand on the gait belt in the back. 1. Review of Resident #39's face sheet (a resident's information at a glance) showed the following information: -admitted [DATE]; -Diagnoses included protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function), stiffness of unspecified shoulder, and thrombocytopenia (condition in which there is a lower than normal number of platelets in the blood). Review of the resident's quarterly Minimum Data Set (MDS - federally mandated assessment tool completed by facility staff), dated 04/04/24, showed the following information: -Severe cognitive impairment; -Dependent on staff for toileting, showering, dressing, personal hygiene, and mobility. Review of the resident's care plan, revised 10/05/23, showed the following formation: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required total assistance with activities of daily living (ADL's -fundamental skills required to independently care for oneself, such as eating, bathing, and mobility); -Required assistance of one staff for transfers, but required one to two for toileting; -Required body repositioning to assist in minimizing skin break down; -Required total assist of all ADL's by one to two staff members. Left sided weakness to upper extremities and wore a sling on that shoulder/arm; -Provide night cares with two staff. Review of the resident's clinical health review, dated 03/31/24, showed the following information: -Total dependence on staff for transfers; -Total mechanical lift for transfers; -Not able to consistently bear weight on at least one leg; -Other considerations for mechanical lift use are as follows, history of falls, very fragile skin, and fractures. Review of the resident's progress note, dated 04/02/24, showed the resident required the use of a mechanical lift for transfers. Review of the resident's care plan, revised 10/05/23, showed staff did not update the care plan to show use of the mechanical lift. Observation on 06/10/24, at 2:46 PM., showed Certified Nursing Assistant (CNA) F and CNA G entered the resident's room. The resident sat in his/her wheelchair while both aides placed a gait belt around the resident and fastened it. CNA G pushed the wheelchair to the side of the bed next to the resident. CNA F stood on one side of the resident, held onto the gait belt, and put his/her arm under the resident's shoulder. CNA G stood on the other side of the resident, held onto the gait belt, and put his/her arm under the resident's shoulder. The CNAs lifted the resident out of the wheelchair and his/her legs were hanging in the air, not bearing any weight. Both aides pivoted resident to the side of the bed and lowered him/her onto the bed. CNA F removed the gait belt from the resident and supported the resident's back, while CNA G obtained the resident's legs and swung them into the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/11/24, at 12:56 P.M., showed Nursing Assistant (NA) A and Registered Nurse (RN) D entered the resident's room. The resident sat in his/her wheelchair. RN D removed resident's glasses and footrests from the wheelchair. NA A placed and fastened a gait belt around the resident. NA A stood on one side of the resident, held onto the gait belt, and under the resident's shoulder. RN D stood to the other side of the resident, held onto the gait belt and under the resident's shoulder. The NA and RN lifted the resident out of the wheelchair with the resident's lower extremities hanging with knees bent. The resident did not touch the ground with any pressure. Both staff pivoted resident to the side of the bed and NA A pulled down the resident's slacks. Both staff lifted the resident into the bed and lowered him/her onto the bed. RN D removed gait belt from the resident and supported the resident's upper body, while NA A obtained the resident's legs and swung them into the bed. During an interview on 06/12/24, at 10:03 A.M., NA A said the resident is a one-to-two-person pivot transfer. This information is shown to the aides on the Kardex. The Kardex is shown on the computer charting system and it includes all information regarding the residents. He/she believes the resident was transferred with a mechanical lift at one time because of his/her fragile skin, but the resident didn't like the mechanical lift, so it is back to one-to-two staff transfer. Transfer status is decided during care plan meetings and the Administrator updates that status within the computer system. During an interview on 06/12/24, at 12:31 P.M., LPN B said the aides are aware of how to transfer residents by looking at the Kardex, which is found within their computer charting system. The MDS nurse is who is responsible for updating the Kardex. The resident is usually a two-person transfer. LPN B looked in the computer system and said that it shows the resident as a one-person transfer with a gait belt. He/she believes at this time the resident should be a mechanical lift. When a resident is no longer able to bear weight, such as this resident, they should be made a mechanical lift. During an interview on 06/14/24, at 11:26 P.M., the Director of Nursing (DON) said If the resident cannot bear weight, it would not be safe to transfer with gait belt and one or two people. If they cannot bear any weight a gait belt is not going to help, they are going to fall. If they can bear weight on at least one leg, they can continue to be a gait belt transfer. She is unsure of how the resident is currently being transferred, but if the resident cannot bear any weight, staff would not want to put him/her in harm's way. She does not believe the resident can bear any weight at this time. During an interview on 06/24/24, at 1:24 P.M., the Administrator said the aides are aware of how to transfer residents by looking at the Kardex, that information comes directly from the resident's care plan. If the resident is unable to bear weight, follow simple commands, and communicate the way they usually communicate, they would need to be a mechanical lift. The resident is typically a one person, gait belt transfer. However, this past week indicates he/she needs to be a mechanical lift since staff cannot lift dead weight with a gait belt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
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** 50185 Based on observation, interview, and record review, the facility failed to ensure proper assessment and documentation was completed before side rail use when staff used side rails for two residents (Resident #39 and #40) who has been assessed as not appropriate for side rail use and when staff failed to document risk versus benefit review, failed to obtain informed consent for use, failed to care plan side use, failed to obtain physician orders for the use of side rails, and failed to complete measurements to reduce risk of entrapment for two residents (Resident #10 and #29). The facility census was 45. Review showed the facility did not have a policy regarding side rail/grab bar use that were not restraints. 1. Review of Resident #39's face sheet (resident's information at first glance) showed the following information: -admitted [DATE]; -Diagnoses included anemia (red blood cell deficiency), high blood pressure, kidney failure, and malnutrition. Review of the resident's quarterly Minimum Data Set (MDS - federally mandated assessment instrument completed by facility staff), dated 04/04/24, showed the following information: -Severe cognitive impairment; -Dependent on staff for toileting, showering, dressing, personal hygiene, and mobility. Observations showed the following: -On 06/10/24, at 11:15 A.M., the resident was in bed with the grab bar on the side of the bed in the upright position; -On 06/10/24, at 2:46 P.M., the resident transferred into his/her bed with two staff assist. The grab bar was in upright position on the side of the bed; -On 06/11/24, at 12:56 P.M., the resident transferred into his/her bed with two staff assist. The grab bar was in upright position the side of the bed; -On 06/11/24, at 3:57 P.M., the resident lay in his/her bed, call light on top of the resident, head of bed elevated, and grab bar in upright position on the side of the bed; -On 06/12/24, at 8:59 A.M., the resident was in his/her bed with the grab bar in upright position on the side of bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, last revised 10/05/23, showed the following: -Required total assistance with activities of daily living (ADL's -fundamental skills required to independently care for oneself, such as eating, bathing, and mobility). (Staff did not are plan regarding grab bar use.) Review of the resident's clinical health review, dated 03/31/24, showed based on assessment, side rails, grab, or transfer bars will not be utilized at this time. Review of the Maintenance Director's gap measurement binder showed staff did not document use of the resident's grab bar or measurements for the resident's grab bar. During an interview on 06/13/24, at 11:55 A.M., Licensed Practical Nurse (LPN) C said he/she looked in the resident's chart and was unable to find any grab bar use documentation for the resident. 2. Review of Resident #40's face sheet showed the following information: -admitted [DATE]; -Diagnoses included urinary tract infection, high blood pressure, diabetes, and muscle weakness. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Cognitively intact; -Required partial to moderate assistance for mobility. Observation and interview on 06/11/24, at 11:09 A.M., showed the resident sat in wheelchair beside his/her bed. A grab bar was in an upright position on the side of the bed The resident said the therapy department put it on his/her bed. He/she did not have to sign anything for it. At first, he/she thought the staff were trying to keep him/her in the bed, but later discovered it helps with mobility. Observation on 06/12/24, at 9:02 A.M., showed the resident sat in the wheelchair in his/her room. A grab bar was in the upright position on the side of the bed. Observations on 06/12/24, at 11:32 A.M., showed the resident sat in the wheelchair in his/her room, awaiting a shower. A grab bar was in the upright position on the side of the bed. Review of the resident's care plan, revised on 01/27/24, showed the following information: -Required staff assistance with ADL's; (Staff did not care care plan the use of the grab bar.) Review of the resident's clinical health review, dated 01/27/24, showed based on assessment, side rails, grab or transfer bars will not be utilized at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Maintenance Director's gap measurement binder showed staff did not document use of the resident's grab bar or measurements for the resident's grab bar. During an interview on 06/13/24, at 11:55 A.M., LPN C said he/she looked in the resident's chart and was unable to find any grab bar use documentation for the resident. 41787 3. Review of Resident #10's face sheet showed the following information: -admitted date of 02/22/24; -Diagnoses included hemiplegia and hemiparesis (paralysis of one side of the body) following cerebrovascular disease (stroke) affecting left non-dominant side, Parkinsons (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and post traumatic stress disorder (PTSD - disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Review of resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Use of electric wheelchair for mobility. During an interview and observation on 06/11/24, at 1:45 P.M., a one-quarter side rail was in the upright position on the the side of the resident's bed. The resident was seated in his/her electric wheelchair in his/her room. He/she said that he/she used the side rail to assist with mobility when in the bed. Review of the resident's care plan, reviewed 06/03/24, showed the following: -Required staff assistance with ADL's related to physical limitations; -Left sided hemiparesis; -Resident at risk for falls and injury related to left sided weakness. (Staff did not care plan related the resident's side rail use.) . Review of the resident's physician order sheet, current as of 06/14/24, showed no order for the use of side rails. Review of the resident's medical record showed no consent of risk and benefits, side rail risk assessment, or bed rail safety measurements documented. 4. Review of Resident #29's face sheet showed the following information: -admitted [DATE]; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), fibromyalgia (chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), and repeated falls. Review of the resident's significant change of status MDS, dated [DATE], showed the following: -Cognitively intact; -Use of wheelchair for mobility; -Dependent on staff for toileting hygiene, showering, dressing, personal hygiene. Observations and interview on 06/10/24, at 10:13 A.M., showed the resident had bilateral side rails present on his/her bed. The resident said he/she used the bilateral side rails for mobility in bed and assist with transfers. Observation on 06/12/24, at 9:30 A.M., showed bilateral side rails in the upright position on the resident's bed. The resident was in his/her wheelchair in the room. Review of the resident's care plan, reviewed 05/25/24, showed the following: -Resident at risk for falls and injury related to history of falls; -Resident required staff assistance with ADL's related to physical limitations; -Resident will have a transfer bar; -Resident will use the transfer bar to transfer; -Resident will use the transfer bar to get up and down; -Staff should encourage resident to use assistive devices. Review of the resident's physician order sheet, current as of 06/14/24, showed no order for side rail use. Review of the resident's medical record showed no consent of risk and benefits, side rail risk assessment, or bed rail safety measurements documented. 5. During an interview on 06/12/24, at 9:00 A.M., the Maintenance Director said the nursing staff make him aware of any grab bars that need to be installed. After he installs them, he completes the safety measurements and keeps that information in a binder. 6. During an interview on 06/12/24, at 10:03 A.M., Nursing Assistant (NA) A said he/she did not know what the steps are that required for a resident to have a grab bar. He/she is not sure if a consent form is required, or any type of assessment. He/she said they are used for mobility. He/she believes maintenance installs them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During interviews on 06/12/24, at 12:31 P.M. and at 4:16 P.M., LPN B said grab bars have to have an assessment completed. After the assessment is completed and showed the grab bar would be used for mobile residents, they are installed by the maintenance department. He/she is unsure if there is any monitoring system in place. He/she has never seen a consent form being completed or needing to be completed for any type of grab bar. The therapy department is who completes measurements on the bars, and they do so every three months. 8. During an interview on 06/13/24, at 11:55 A.M., LPN C said residents get grab bars for mobility. The nurses are to complete an assessment in their computer charting system, titled side rail assessment. There needs to be a physician order obtained. He/she is not sure if consents are supposed to be completed. Maintenance does all the measurements and installs the rails. Grab bar use should be documented in the resident's care plan as well as in an assessment within their computer charting system titled clinical health review. 9. During an interview on 06/14/24, at 11:26 A.M., the Interim Director of Nursing (DON) said she was not aware of the process for a resident to use grab bars. She is unsure if any assessment, consent, or monitoring should be completed. The maintenance department should have to measure the bars. 10. During an interview on 06/14/24, at 1:24 P.M., the Administrator said grab bar use should be discussed with the DON and should be used for mobility. The maintenance department will measure them initially and frequently to make sure they are safe. A pre-assessment should be completed, but she is unsure if consents should be.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
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. 41787 Based on interview and record review, the facility failed to ensure three nurse aides (NA) (NA A, NA H, NA J) of six sampled NAs, completed a certified nurse aide (CNA) training program within four months of employment in the facility. The facility census was 45. Review showed the facility did not provide a policy regarding nurse aide certification or training. 1. Review of NA H personnel file showed the following: -Date of hire on 09/07/23; -No documentation NA H had completed the nurse aide training program. During an interview on 06/13/24, at 9:50 A.M., NA H said that he/she was hired in September 2023. He/she was unsure when he/she had started the CNA classes online. He/she said that he/she had almost completed the online classes. 2. Review of NA J personnel file showed the following: -Date of hire on 09/11/23; -No documentation NA J had completed the nurse aide training program. During an interview on 06/12/24, at 2:10 P.M., Licensed Practical Nurse (LPN) I said NA J had taken his/her test last week with results pending. 3. Review of NA A personnel file showed the following: -Date of hire on 10/19/23; -No documentation NA A had completed the nurse aide training program. During an interview on 06/12/24, at 2:10 P.M., LPN I said NA A started class in May 2024, but there was some technical issues and they had to reset his/her online classes. 4. During an interview on 06/12/24, at 2:10 P.M., LPN I said that training is at the staff persons own pace and they are told to be ready to test by day 89. All aides were in online classes. He/she was the clinical training supervisor and all classes were completed online. 5. During an interview on 06/14/24, at 10:50 A.M., the Director of Nursing (DON) said she had been in the DON position about two months. Nurse aide training should be done within 4 months of hire. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 06/12/24, at 2:25 P.M., the Administrator said the staff were hired as NA and worked as a NA onsite. Staff should be certified within four months of hire. She was aware that the facility was out of the window with these staff. There was not a policy on NA training to CNA, the facility followed state guidelines. MO00237558 MO00237588

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on interview and record review, the facility failed to have a process in place to ensure pharmacist recommendations were follow-up and implemented if approved by the physician, when the facility failed to to adjust one resident's (Resident #23) medication as recommended by the pharmacist and agreed to by the physician. The facility census was 45. Review showed the facility did not provide a policy or procedure regarding following physician orders for pharmacist recommendations. 1. Review of Resident #23's face sheet showed the following information: -admitted [DATE]; -Diagnoses included left sided hemiplegia (paralysis of one side of the body), dementia, diabetes, and heart failure. Review of the resident's care plan, revised on 09/01/23, showed the following information: -Resident takes medications that have a Black Box Warning, (a serious warning from the FDA that appears on the labeling of certain prescription medications that have major risks associated with the drug) or have nursing considerations that need to be monitored; -High risk for potentially higher risk adverse reactions; -Pharmacy/physician/psychiatrist to review medications per protocol and as needed. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 02/29/24, showed the following information: -Severe cognitive impairment; -No gradual dose reductions completed due to resident not being on any antipsychotics. Review of the resident's pharmacy consultant's recommendation, dated 05/27/24, showed the following: -The resident received Namenda (medication used to treat moderate to severe dementia) 5 milligrams (mg) at bedtime. The maintenance dose of Namenda, after titration is 10 mg, by mouth twice daily; -If it is clinically appropriate, please titrate to 5 milligrams twice daily for seven days; -Then titrate to 10 milligrams in the morning, and 5 milligrams at night; -Then titrate to 10 milligrams twice a day; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A check mark by the agreed box and signed by the resident's physician. Review of the resident's physician order sheet, dated 06/14/24, showed the following order: -An order, dated 02/27/24, for Namenda 5 mg by mouth at bedtime; -No titration attempts documented in physician order sheet. During an interview on 06/14/24, at 12:35 P.M., Registered Nurse (RN) D said he/she sometimes receives orders via fax in nurses' station. Whoever sees the order come through, is who is supposed to enter the order. Orders should be entered in a timely manner, not several days later. Sometimes it is hard to know who is taking off the orders as the faxes come to multiple machines. The was no process of follow-up on pharmacy recommendations. During an interview on 06/14/24, at 10:50 A.M., the Director of Nursing (DON) said it is ultimately Licensed Practical Nurse (LPN) I's responsibility to ensure orders are taken off. She is unsure why the titration was never completed. The was no process of follow-up on pharmacy recommendations. During an interview on 06/14/24, at 1:24 P.M., the Administrator said if staff received any type of new order, they should go ahead and put those orders into the computer system. After that, it should be given to LPN I for review. LPN I should be reviewing new orders within 24 hours. New orders are reviewed in their clinical excellence meeting every morning. If LPN I is the one receiving the orders, he/she makes a copy for the nurses, and they can follow up as needed. She would expect the nurses take off orders daily, but she has had some trouble with nurses not following through with orders. If something gets missed its because someone didn't do something correctly. The was no process of follow-up on pharmacy recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on interview and record review, the facility staff failed to employ a qualified dietary manager for food and nutrition services with accredited education in food service management. The facility census was 45. Review showed the facility did not provide written policy regarding the certification requirements of the dietary manager. 1. Review of the facility's new hire list, generated on [DATE], showed the Dietary Manager (DM) was hired on [DATE]. Review showed the facility did not provide documentation of the DM's training, experience, or qualifications that met the required certification requirements for the DM position. During an interview on [DATE], at 12:05 P.M., the DM said he/she had six years of experience in cooking and ten years experience as a food industry manager. The DM said he/she had started an online dietary certification program in [DATE], but had not yet completed the course. During an interview on [DATE], at 9:20 A.M., the Administrator said they received verbal verification of the DM's work experience. However, the DM's training and certification was in another state and had expired when he/she was hired at this facility. The facility did not have documentation of sufficient training or current certification. The DM had not completed the online dietary certification course he/she started in [DATE], but must complete the course in order to be certified per regulations. MO00237558 MO00237588

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 31464 Based on interview, and record review, the facility failed to follow approved menus to ensure the nutritional needs of all residents were met when staff did not provide the approved pureed meals to two residents (Residents #24 and #95) and substituted nonequivalent items. The facility census was 45. Review showed the facility did not provide a policy regarding pureed diets. 1. Review of diet cards showed Residents #24 and #95 required puree textured diets. Review of the Pureed menu, for 06/13/24, showed the following: -Pureed honey glazed pork loin; -Pureed roasted sweet potatoes; -Pureed crunchy cabbage bake; -Pureed Gooey Butter Bar; -Pureed buttered dinner roll. During an interview on 06/13/24, at 11:00 A.M., the Dietary Manager (DM) said he/she did not know how to puree cabbage, so they were substituting with cottage cheese. During an interview on 06/14/24, at 12:20 P.M., Dietary Aide AA said the DM told him/her to substitute yogurt for the side salad, which would not puree appropriately. During an interview on 06/18/24, at 11:38 A.M., Registered Dietician (RD) Z said the dietary staff should follow the approved menu, substituting like-kind menu items if necessary or to try to match a resident's likes/dislikes. A protein, like cottage cheese or yogurt, should not be substituted for a vegetable. The RD agreed that a side salad would not work well pureed, so they should substitute with a different vegetable. During an interview on 06/14/24, at 10:53 A.M., the Director of Nursing (DON) said dietary staff should follow the prescribed menu as approved by the Registered Dietician (RD). The dietary staff should also follow each resident's menu/diet card regarding food consistency, allergies, and likes/dislikes. During an interview on 06/14/24, at 1:24 P.M., the Administrator said dietary staff should be following the menus, unless they have to do a substitution for some reason, then a nutrient equivalent food item might be substituted. The puree menu should be followed as well. Staff should not substitute a vegetable with cottage cheese or yogurt, as that is not equivalent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00237558 MO00237588 MO00237628 41787

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 31464 Based on observation, interview, and record review, the facility failed to ensure suitable, nourishing snack alternatives were available and provided to residents outside of schedule mean services for diabetic residents. The facility census was 45. 1. Review of facility records showed there were 13 diabetic resident at the facility. Observation on 06/17/24, at 8:20 P.M., showed a tray on a shelf in the nurses' station containing multiple pre-packaged cookies and other sweet or salty snacks and a coffee carafe with assorted creamers/sugars. During the observation, Licensed Practical Nurse (LPN) L said the dietary staff usually put a few sandwiches on the tray when they bring it to the station at 7:00 P.M. nightly, but the sandwiches always went fast and none were left at that time. None of the present snacks were considered protein by the nurse. The evening shift and night shift staff did not have access to the kitchen or other food items after 7:00 P.M. During an interview on 06/17/24, at 9:00 P.M., Resident #20 said he/she was diabetic. The resident said they do not provide enough non-sugary evening snacks for diabetics. Most of the snacks are sugary. There are rarely any sandwiches left in the evening if he/she wants one. During an interview on 06/18/24, at 11:10 A.M., the DM said that dietary staff provided approximately three sandwiches (peanut butter and jelly) in the evening to be used for diabetics at night if their blood sugar went low. They provided about 40 other snacks, such as brownies, fig bars, and oatmeal pie cakes. No staff had access to food after the kitchen closed at 6:30 P.M. There was no refrigerator available to non-kitchen staff to keep meat and cheese sandwiches as an evening snack. There was no food available through the night for any residents otherwise. During an interview on 06/18/24, at 11:38 A.M., Registered Dietician (RD) Z said appropriate snacks should be offered to residents at least three times daily; between breakfast and lunch, between lunch and dinner, and in the evening. Although they have the right to refuse and choose something sugary, diabetic residents should be first offered fruit or a protein snack such as cheese/crackers, a meat or peanut butter sandwich, or yogurt. During an interview on 06/14/24, at 1:24 P.M., the Administrator said that before they leave at 7:00 P.M., the kitchen staff puts coffee at the nursing station with a tray of snacks to pass in the evenings. This included sandwiches (peanut butter/jelly and bologna) and a variety of snacks. MO00237558 MO00237588 MO00237628

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on observation, interview, and record review, the facility failed to maintain a complete infection prevention and control program when the facility failed to implement the policy regarding enhanced barrier precautions (EBP-precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO-microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) and failed to train staff on EBP. Staff failed to practice proper hand hygiene to prevent possible infection when completing wound care for two residents (Resident #30 and #40). The facility census was 45. 1. Review of the CDC's Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms, dated 07/12/22, showed the following: Review of the facility's table titled Summary of Personal Protective Equipment (PPE) use and Room Restriction for Residents in Nursing Homes, undated, showed the following: -Staff should use EBP for all residents with any of the following: -Infection or colonization with a multi-drug resistant organism (MDRO - bacteria that resist treatment with more than one antibiotic) when contact precautions do not otherwise apply; -Wound and/or indwelling medical devices (example: urinary catheter (A sterile tube inserted into the bladder to drain urine) central line (intravenous (IV) much longer than a regular IV, goes all the way up to a vein near the heart or just inside the heart), feeding tube (medical device used to provide nutrition to people who cannot obtain nutrition by mouth or are unable to swallow safely)) regardless of MDRO colonization status: -Staff should wear gloves and gown prior to high contact care activity; -Staff should change PPE before caring for another resident; -High contact activities included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care such as urinary catheter, wound care of any skin opening requiring a dressing. During an interview on 06/13/24, at 3:00 P.M., Certified Medication Technician (CMT) K said he/she was not aware of the need to wear a gown when completing catheter cares. During an interview on 06/14/24, at 9:35 A.M., Registered Nurse (D) said he/she was unsure if staff should be gowned for catheter care. He/She was unsure if staff should be gowned for wound care unless there is an infection present. During an interview on 06/14/24, at 10:50 A.M., the Director of Nursing (DON) said there had been some recent training of EBP. EBP was not something that staff had been doing for residents with catheters or chronic wounds unless there was a lab confirmation of a positive organism on culture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/14/24, at 1:24 P.M., the Administrator said they had heard of EBP, but were struggling with this a little. If a resident had a bacterial infection, staff had to wear gowns and gloves when providing any care or changing the wound dressing. There was company wide training about two months ago to discuss the regulation change. 41787 2. Review of the facility policy titled Hand Hygiene, dated May 2017, showed the following: -The purpose of the policy was to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases (spread from one person to another through a variety of ways) and infections; -Staff to complete hand hygiene before and after direct resident care; before and after handling food; after handling of bodily fluids; after handling soiled linens; between glove changes during care or procedures; and upon beginning work, before and after breaks, and end of shift; -When hands were not visibly dirty, alcohol-based hand sanitizers were the preferred method for cleaning hands; -Soap and water recommended when hands are visibly dirty; after exposure to Clostridium difficile (C-Diff - bacteria causing diarrhea); and after exposure to patients with infectious diarrhea. Review the facility's did not provide a policy or procedures regarding wound care. 3. Review of Resident #30's face sheet showed the following information: -admitted [DATE]; -Diagnoses included bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), severe protein calorie malnutrition (a wasting condition resulting from a diet inadequate in either protein or calories or both), depression (constant feeling of sadness and loss of interest, which stops you doing your normal activities), and chronic pain. Review of the resident's physician order sheet, active as of 06/14/23, showed the following: -An order, dated 04/16/24, to cleanse coccyx (tailbone) with hypochlorous acid (disinfectant that can destroy bacteria and viruses), pat dry, apply Santyl (prescription ointment removes dead tissue from wounds so can start to heal) to wound bed, apply calcium alginate (highly absorptive, non-occlusive dressings made of soft, non-woven fibers derived from brown seaweed or kelp tow help with wound healing), and cover with foam bordered dressing one time per day for pressure ulcer/ Review of the resident's significant change in status Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 05/02/24, showed the following: -Severe cognitive deficit; -Dependent on staff for oral hygiene, toileting hygiene, shower, dressing, and personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's care plan, revised 05/14/24, showed the following: -Resident required staff assistance with activities of daily living (ADL) related to physical limitations; -Resident required staff assistance with hygiene and peri-care. Observation on 06/12/24, at 9:45 A.M., showed the following: -Licensed Practical Nurse (LPN) B prepared to complete wound care for the resident. The LPN entered the resident's room with a clean tray with wound care supplies, including the facility shared wound care cleanser bottle. He/she placed the supplies on the bedside table. He/she washed his/her hands at sink, then applied gloves; -The LPN opened the resident's incontinent brief on left side. He/she said the brief was wet and the wound dressing was not intact; -The LPN opened the dresser drawer and obtained a clean incontinent brief and wet wipes. He/she wiped the left side of the buttock with a wet wipe. The LPN rolled the wet incontinent brief under the resident, rolled the resident to his/her back side, and pushed the brief out from between the resident's legs and tucked under the buttock. The LPN wiped the resident's front private area. He/she then rolled the resident further to his/her left side. The LPN wiped the right buttock and tucked the clean incontinent brief under the resident. He/she rolled the resident to his/her right side, pulled out the wet brief, and pulled the clean incontinent brief through with the same contaminated gloves. The LPN wiped the resident's buttock again with a clean wet wipe. The LPN placed the wet brief and wet wipes into the trash; -The LPN removed his/her gloves and without completing hand hygiene, pulled the blanket up over the resident. The LPN went to the sink and washed his/her hands; -The LPN applied new gloves, picked up the wound cleanser bottle, and sprayed the cleanser onto dry gauze. He/she washed the wound on coccyx with the wet gauze. The LPN patted the wound dry with clean dry gauze. Without changing gloves or completing hand hygiene, the LPN applied Santyl to the cotton tip applicator and applied the cream to the wound. He/she then applied dressing cover to wound. The LPN then closed and taped brief close; -Without changing gloves or completing hand hygiene, the LPN placed a pillow under resident's head, then removed his/her gloves. He/she changed the resident television channel with the remote before completing hand hygiene; -He/she removed the supplies from the bedside table and washed hands at sink. 4 Review of Resident #40's face sheet, showed the following information: -admitted [DATE]; -Diagnoses include urinary tract infection, high blood pressure, diabetes, and pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Cognitively intact; -Requires substantial to maximum assistance from staff for lower body dressing, showering, and personal hygiene and requires partial to moderate assistance with mobility; Review of the resident's care plan, revised on 05/17/24, showed the following information: -Required staff assistance with ADL's; -Wound on left second toe 1 centimeter (cm) x 1.2 cm. Treatment to cleanse the wound with wound cleanser, pat dry, apply calcium alginate, cover with band-aid, change daily. Placed on Levaquin (antibiotice) 500 milligram daily for 10 days (5/14/24-5/24/24); -Referral to wound care clinic. Observation on 06/12/24, at 12:29 P.M., showed RN D and Nursing Assistant (NA) A in the shower room with the resident. The resident sat in the shower chair with a blanket covering him/her. LPN B entered the shower room and brought a clean tray with the following supplies: wound cleanser, gauze, gentamycin (an antibiotic) , tape, and a q-tip, and placed the tray on top of the resident's wheelchair. LPN B performed hand hygiene and donned gloves. LPN B obtained wound cleanser and gauze pad and cleansed wound starting at the center of the wound. LPN B threw away dirty items and gloves, washed hands, and did not don new pair of gloves. LPN B obtained a q-tip and gentamycin from the tray. He/she applied gentamycin onto the q-tip and rubbed it onto the wound. The LPN threw away the Q-tip and placed gauze placed over the wound without performing hand hygiene. LPN B applied gloves, without hand hygiene) and taped gauze into place. LPN B signed/dated on the dressing, performed hand hygiene, and exited the room. Surveyor [NAME], [NAME]: 5. During an interview on 06/13/24, at 3:00 P.M., CMT K said staff should complete hand hygiene before and after all types of resident cares and should clean hands between glove changes. 6. During an interview on 06/14/24, at 9:35 A.M., RN D said he/she would expect staff to wash their hands prior to donning gloves, changing gloves, and going from dirty to clean. 7. During an interview on 06/14/24, at 11:26 A.M., the DON said she expects all staff to wash their hands as soon as they go into a resident's room. If gloves become soiled, they should be changed, and hands should be washed before donning a new pair. Hands should also be washed if staff are going from a dirty to a clean surface. She would never want to see a staff member touching a dirty environment then going to a clean one without washing their hands and donning new gloves. 8. During an interview on 06/14/24, at 1:24 P.M., the Administrator said she expects staff to wash their hands before and after providing care, and when going from a dirty to a clean surface. MO00237558

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 31464 Based on interview and record review, the facility failed to designate one or more individuals with specialized training in infection prevention and control (IPC) as the infection preventionist (IP) for the facility's infection prevention control program. The census was 45. Review showed the facility did not provide a policy related to the position of infection preventionist and required certification. 1. During an interview on 06/10/24, at 10:55 A.M., the Administrator said the interim Director of Nursing (DON), in the position for about two months, was currently enrolled in the State's online IPC program, but had not completed the certification. The Administrator said the facility was offering the other staff nurses the chance to enroll and become certified, but none had completed the course as yet. Review showed the facility did not provide documentation of the required certification for the IP position for the DON. During an interview on 06/14/24, at 10:53 A.M., the interim DON said he/she had begun, but was not finished with the online IPC training and certification. The DON said he/she needed to complete the certification, because the facility did not have anyone else who was certified. During an interview on 06/11/24, at 3:00 P.M., the Administrator said the previous interim DON, who was in the position for approximately one month and now works only monthly as needed, was not certified in the IPC program. Someone in the facility should be certified as the IP and she expected the DON to complete the certification process. The other nurses had also been invited to enroll in the online course, but nobody else had done so to date. MO00237558

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to ensure a properly working and monitored call light system was in place when staff failed to fix one resident's (Resident #41) nonfunctional call light, failed to answer one resident's (Resident #200) call light before it automatically reset, and failed to ensure the call lights alerted to a central location and all care staff have access to pagers that alerted to call lights. The facility census was 45. Review showed the facility did not provide have a written policy regarding the call system. 1. Review of Resident #41's face sheet (first glance at resident's information) showed the following information: -admitted [DATE]; -Diagnoses included heart failure, high blood pressure, sleep apnea (sleep disorder in which breathing stops and starts repeatedly), and squamous cell carcinoma (cancer that starts as a growth of cells on the skin). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 02/27/24, showed the following information: -Moderate cognitive impairment; -Independent for all Activities of Daily Living (ADL's- fundamental skills required to independently care for oneself, such as eating, bathing, and mobility). Review of the resident's care plan, revised on 04/09/24, showed independent with personal care. During interviews on 06/10/24, at 2:43 P.M., and on 06/13/24, at 9:38 A.M., the resident said the following: -Staff take longer than 30 minutes to answer to his/her call light; -He/she had fallen recently at night and used his/her call light for help. He/she had to wait twenty minutes for help, and no staff member came. He/she then crawled to the roommate's side of the room and used their call light. The staff responded to that call light; -Staff never come to help when he/she uses his/her own call light. Review of the resident's progress notes showed staff documented the resident had a fall on 05/29/24 in the early morning hours, which resulted in a skin tear to the resident's right elbow and right knee. The resident was encouraged to use his/her call light during the night if he/she is needing assistance. The resident was also encouraged to use proper footwear. The Medical Records Nurse documented a root cause analysis in the progress notes, which said the fall was due to the resident's failure to use the call light and ask for staff to help. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/13/24, at 10:14 A.M., showed the following: -The resident sat in the wheelchair in his/her room. He/She pressed the call light at 10:14 A.M. Staff did not respond for over twenty minutes without response; -At 10:38 A.M., it was observed the resident's call light not coming through on the staff pagers; -At 10:43 A.M., the resident pressed his/her call light again. No staff responded continued until 10:52 A.M., when Certified Nursing Assistant (CNA) N and Licensed Practical Nurse (LPN) C entered the resident's room and said the call light must not working; -The two staff checked the resident's call light again and said it was not sending a signal to their pagers. The two staff checked the roommate's call light as well, which was said to be working. During an interview on 06/13/24, at 12:52 P.M., the Maintenance Director and Administrator said that the resident doesn't use his/her call light. He/she just wheels him/herself out into the hall when assistance is needed. The two of them were not aware that the resident wasn't receiving care due to a non-functioning call light. During an interview on 06/13/24, at 12:11 P.M., the Administrator said maintenance checks call light function monthly and changes batteries in pagers and in the call lights in rooms. 41787 2. Review of Resident #200's face sheet showed the following: -admitted [DATE]; -Diagnoses included displaced intertrochanteric fracture (type of hip fracture) of right femur (thigh bone), chronic atrial fibrillation (an irregular and often very rapid heart rate that can lead to blood clots in the heart), presence of left artificial hip joint (hip replaced by surgery), and pain. Review of the resident's care plan, dated 06/13/24, showed the following: -Resident received skilled services related to right hip fracture and falls; -Staff had pain; -Staff should respond to resident and empathetic to resident concerns. Review of the resident's entry tracking MDS, dated [DATE], showed the following: -admitted on [DATE]; -admitted from acute hospital stay. Observation and interview on 06/17/24 of the resident showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 8:19 P.M., the resident was seated in a recliner in his/her room and said, Hey, hey! as other persons walked by the room; -At 8:32 P.M., the resident yelled out, stating that he/she had pushed the call light 45 minutes ago. He/she was seated in a recliner with the feet elevated. He/she said that he/she needed help to go back to bed; -At 8:46 P.M., the resident remained in the recliner and said that he/she was going to pee his/her pants if someone did not come in and help. He/she said he/she had pushed the call light four times already. The resident pushed the call light again; -At 8:51 P.M., Certified Medication Technician (CMT) K entered the resident's room to assist. Review of the facility provided call light history for the resident's room, as of 06/18/24, showed the following: -On 06/15/24, at 8:35 A.M., call light announced 9 times. Response required, but not received as of 9:02 A. M. The alert was never responded to; -On 6/15/24, at 9:05 A.M., call light announced 9 times. Response required, but not received as of 9:32 A.M. The alert was never responded to; -On 06/16/24, at 6:41 A.M., call light announced 9 times. Response required, but not received as of 7:08 A. M. The alert was never responded to; -On 06/16/24, at 1:00 P.M., call light announced 9 times. Response required, but not received as of 1:27 P. M. The alert was never responded to; -On 06/16/24, at 9:05 P.M., call light announced 9 times. Response required, but not received as of 9:32 P. M. The alert was never responded to; -On 06/17/24, at 6:51 A.M., call light announced 9 times. Response required, but not received as of 7:18 A. M. The alert was never responded to; -On 06/17/24, at 7:29 A.M., call light announced 9 times. Response required, but not received as of 7:56 A. M. The alert was never responded to; -On 06/17/24, at 1:05 P.M., call light announced 9 times. Response required, but not received as of 1:32 P. M. The alert was never responded to; -On 06/17/24, at 7:57 P.M., call light announced 9 times. Response required, but not received as of 8:24 P. M. The alert was never responded to; -On 06/18/24, at 5:51 A.M., call light announced 9 times. Response required, but not received as of 6:18 A. M. The alert was never responded to; -On 06/18/24, at 6:28 A.M., call light announced 9 times. Response required, but not received as of 6:55 A. M. This alert was never responded to. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/18/24, at 10:10 A.M., CMT K said that all staff have pagers for call lights, and staff should answer the call lights as quickly as possible. He/she did not know if the call lights turned off without staff pushing the button. During an interview on 06/18/24, at 11:15 A.M., the Director of Nursing (DON) said that staff should answer call lights as soon as possible. She said that residents should not have to wait over 30 minutes for a response to the call light. During an interview on 06/18/24, at 10:35 A.M., the Administrator said that if the call light history showed This alert was never responded to it means that no staff answered the call light and the call light automatically reset to off. She said that staff should respond to call lights in a timely manner. It was not appropriate that residents call lights were not responded to before automatically resetting. 3. Observation and interview on 06/13/24 showed the following: -At 10:42 A.M., Certified Medication Technician (CMT) Q said he/she did not have a pager for call lights that day. He/she was supposed to have one, but they were short of pagers currently; -At 10:56 A.M., Nurse Aide (NA) A said he/she gave his/her pager to another staff person as he/she was going on break; -At 10:57 A.M., CNA N had a pager on his/her shirt with no pages on the pager; -At 10:58 A.M., CNA R had a pager that showed rooms [ROOM NUMBERS] alerting; -At 10:58 A.M., LPN B was seated at the nurse desk. The call light monitor was not turned on. It was on a shelf above six foot high. The LPN said that the monitor had not been on due to recent remodeling of the nurses' station and he/she did not know how to turn on the monitor to see the call light announcements; -At 10:58 A.M., LPN I/Medical Records said he/she did not have a pager, it was loaned out and never returned; -At 10:59 A.M., NA H had a pager with no pages alerting. During an interview on 06/13/24, at 12:09 P.M., Housekeeping (HK) V said he/she did not carry a call light pager and would not know if a resident was calling for assistance unless he/she was near or in the resident's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/14/24, at 3:55 P.M., CNA P said aides are each assigned to one hallway. Generally, whoever was assigned to the hallway should immediately answer the call light. Other staff should assist if that aide was busy in another room. Everyone should answer call lights. Up until yesterday, only the aides had call light pagers, as several of the pagers had been lost. There was no need for staff to turn their pager over to anyone when going on break because everyone should have a pager. All staff should communicate with coworkers to let them know that you were on a break and should also let coworkers know when taking a resident into the shower, so the other staff could watch the call lights for that hall. If a CNA does not respond to a call light within 12 minutes (two indicators of 6 minutes each), the page should go to the nurse for next page. During an interview on 06/14/24, at 4:15 P.M., Registered Nurse (RN) D said that all staff were responsible to answer call lights. There was a change just made to the pagers regarding triage level 1 and level 2. The calls would escalate up to the next supervisory level if not answered promptly. No one should need to pass off their pager for breaks, because everyone should have a pager. If a staff member were to leave the building for a meal/break, they should leave their pager on the nurses' desk area and should be sure to let their coworkers know when they were going on break or when they would be busy giving a resident shower. During an interview on 06/13/24, at 12:25 P.M., the Social Services Director (SSD) said he/she had a pager, but is often tied up when alerts go out. If he/she notices a re-alert two to three times, he/she will try to go out of his/her office to help. During an interview on 06/14/24, at 10:50 A.M., the DON said that the aides, CNA or NA, should each have a pager. The med techs, nurses, and the DON should also have pagers. She said that her understanding of the system was that calls would first notify the aides on their pager, but she was not sure. She said that her pager rang on the first call to her knowledge. The goal was to get the pager system to go to different levels when not answered. The aides should first answer call lights, then floor nurses should respond if not answered. She said that any staff can and should respond to a call light if noted on the pager. The maintenance and housekeeping staff would not know if a call light was alarming, but if a resident was yelling out they could respond to the resident and go get staff to assist or assess. All staff should be able to stop what they are doing to help residents with their basic needs. She had not had any residents tell her that call lights were not working or that staff were not responding. Social Services will notify all staff in morning meetings when grievances are received related to call lights. She was not aware that some call lights were not working. During interviews on 06/14/24, at 10:45 A.M., 12:11 P.M., and 1:24 P.M., the Administrator said all CNAs/NAs, CMTs, nurses, and department heads are supposed to carry pagers. However, they were currently short of pagers due to staff breaking/losing/not returning them. All call lights should hit all pagers. Anyone can respond if they notice it's been a little bit and the resident was still calling. Staff that do not have pagers would not be able to tell if a call light had been activated. All call lights should be answered promptly and in a timely manner. The nursing station had a remodel done the beginning of May. There was a monitor at the nurses' station, but it didn't work quite right and went dark often. It worked before the remodel of the station area. CNAs and NAs are assigned halls to work and given call system pagers; they should answer calls immediately or as soon as possible. The aides should tell other staff if they will be tied up or on break so others can cover pages. The Administrator recently found out they could set the pager system to roll up to the next supervisory level if an alert was not answered within two to three re-alerts. The pagers are signed out and should be passed to the next shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Nevada	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	31464