STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265501	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odessa Health Care Center	609 Golf Street Odessa, MO 64076

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure bathing was completed twice weekly by nursing staff in addition to bathing that was completed by hospice (end of life) staff for one sampled resident (Resident #10) out of 15 sampled residents. This deficient practice potentially affected all residents on hospice services. The facility census was 60 residents. Review of the facility undated Shower Expectations procedure showed:-Residents on Hospice must be offered 2 showers a week from the facility for a total of 4 showers a week.-Bed Baths must be approved by the charge nurse and only ONE shower per week can be a bed bath unless otherwise arranged/care planned by the Director of Nursing (DON).-All shower declines must immediately be told to the charge nurse so they can follow up.-If the resident continues to decline, the DON or Administrator must be notified immediately.-Do not wait until the end of the day to tell the charge nurse about shower declines.-If a resident continues to decline, you must get their signature on the declined shower sheet.-ALL shower sheets MUST be signed by the resident, after the shower is completed. If the resident is unable to sign, it must be signed by a staff who witnessed some part of the showering process (in, out, during, etc.) and the shower aide.-Only the charge nurse, DON, or Administrator can fill out a refusal shower sheet.-Showers must be done even if there is not a shower aide.-Saturday showers must be completed.-Every resident must be offered at least 2 showers a week.-If a resident requests a shower on a random day, they are to get a shower that day.-Nurses must sign all shower sheets & address any issues on the shower sheet.-All Hospice showers must have a shower sheet turned in by the hospice aide.1.Review of Resident #10's Face Sheet showed the resident was admitted on [DATE], with diagnoses including heart failure, high blood pressure, diabetes, high cholesterol, heartburn, arthritis, stroke, traumatic brain injury (a disruption in normal brain function caused by an external physical force, such as a bump, blow, jolt, or piercing object) anxiety and depression.1. Review of the resident's comprehensive Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/8/26 showed the resident:-Was alert with minimal cognitive incapacity.-Had lower extremity impairment on both sides and used a wheelchair for mobility.-Needed maximum assistance with bathing, dressing, toileting, hygiene and transfers.-Received Hospice care.Review of the resident's Care Plan updated on 11/17/25 showed the resident had limited physical mobility related to neuropathy (a condition resulting from damage to the nerves outside the brain and spinal cord that can cause numbness, tingling, burning pain, and muscle weakness, commonly starting in the hands or feet) and pain. Interventions showed:-Dressing: The resident relied on staff for dressing his/her lower body. The resident was able to assist with upper body dressing with extensive assist.-Oral Care: The resident required one person to assist with oral cares.-Toileting: The resident required assist with toileting by two staff and wore an adult incontinence product. -Transfer: The resident transferred with a full body mechanical lift and assisted by two staff persons. -NOTE: The care plan did not show the (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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's capability for bathing or amount of assistance needed. It did not show that the resident resisted bathing or resident cares.Review of the resident's bath sheets dated November 2025 showed:-On 11/20/25 the resident refused the bath-On 11/27/25 there was nothing that indicated the bath was offered or given (no signatures were on the form).Review of the resident's bath sheets dated December 2025 showed:-On 12/11/25 the resident refused the bath. -On 12/12/25, 12/19/25, 12/22/25, 12/23/25, 12/27/25, 12/29/25, 12/31/25 Hospice gave the resident baths.-The facility staff did not provide their required baths to the resident.Review of the resident's Hospice Note dated 12/31/25, showed:-The resident was now bedbound and required at least 40 percent of activity of daily living assistance (bathing, dressing, eating, toileting, transfers and mobility) needed.-The resident no longer got out of bed, used a full body mechanical lift for transfers, had increased confusion, poor appetite but drank very well, -The resident also used oxygen at 2-4 liters per minute.-Notes showed the bath aide visited daily to complete care/bathing and feeding/drinking assistance.Review of the resident's bath sheets dated January 2026 showed:-On 1/2/26, 1/9/26, 1/12/26, 1/16/26, 1/20/26, 1/23/26, and 1/30/26 baths were completed by the Hospice aide. -There was no documentation showing the facility nursing staff or bath aide gave any resident baths. -The resident did not receive the minimum number of baths during the month.Observation on 1/28/26 at 8:46 A.M., showed the resident was lying in bed with his/her eyes closed and he/she was resting comfortably. His/Her oxygen was on and running and there were no signs or symptoms of distress. The resident was not odorous.Observation on 1/30/26 at 12:07 P.M., showed the resident was lying in a low bed with positioning pillows and Prafo boots (a custom-fitted, adjustable medical device designed to suspend the heel) on. The resident was dressed for the weather without odors. His/her oxygen was on and running the resident's eyes were closed and he/she was resting comfortably.During an interview on 2/2/26 at 3:05 P.M., the Bath Aide said:-He/She was supposed to give baths to all residents including those who were on Hospice.-He/She was supposed to give baths twice weekly to the residents.-He/She worked five days weekly and was responsible for giving 120 baths every week.-The resident's Hospice staff also gave baths to the resident at least twice weekly.-The Hospice staff did not know they were supposed to use their bath sheets, so they were using the facility bath sheets to document their baths, and they documented Hospice on the bath sheets.-He/She focused on giving showers to those residents who were not on Hospice first to try to get at least one bath weekly to every resident.-He/She had not been able to get to the residents who were on Hospice services because he/she had so many residents to give showers to and was not able to do so without some help.-The baths he/she was supposed to give to residents on Hospice were not getting done.During an interview on 2/2/26 at 3:10 P.M., Certified Nursing Assistant (CNA) A said: -Residents on Hospice were to receive four baths weekly.-When the Bath Aide was not there or was unable to complete resident baths, the CNAs were supposed to assist with giving resident baths.-Nursing staff did help give baths if they had three CNA staff working-one would be designated to provide bathing.-They did not often have enough nursing staff daily to assist with giving baths.-Other times they would try to give baths on Sundays.-They would always document the baths they gave on the resident bath sheets.-The Bath Aide was not able to get all the resident baths completed because there were too many residents to give baths to.-He/She did not think that the residents on Hospice received four baths weekly, but they did receive the baths that Hospice came in to give.During an interview on 2/2/26 at 3:58 P.M., the Director of Nursing (DON) said:-Hospice aides bathe their residents twice weekly and the facility bath aide was supposed to give two baths to every resident weekly for a total of four baths for those residents receiving Hospice services.2702915

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have sufficient staffing to meet the needs of two sampled residents (Resident #5 and #54) out of 15 sampled residents. The facility census was 60 residents. Review of the facility's Sufficient Staff Policy dated 5/18/24 showed:-It was the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnosis of the resident population will be considered based on the facility assessment.--The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.---Except when waived, licensed nurses; and other nursing personnel, including but not limited to nurse aides.--Except when waived, the facility must designate a licensed nurse to serve as a charged nurse on each tour of duty.--The facility was required to provide licensed nursing staff 24 hours a day, seven days a week.--The facility must ensure that licensed nurses have the specific competencies, and skill sets necessary to care for resident's needs as identified through resident assessments and described and the plan of care.--Providing care includes, but was not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.--The facility must ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for resident's needs, as identified through resident assessments, and described and the plan of care.--The facility was responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system.--Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, seven days a week.--The director of nursing may serve as a charged nurse only when the facility had an average daily occupancy of 60 or fewer residents.1. Review of the Resident Counsel Minutes dated 10/29/25 showed the resident's indicated the following:-There needs to be more workers.-Some Certified Nursing Assistants (CNA) were afraid to wipe/clean certain areas.-Bed linens do not get changed; staff had to be reminded to change the bed.-Had to remind staff to make the bed.-Staff took a long time to answer call lights.-There are lifts but not enough help.Review of the Resident Counsel Minutes dated 11/26/25 showed the resident's indicated the following: -Staff did not answer call lights fast enough.-Beds were not being made.-Staff were not giving showers twice a week.-Staff were not changing the sheets on the beds. --This was also mentioned in the October meeting.Review of the Resident Counsel Minutes dated 12/17/25 showed:-The beds were not being made.-Call lights were not being answered in a timely manner.-Staff were not giving showers twice a week.-Staff were not changing the sheets on the beds.--This was mentioned in the October and November meetings. 2. Review of Resident #5's Quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/19/26, showed the resident:-Was cognitively intact.-Required substantial/maximum assistance with bathing and dressing.During an interview on 1/27/26 at 11:41 A.M. the resident said: -Staff was slow to answer his/her call light.-It didn't matter if it was day or night. -He/She had only been receiving one bath a week when he/she was supposed to be getting two.3. Review of the Resident #54 Comprehensive MDS, dated [DATE], showed the resident:-Was moderately cognitively impaired. -Required substantial/maximum assistance with bathing.-Required supervision or touching assistance for dressing.During an interview on 1/27/26 at 11:45 A.M. the resident said:-Night shift staff was slow to answer his/her call light. -He/She had only been receiving one bath a week when he/she was supposed to be getting two.4. During an interview on (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/29/26 at 9:56 A.M., Certified Nursing Assistant (CNA) D said: -The residents did not get two showers a week because he/she was the only person designated for baths/showers. -He/She had residents tell him/her that if he/she was not at the facility they did not get their baths/showers.-He/She knew some CNAs would try to give baths/showers. -He/She would get pulled to assist to feed the residents, pass trays, and help with transfers.-If a resident needed assistance, then he/she would assist them. -If a resident had an appointment like physical therapy, it was not always possible to get back to them before the end of the day to give them a bath/shower. -He/She was assigned 20 showers a day.-Gave between 15 and 18 baths/showers a day.-With there being 60 residents that was 120 baths a week.During an interview on 1/30/26 at 2:02 P.M. CNA C said:-There had been times when he/she was supposed to leave and knew there were residents who needed assistance. -They had been short because of scheduling.-He/She had to wait 15 minutes for another staff member to assist with a transfer with a mechanical lift. -He/She heard a few residents complain about not having enough help on night shift. -It had seemed like night shift had been short.-The bath aid was responsible for giving baths.-If a CNA had time they could assist with baths.-When the bath aid wasn't at the facility, the CNAs were supposed to give baths.-He/She was assigned as the bath aid for a day and was supposed to give 18 to 20 baths but was only able to do 14 baths.-He/She was pulled to the floor to help assist with residents and help with meals. -If a resident said to come back later for the bath it could be difficult to get back to them. -The residents were supposed to be offered a bath on another day if they did not get their bath on their assigned day. During an interview on 2/2/26 at 9:00 A.M. CNA A said:-He/She was not able to get his/her job done on time and would have to come in early or stay late. -The facility was short on staff.-Had residents and families complained all the time that there was not enough staff.-The bath aid was responsible for giving baths.-When the bath aid was not at the facility it was up to whoever was at the facility to give baths.-He/She had no idea how many baths he/she had given in a day.-If a resident did not get their baths on their assigned days, they could get them on Sundays which was the make-up day. During an interview on 2/2/26 at 10:24 A.M. Certified Medication Technician (CMT) A said:-The facility was short staffed.-When he/she worked the floor as a CNA sometimes he/she was unable to get the work done but would let another staff member know.-He/She heard of residents and family members complain about the facility being short staffed.-The bath aid was responsible for giving baths.-A CNA, who was on the floor, would fill in when the bath aid was not working.During an interview on 2/2/26 at 1:29 P.M., the Activity Director said: -He/She would get pulled to assist on the floor and it would put him/her behind on the scheduled activities. -He/She was called to the floor to assist with getting a resident ready to go to an appointment, but he/she was also supposed to do a scheduled activity at the same time. -Since he/she was on the floor he/she was not able to do the activity and was hoping to get it done before the afternoon activity. -He/She was pulled to the floor to assist with getting the residents up out of bed and this put him/her behind on the morning activity.-They were supposed to do coffee, news, and devotion readings and a scheduled activity and none of it was able to be done because of being pulled to the floor.-He/She was the only person doing the activities.During an interview on 2/2/26 at 1:54 P.M., CNA D said: -He/She was not able to get his/her job done on time and would have to stay late. -He/She had heard of residents and family members complain about the facility being short staffed on all shifts. -He/She was responsible for showers every week unless someone called in, then he/she would have to work the floor. -Usually, he/she would not take a lunch break because it would mean a resident would not get their bath on the assigned day. During an interview on 2/2/26 at 2:12 P.M. Registered Nurse (RN) A said:-The staff could come to him/her for assistance. -He/she had heard resident's ask if they were low on staff (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and saying there were not enough people to meet his/her needs. -The bath aide was responsible for giving baths.-If the bath aide was not at the facility, then a CNA would give the bath/shower.-He/She would comprise a list of the residents who did not receive their scheduled bath and let the night nurse know. -If a resident still did not receive their bath they would try the next day. -Baths were scheduled Monday through Saturday.-Sunday was the make-up shower day and a CNA would give the resident's their baths/showers. During an interview on 2/2/26 at 3:57 P.M. the Director of Nursing (DON) said:-If staff were unable to get their work done, they should let the charge nurse know and he/she would assign someone. -Call lights were to be answered as quickly as possible, no longer than 10 minutes.-The CNAs were able to give baths when the bath aid was not in the building.-Baths could be given on the night shift and weekend.-There should not be any reason why a resident would not receive two baths a week. -The current floor staff or next shift staff would assist.-Bath sheets were monitored by the charge nurse and audited by him/her.-The charge nurse would reassign any baths. -Resident #5 and Resident #54 should have received two baths/showers a week.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview and record review, the facility failed to ensure a physician's response related to the pharmacist's Gradual Dose Reduction (GDR) recommendation and pharmacy monthly Medication/Drug Regimen Review(MRR or DRR) for as needed antipsychotic medication (used to manage psychosis symptoms, including hallucinations, delusions, paranoia, and severely disordered thinking) for one sampled resident (Resident #51) out of 15 sampled residents. Facility census was 60 residents. Review of the facility Pharmacy Services policy revised on 5/18/24 showed:-The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.-The pharmacist, in collaboration with the facility and medical director, may include other aspects of pharmaceutical services such as:--Development of procedures and guidance in relation to medication issues and/or adverse effects.--Development of processes for receiving, transcribing or recapitulation of medication orders.--Recommendations of type(s) of medication delivery system(s) to standardize packaging, to minimize medication errors.1. Review of Resident #51's admission Record showed he/she was admitted with diagnoses that included:-Anxiety (is a persistent, excessive fear or worry that interferes with daily life).-Personality disorder (as the manifestation of extreme personality traits that interfere with everyday life and contribute to significant suffering, functional limitations, or both).-Hospice care (is a special kind of care that focuses on a person's quality of life and dignity as they near the end of their life) on 9/3/25 with diagnosis of severe protein-calorie malnutrition (s a life-threatening, often chronic, condition caused by extreme deficiencies in macronutrient intake such as protein, calories, and nutrients). Review of the resident's Physician Order Sheet (POS) dated December 2025 showed:-Lorazepam Oral Concentrated 2 milligrams (mg)/ milliliter (ML) give 0.25 ml by mouth every one hour as needed for agitation, was ordered on 9/10/25. -Olanzapine 10 mg give one tab for prophylaxis, was ordered on 5/9/25. -Quetiapine Fumarate give 50 mg by mouth one time a day for agitation/anxiety, was ordered on 5/9/25.-Quetiapine Fumarate give 100 mg by mouth every night at bedtime for agitation/anxiety, was ordered on 5/9/25.-NOTE: Did not have a documentation in nursing notes or physician progress noted showing had been reviewed by the resident's physician that he/she agreed or disagreed with pharmacy recommendation.Review of the resident's Pharmacy Review Note dated 12/18/25 at 4:13 P.M. showed GDR recommendation resident was receiving the following psychotropic medications (drugs that change brain chemical makeup to treat mental illnesses, emotional disorders, or behavioral issues) that were due for review:-Escitalopram (Lexapro, used for depression) give 20 milligrams (mg) one time a day.-Lorazepam (used to treat anxiety, agitation) 1 mg three times a day (TID) as needed (PRN).-Olanzapine (used to treat schizophrenia and bipolar I disorder)10 mg twice a day.-Quetiapine(an atypical antipsychotic medication used for schizophrenia, bipolar disorder, mania/depression) 50 mg in the morning and 100 mg at bedtime.-The following pharmacist recommendation was made:--Decrease the Lorazepam to 0.5mg TID (If as needed order then as needed x 14 days).-The form contained a blank line for a check mark or initial with the following comment:--An attempted GDR of listed medication is likely to result in destabilization, impairment of function or increased distressed behaviors.-The form contained a blank line for a check mark or initial with the following comment: --Target symptoms returned or worsened after the most recent attempt at a GDR within the facility and any additional attempted dose reduction at that time would be likely to impair the resident's function, exacerbate an underlying medical or psychiatric disorder or increased distressed (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavior. Document supporting rationale. There was a blank line for the physician to document his/her response.-The form contained the following statement: The resident has specific, enduring, progressive, or terminal conditions (i.e. chronic depression, Parkinson's psychosis) which affect brain activity indefinitely. Chronic condition.--There was an area left blank for the physician to document his/her response. -There was nothing indicated on the form as a response to any of the areas by the physician. -There was no documentation in the resident's nursing notes or physician progress notes that indicated the GDR form had been reviewed, agreed of disagreed with the pharmacist recommendations. Review of the resident's Quarterly Minimum Data Set (MDS a federally mandated assessment instrument completed by facility staff for care planning) dated 12/24/25, showed he/she:-Was moderately cognitively impaired. -Was able to understand others and make his/her needs known.Review of the resident's Pharmacy Review Note dated 1/21/26 at 6:06 A.M. showed: -The resident was recently started on the following PRN antipsychotic medication(s):-Lorazepam 1 mg given by mouth three times a day as needed with start date of 9/10/25).-Lorazepam (concentrated) 0.25 ml given by mouth every hour PRN for agitation was started on 9/10/25.--This was a second attempt to reduce the PRN medication. -The form contained the following statement: --As of 11/28/17 new CMS regulation 483.45(e)(5) states that as needed orders for all antipsychotic drugs have a maximum duration of 14 days and then be discontinued. There are no exceptions to this rule (including hospice) and any order for a as needed antipsychotic >14 days will result in an F tag from state surveyors. A new order may be written every 14 days after the prescriber meets the following and documents ongoing need for as needed antipsychotic. New regulations that these orders cannot be renewed unless the following conditions are met:1)Prescriber evaluates patient in person to assess for a new PRN order for the medication2)Prescriber documents in the residents chart the medical reason why the PRN is necessary.Please discontinue this residents' current antipsychotic as needed order and following the previously mentioned steps if the order is still medically necessary.-The form contained a blank line for a check mark or initial to DISCONTINUE the PRN medication. -The form contained a blank line for a check mark or initial with the following:--LORAZEPAM (X2). The form had a blank line for a check mark or initial with the following statement:-To comply with CMS Guidelines. If this medication is to be continued long term the afore mentioned steps are required each renewal. -There was no documentation in the resident's nursing notes or physician progress notes that indicated the GDR form had been reviewed, agreed of disagreed with the pharmacist recommendations. Review of the resident's Physician's monthly progress note dated 1/17/26 at 9:27 A.M. showed: -There was no documentation of any medication changes.-The resident's mood and behaviors were acceptable. -There was no documentation that indicated he/she reviewed the pharmacy recommendation or GDR. During an interview on 2/2/26 at 10:16 A.M., the Director of Nursing (DON) said:-He/She would be responsible for the facility audit of the resident's medical record for accuracy and any transcription errors. -He/She would be responsible for oversight of the pharmacy monthly review. -The resident's pharmacy monthly DRR that had pharmacy recommendations and the GDR recommendations had not been followed-up by nursing staff to ensure the recommendations had a physician's response.-The facility did not have a physician's response documented for the resident's GDR recommendations. -It was night shift's staff responsibility to ensure there was a physician's response related to any pharmacy recommendation. During an interview on 2/2/26 at 2:00 P.M. the Administrator said the facility received the DRR from the pharmacist monthly with his/her recommendations.