STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265555	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eldon Nursing & Rehab	1001 East North Street Eldon, MO 65026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to ensure one resident (Resident #1) remained free from physical abuse when Resident #2 with a history of physical aggression punched Resident #1 in the face which resulted in bruising to his/her eye. The facility census was 65.Review of the facility's abuse and neglect policy, undated, showed staff are directed that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion. Residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for Protection.1. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 04/04/25, showed staff assessed the resident with severe cognitive impairment.Review of the resident's nurse's notes, 04/17/25 at 04:16 A.M., showed staff documented Resident #1 reported he/she was shoved by Resident #2.Review of the resident's nurse's notes, 05/03/25 at 1:28 P.M., showed staff documented a yelling altercation occurred between Resident #1 and Resident #2 over a chair in the day room.Review of the resident's plan of care, dated 5/12/25, showed staff assessed the resident with behavior disturbances due to intellectual disabilities. Review showed staff did not document the altercations with Resident #2 or interventions to direct staff on how to handle them and did not contain information to direct staff related to abuse.Review of the resident's nurse's notes, 05/27/25 at 12:27 A.M., showed staff documented Resident #2 entered Resident #1's room and Resident #1 started screaming he/she choked me, he/she hit me. Nurse assessment of Resident #1's skin showed red mark on side of neck. Resident #1 cried throughout assessment. Review of the resident's nurse's notes, 06/26/25 at 6:07 A.M., showed staff documented Resident #1 with a black eye and bruising to his/her shoulders. Physician and DON notified. Staff documented Resident #1 said Resident #2 hit him/her. Observation on 6/30/25 at 2:00 P.M., showed the resident in his/her room, his/her left eye had black discoloration around the eye and the white of the eye was red. 2. Review of Resident #2's MDS, dated [DATE], showed staff assessed the resident as moderate cognitive impairment.Review of the resident's plan of care, dated 1/20/25, showed staff did not document the altercations with Resident #1 and did not contain anything to direct staff on abuse.Review of the resident's nurse's notes, dated 04/17/25, showed staff documented Resident #2 shoved Resident #1. Review of the resident's nurse's notes, dated 05/15/25, showed staff documented Resident #2 told Resident #1, Don't yell at me I'll drag your ass outside, you loud son of a bitch. Review of the resident's nurse's notes, dated 05/27/25, showed staff documented Resident #2 was physically aggressive with Resident #1, because he/she stated he/she was trying to get Resident #1 out of his/her room.Review of the resident's nurse's notes, dated 05/27/25, showed staff documented at 12:20 A.M. Resident #2 entered Resident #1's room and nurse heard Resident #1 scream out he/she is choking me and hitting me.Review of the resident's nurse's notes, dated 06/29/25, showed staff documented Resident #1 was at the nurse's desk tearful and calling out wanting copies. Resident #2 comes up toward the desk and said, I'm going to beat the fuck out of him/her.During an interview on 06/30/25 at 2:07 P.M., Resident #2 said he/she had an altercation with Resident #1, due to Resident #1's mouth. Resident #2 said it was two or three in the morning. Resident #2 said he/she knocked on Resident #1's door and told Resident #1 to knock it off. Resident #2 said then Resident #1 threw a fit and Resident #2 said he/she hit Resident #1. 3. During an interview on 06/30/25 at 3:30 P.M, the Nurse Practitioner (NP) said on 06/27/25 he/she voiced concern Resident #1 was potentially hit by Resident #2The NP said what Resident #2 has done to Resident #1, he/she would consider abuse. During an interview on 06/30/25 at 5:22 P.M., Registered Nurse (RN) B said when he/she came in on 6/27/25 at 7:00 A.M. Resident #1 had a black eye, the resident reported yes to someone hitting him/her the night prior. The RN said knowing the previous altercations between the two residents, he/she would say it is not safe for the two resident's rooms to be next to each other. The RN said he/she would consider hitting abuse. During an interview on 07/02/25 at 8:32 A.M., the administrator said when Resident #2 said he/she hit Resident #1 he did not necessarily believe it. During an interview on 07/02/25 at 9:17 A.M. the DON said he/she does not remember anything being reported to him/her, about Resident #2 hitting Resident# 1. The DON said that would have been a big deal. The DON said staff did call him/her when he she pulled into the facility on [DATE] about Resident #1's black eye and he/she immediately went back on the unit and Resident #1 was sitting on his/her bed. The DON said there had been with

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, and record review, the facility staff failed to report an allegation of abuse for one resident (Resident #1) out of four sampled residents within in two hours to the administrator and the Department of Health and Senior Services (DHSS). The facility census was 65.1. Review of the facility's Abuse and Neglect policy, undated, showed all allegations of abuse will be reported no later than two hours to the State Survey Agency and if applicable law enforcement.2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 04/04/25, showed staff assessed the resident with severe cognitive impairment.Review of the resident's nurse's notes, 06/26/25 at 6:07 A.M., showed staff documented Resident #1 with a black eye and bruising to his/her shoulders. Review showed staff documented the resident said someone hit him/her. Physician and DON notified.Review of the resident's nurse's notes, dated 6/26/25 to 07/09/25, did not contain documentation staff notified DHSS of the allegation of abuse within the required two hours.During an interview on 07/02/25 at 10:44 A.M., Licensed Practical Nurse (LPN) E said he/she called the Director of Nursing (DON) and told the DON about the resident's black eye and told the DON he/she could not make out what happened to the resident. The LPN said told DON the resident said someone hit him/her. The LPN said he/she even asked the DON if this is reportable to the state and the DON said No, he/she will come in and talk to the resident.During an interview on 07/09/25 at 10:45 A. M., Registered Nurse (RN) D said if staff hear an allegation of abuse, or see it, staff will investigate and report it if the investigation comes back there is actual abuse. The RN said the facility has two hours to report abuse to state health agency. During an interview on 07/10/25 at 10:57 A.M., the Director of Nursing (DON) said he/she has two hours to report abuse, or allegations of abuse to state health agency. The DON said he/she was not told about the allegations of abuses in the nurse's notes, so he/she did not report the allegation to the state agency. During an interview on 07/09/25 at 11:08 A.M., the administrator said the facility has two hours to report abuse, or allegations of abuse to state health agency. The administrator said staff should report allegations of abuse or abuse to their immediate supervisor and then it is forwarded up the chain to him/her. The administrator said the allegation of abuse were not reported to state, because the allegations had not been reported to the DON or himself/herself. The administrator said if he/she had been made aware, he/she would have reported to state.Complaint #1579387

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record reviews, facility staff failed to initiate and complete a thorough investigation of alleged resident to resident abuse for one resident (Resident #1). The facility census was 65.1. Review of the facility's Abuse and Neglect policy, undated, showed when an incident of abuse is reported the administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: Who was involved; Resident's statements; Resident roommates' statements; Interviews obtained from 3-4 three to four residents; Involved staff and witness statements of events; A description of the resident's behavior and environment at the time of the incident; Injuries present including a resident assessment; Observation of resident and staff behaviors during the investigation and environmental considerations. The designated personnel will begin the investigation immediately.2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 04/04/25, showed staff assessed the resident with severe cognitive impairment.Review of the resident's nurse's notes, 06/26/25 at 6:07 A.M., showed staff documented the resident had a black eye and bruising to his/her shoulders. Review showed staff documented the resident said someone hit him/her. The nurse's note did not contain documentation staff investigate the black eye and bruising. Review of the resident's nurse's notes, dated 6/26/25 to 07/09/25, did not contain documentation the facility completed an investigation. During an interview on 07/02/25 at 10:44 A.M., Licensed Practical Nurse (LPN) E said he/she called the Director of Nursing (DON) to inform of the resident's black eye and told the DON he/she could not make out what happened to the resident. The LPN said he/she did tell the DON the resident said someone hit him/her. LPN E said he/she does not do investigations the DON is responsible to start them once they report to his/her. During an interview on 07/02/25 at 9:17 A.M. the DON said staff did call him/her when he/she pulled into the facility about the resident's black eye and he/she immediately went back on the unit. He/She said the resident was sitting on his/her bed. The DON said he/she asked what happened, and he/said he/she did it. The DON said he/she did not do a formal investigation with all the paperwork, because the resident hits himself/herself all the time, he/she would be filling out paperwork all day. During an interview on 07/09/25 at 11:08 A.M., the administrator said if a resident says another resident hit them, it's an allegation. The administrator said staff should report allegations of abuse or abuse to their immediate supervisor and then it is forwarded up the chain to him/her. The administrator said abuse investigations should be taken care of as soon as the abuse is reported but depends on if you're talking about abuse or an allegation of abuse. The administrator said the allegations of abuse were not investigated or reported to state, because the allegations had not been reported to the DON or himself/herself. incident #1579387

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to update the plan of care with changes in the resident's behaviors and measurable interventions for one resident (Resident #2) out of four sampled residents. The facility census was 65.1. Review of the facility's Comprehensive Care Plan policy, dated March 2015, showed an individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be based on a thorough assessment that includes, but is not limited to, the Minimum Data Set (MDS), a federally mandated assessment tool. Assessment of each resident is an ongoing process, and the care plan will be revised as changes occur in the resident's condition. The interdisciplinary care plan team is responsible for the periodic review and updating of care plans when changes occur that impact the resident's care. 2. Review of Resident #2's MDS, dated [DATE], showed staff assessed the resident as moderate cognitive impairment. Review of the resident's care plan, dated 01/20/25, showed staff did not assess the resident with behaviors and did not document interventions to direct staff on how to handle them. Review of the resident's nurse's notes, showed staff documented the following: -04/17/25: The resident shoved another resident;-05/15/25: The resident told another resident, Don't yell at me I'll drag your ass outside, you loud son of a bitch.;-05/27/25: The resident had been physically aggressive with another resident; had been physically aggressive with another resident.-05/27/25: The resident entered another resident's room, and the nurse heard the other resident scream out he/she is choking me and hitting me. -06/29/25: The resident told another resident I ' m going to beat the fuck out of him/her. During an interview on 06/30/25 at 2:07 P.M., the resident said he/she had an altercation with another resident, and he/she hit the other resident. During an interview on 07/09/25 at 10:40 A.M., Certified Nurse Aide (CNA) K said if a resident has verbal or physical behaviors directed at others it should be in the resident's care plans. During an interview on 07/09/25 at 10:45 A.M., Registered Nurse (RN) D said if a resident has physical or verbal behaviors directed towards others it should be care planned. During an interview on 07/09/25 at 10:51 A.M., The MDS Coordinator said if a resident has behaviors, the behaviors should be coded on the MDS, so all the staff know. The MDS Coordinator said besides nurses' notes, he/she is not sure where staff documents the behaviors. The MDS Coordinator said if he is told about the behaviors, he/she will ensure it is on the care plan. Care plans should highlight the type of behavior, so staff know what they are monitoring for. The care plan should have interventions for the behaviors and be updated with new behaviors and new interventions for staff. The MDS Coordinator said he/she does not know why the resident's care plan did not have behaviors listed with interventions, it should have. The MDS Coordinator said he/she is responsible for updating the care plans. During an interview on 07/10/25 at 10:57 A.M., the Director of Nursing (DON) said a resident's physical and verbal behaviors should be on the care plan. The DON said behavioral interventions should be on the resident's care plan. The DON said he/she doesn't know why the resident's behaviors and interventions had not been care planned, unless the MDS Coordinator was not notified. The DON said the behaviors and interventions should have been care planned for the resident's behaviors. During an interview on 07/09/25 at 11:08 A.M., the administrator said resident behaviors should be care planned and there should be interventions for the behaviors. The administrator said he/she did not specifically know why the resident's behaviors and interventions had not been care planned, but assumed it was because it had not been reported. Complaint #1579387