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	02/26/2026

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

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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 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** Based on observation, interview, and record review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants during perineal and/or wound care, when staff failed to perform appropriate hand hygiene, and glove changes for three residents (Resident #1, #6, and #34), of five sampled residents, Facility staff failed to ensure sanitary conditions for catheter tubing when they failed to keep the tubing off the floor for three residents (Resident #2, #48, and #54) out of three sampled residents. Facility staff failed to post Enhanced Barrier Precautions (EBP) signs for five residents (Resident #2, #23, #31, #48, and #54) out of five sampled residents. The facility census was 53.1. Review of the facility's policy titled, Perineal Care, undated, showed the policy did not direct staff on appropriate hand hygiene and glove changes during care. Review of the facility's policy titled, Handwashing, undated, showed the policy did not direct staff on when to wash hands. Review of the facility's policy titled, Gloves, undated, showed dirty gloves are worse than dirty hands because microorganisms adhere to the surface of the glove easier than to the skin on your hands and directed staff to change gloves between contacts with different residents or with different body sites of the same resident. 2. Review of Resident #1's Quarterly Minimum Data Set Assessment (MDS), a federally mandated assessment tool, dated 02/06/26, showed staff assessed the resident as: -Always incontinent of bowel and bladder; -Dependent on staff for toileting, and shower/bathe; -Diagnosis of traumatic brain injury, Paraplegia (impairment or loss of motor and sensory function in the lower half of the body). Observation on 02/24/26 at 9:20 A.M., showed Certified Nursing Assistant (CNA) B and CNA M entered the resident's room to provide perineal care, both CNA's applied gloves. CNA B cleaned the residents front side, rolled the resident to his/her side and CNA M cleaned the residents back side. CNA B and CNA M did not change their gloves, and with the same soiled gloves placed a clean pad under the resident and covered the resident up with a blanket. During an interview on 02/24/26 at 9:35 A.M., CNA B said he/she should have changed his/her gloves when going from front to back, and a clean to dirty task. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/24/26 at 9:36 A.M., CNA M said he/she did not think about changing gloves throughout the task but should have. 3. Review of the facility's policy titled, Wound care and Treatment, undated, showed staff were directed as follows: -Hand washing must be done as outlined in the guidelines; -Put on gloves; -Remove the soiled dressing and place in the trash bag; -Remove gloves and discard in the bag; -Wash your hands and put on clean gloves; -Clean the wound according to order; -Remove gloves, place in the trash bag, and put on clean pair of gloves; -Apply clean dressing as ordered; -Wash your hands. 4. Observation on 02/25/26 at 8:50 A.M., showed Licensed Practical Nurse (LPN) A placed gauze in a cup with his/her bare hands and sprayed the gauze with wound cleanser. The LPN did not perform hand hygiene, applied gloves, gown and a mask, and entered Resident #6's room to provide wound care. The LPN touched the resident's pillow and right foot with the same gloves on and then placed wound supplies, and scissors on the resident's dresser without a clean barrier. The LPN touched a trash can and urinal in the room, removed his/her gloves, applied clean gloves, and did not perform hand hygiene with gloves changes. He/She removed the soiled bandage from the resident's right foot, removed his/her gloves, did not perform hand hygiene, put on clean gloves, and applied the gauze from the cup to the resident's wound. The LPN removed his/her gloves, performed hand hygiene, applied new gloves, and used the scissors from the resident's dresser to cut foam and xeroform (Vaseline) gauze, placed the scissors on the bed without a barrier and applied the foam and gauze to the resident's wound. 5. Review of Resident #34's comprehensive MDS, dated [DATE], showed staff assessed the resident as cognitively intact and at risk for developing pressure ulcers/injuries. Review of the resident's care plan, dated 02/24/26, showed the resident receives wound care services for a wound on his/her right lower abdominal fold and right posterior knee. Observation on 02/24/2026 at 9:00 A.M., showed LPN A entered Resident #34's room to provide wound care applied a gown, mask, gloves and washed his/her hands. The LPN pulled the covers back to expose the residents leg bandage, pushed the resident's door closed, removed the leg bandage. He/She did not change his/her gloves before he/she removed the clean gauze sponges, applied wound cleaner to the sponges, and placed the wet sponges on the wound. He/She removed his/her gloves, left the resident's room with gown and mask on, removed supplies from the treatment cart, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	returned to the resident's room and did not perform hand hygiene before he/she applied gloves. He/She cleaned the residents wound, applied a petroleum dressing, covered with a bandage and wrapped the resident's lower leg with gauze. With the same gloves he/she cleaned the resident's foot with wound cleaner. LPN A replaced his/her gloves and touched the bathroom door, water faucet, the basin, turned off the faucet, turned on the call light, moved the bipap machine mask, removed the bandages from the resident's right toe, and cleaned the right toe wound with gauze sponges. He/She did not perform hand hygiene before he/she applied new gloves and bandaged the right toe. He/She removed the gloves, gown and mask and did not perform hand hygiene before he/she left the resident's room. The LPN returned to the resident's room to perform perineal care. He/She used the same area of the washcloth multiple times to clean the resident's groin area. With the same soiled gloves, the LPN opened the wipes container and removed a wipe. He/She used the same are of the wipe to clean the resident's groin three times, folded the wipe over, and wiped three more times with the same area of the wipe. He/she removed another wipe and wiped the resident's groin four times, folded it, wiped five times with the same area, folded it and wiped five more times with the same area. Observation on 02/24/26 9:44 A.M., showed the resident's room did not contain posted EBP signs. Observation on 02/25/26 at 12:19 P.M., showed resident's room did not contain posted EBP signs. Observation on 02/26/2026 12:37 P.M., showed resident's room did not contain posted EBP signs. During an interview on 2/26/26 at 4:04 P.M., Registered Nurse (RN) I said staff are expected to perform hand hygiene between dirty and clean tasks and when gloves are changed. 6. Review of the facility's policy titled, Catheter Care, undated, showed the policy did not direct staff on the appropriate placement of catheter tubing or the level of the catheter bag. Review of the facility's policy titled, EBP to Infection Control Guidance, revised 3/2024, showed EBP included residents with an indwelling medical device including urinary catheters and residents with a wound. The policy showed it did not direct staff on the use of EBP signs. Review of the Centers for Disease Control (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), Updated 04/02/24 showed: -EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: --Wounds or indwelling medical devices, regardless of MDRO colonization status; --Infection or colonization with an MDRO; -When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this; --Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves); (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. 7. Review of Resident #2's comprehensive MDS, dated [DATE], showed staff assessed the resident as: -Has indwelling catheter; -Has a pressure injury. Review of the Physician Order Sheet (POS), dated 2/24/26, showed a treatment for a right heel stage three pressure ulcer and a treatment for an unstageable sacral wound. Observation on 2/23/26 at 10:32 A.M., showed the resident in bed, urinary catheter bag hung on side of bed. The resident's room did not contain posted EBP signs. Observation on 2/24/26 at 12:14 P.M., showed the resident wheeled from the dining room past two staff members to the social services office with his/her catheter tube dragging the floor. Observation on 2/24/26 1:40 P.M., showed resident's room did not contain posted EBP signs. Observation on 2/25/26 3:04 P.M., showed resident's room did not contain posted EBP signs. Observation on 2/26/26 at 10:39 A.M., showed resident's room did not contain posted EBP signs. 8. Review of Resident #23's comprehensive MDS, dated [DATE], showed staff assessed the resident as at risk for pressure ulcer/injury. Review of the Resident's care plan, dated 1/06/26, showed the resident sees wound care for a wound located on calf. Review of the POS, dated 2/10/26, showed and order for lower right lateral leg wound care. Observation on 2/23/26 at 11:09 A.M., showed the resident in his/her wheelchair with bandages on his/her legs. The resident's room did not contain posted EBP signs. Observation on 2/24/26 at 11:15 A.M., showed resident's room did not contain posted EBP signs. Observation on 2/26/26 at 925 A.M., showed resident's room did not contain posted EBP signs. 9. Review of Resident #31's comprehensive MDS, dated [DATE], showed staff assessed the resident with two unhealed pressure ulcers. Review of the resident's care plan, dated 10/22/25, showed the resident sees wound care for a wound on the resident's left and right buttock. Review of the resident's POS, date 2/24/26, showed an order to cleans left and right buttock daily and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 02/23/2026 at 10:39 A.M., showed resident's room did not contain posted EBP signs. Observation on 02/24/2026 at 1:49 P.M., showed resident's room did not contain posted EBP signs. Observation on 2/26/26 at 9:25 A.M., showed resident's room did not contain posted EBP signs. 10. Review of Resident #48's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Has indwelling catheter; -Uses a wheelchair for mobility. Review of the resident's POS, dated 02/2026, showed an order for catheter care every shift, change catheter monthly, and to change catheter as needed. Observation on 02/23/26 at 1:45 P.M., showed the resident in the common area with his/her catheter tubing on the floor, with staff present. Observation on 02/24/26 at 9:20 A.M., showed the resident wheeled his/herself around the common area and his/her catheter tubing dragged the floor, with staff present. Observation on 02/24/26 at 9:25 A.M., showed resident's room did not contain posted EBP sign. Observation on 02/25/26 at 3:50 P.M., showed the resident in the common area with his/her catheter tubing on the floor, with staff present. Observation on 2/25/26 at 3:55 P.M., showed resident's room did not contain posted EBP sign. Observation on 2/26/26 at 1:00 P.M., showed resident's room did not contain posted EBP sign. 11. Review of Resident #54's Quarterly MDS, dated [DATE], showed staff assessed the resident has indwelling catheter and a pressure ulcer/injury, one stage two, and two stage three pressure ulcers. Review of the Resident's care plan, dated 12/20/25, showed the resident has a foley catheter. Review of the resident's POS, dated 02/2026, showed an order for catheter care every shift, cleanse sacrum wound once a day, cleanse left foot heel once a day, and cleanse right foot heel once a day. Observation on 02/23/26 at 2:00 P.M., showed resident's room did not contain posted EBP sign. Observation on 02/24/26 at 9:30 A.M., showed the resident in bed with their catheter bag hooked to the bed frame with the bed lowered to the floor and the catheter bag on the floor. The resident's room did not contain posted EBP sign. Observation on 02/25/26 3:55 P.M., showed the resident's room did not contain posted EBP sign. Observation on 02/26/26 at 1:00 P.M., showed the resident's room did not contain posted EBP sign. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 02/24/26 at 9:30 A.M., showed the resident in bed with their catheter bag hooked to the bed frame Observation on 2/25/26 at 3:16 P.M., showed CNA D entered the resident room to perform catheter care. Observation showed CNA D lifted the catheter bag above his/her waistline and the resident's bladder. Observation showed the urine back flowed from the catheter tube into the resident's bladder. CNA D lowered the resident's bed and the catheter bag on the floor. During an interview on 2/25/26 at 3:38 P.M., CNA D said the bag and tubing should not be on the floor. He/She said it is so it doesn't get a hole in the bag or tubing. He/She said the bag should be kept below the bed/below the resident so urine doesn't back flow. He/She said he/she doesn't know why he/she lifted the catheter bag above waist level and does not know why he/she lowered the bed placing the bag and tubing on the floor. 12. During an interview on 2/25/26 at 3:38 P.M., CNA D said catheter bags and tubing should not be on the floor. He/She said it is important that the tubing doesn't drag because it can cause a hole. During an interview on 02/26/26 at 2:15 P.M., CNA B said he/she don't know for sure if a sign needs to be posted for EBP. CNA B said they must wear PPE when doing care for a resident who has a catheter, so thinks there probably should be a sign so everyone knows why they have to wear PPE with certain residents. During an interview on 02/26/26 at 3:55 P.M., with Certified Medication Technician (CMT L) said he/she does not know what an EBP sign looks like. During an interview on 2/26/26 at 4:04 P.M., RN I said catheters should not drag the floor and it is his/her expectation that staff adjust the catheter tubing if they see the tubing dragging the floor. He/She said this is an infection control concern. During an interview on 2/26/26 at 4:36 P.M., the administrator said he/she expects catheters to be up off the floor and not dragging. He/She said it is an infection control concern, and he/she expects staff to step in if they see tubing dragging. he/she believes signs should be placed on the doors to alert staff a resident is on EBP. He/She said anyone with a catheter, or wounds should be on EBP. He/She said he/she is new to the facility and is unsure why staff are not using EBP signs. During an interview on 2/26/26 at 4:28 P.M., the Director of nursing (DON) said catheter tubing should not drag the floor to prevent the spread of infections. He/She said he/she expects staff to keep an eye on catheter tubing as residents ambulate and correct it if they see the tubing dragging. Staff are made aware of who is on EBP residents during shift-to-shift report. He/She said anyone on catheters or have wounds should be on EBP. He/She said he/she was not aware signs needed to be posted.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 53.1.Review of the facility's policy titled, Antibiotic Stewardship Program (ASP), undated, showed it directed staff as follows: -Infection Preventionist (IP): This person will be the hub of the ASP. They will have the knowledge and expertise to effectively develop, implement, and monitor the ASP; -The IP/designee will be responsible to audit the clinical assessment documentation at the time of the antibiotic prescription; -The IP/designee will be responsible for auditing of the completeness of antibiotic prescribing documentation to include dose, route, state date, end date, days of therapy, and indication; -The IP/designee will track C. difficile (a bacterium that causes severe, often painful, watery diarrhea and intestinal inflammation, usually following antibiotic treatment that disrupts healthy gut flora) and antibiotic-resistant infections. The facility will work with the consultant laboratory personnel to develop a quarterly report of any instances of C. difficile or antibiotic-resistant infections, such as methicillin-resistant Staphylococcus aureus ((MRSA) is a type of staph bacteria that causes infections resistant to many common antibiotics) or E. coli (a bacterium commonly found in the intestines of humans and other animals, some strains of which can cause severe food poisoning). This report will be discussed with the Medical Director, Pharmacist Consultant, and Lab Consultant during the quarterly Quality Assurance meeting. Review of the facility's antibiotic stewardship program showed the program did not contain documentation of an infection/antibiotic control log for January 2025 through June of 2025. Review of the facility's Infection/Antibiotic control log, dated July 2025, showed 20 antibiotics used, 12 of the antibiotics did not have documentation of signs and symptoms, four did not have documentation of the site of infection, six did not have documentation of onset of symptoms, four did not have documentation if a culture was done, 17 did not have documentation if the pathogen identified, and 20 antibiotics did not have documentation if the infection was resolved. Review of the facility's Infection/Antibiotic control log, dated August 2025, showed nine antibiotics used, six of the antibiotics did not have documentation of signs and symptoms, one did not have documentation of the site of infection, three did not have documentation if a culture was done, nine did not have documentation if the pathogen identified or documentation if the infection was resolved. Review of the facility's Infection/Antibiotic control log, dated September 2025, showed 18 antibiotics used, 15 of the antibiotics did not have documentation of signs and symptoms, four did not have documentation if a culture was done, 18 did not have if the pathogen was identified or documentation the infection was resolved. Review of the facility's Infection/Antibiotic control log, dated October 2025, showed 11 antibiotics used, two of the antibiotics did not have documentation of signs and symptoms, two did not have documentation of the site of infection, one did not have documentation if a culture was done, 11 did not have if the pathogen was identified or documentation the infection was resolved. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Infection/Antibiotic control log, dated November 2025, showed 17 antibiotics used, 12 of the antibiotics did not have documentation of signs and symptoms, six did not have documentation if a culture was done, 17 did not have if the pathogen was identified or documentation the infection was resolved. Review of the facility's Infection/Antibiotic control log, dated December 2025, showed nine antibiotics used, nine did not have if the pathogen was identified or documentation the infection was resolved. Review of the facility's Infection/Antibiotic control log, dated January 2026, showed 21 antibiotics used, 18 of the antibiotics did not have documentation of signs and symptoms, 17 did not have documentation if the pathogen identified, and 21 antibiotics did not have documentation if the infection was resolved. During an interview on 02/26/25 at 1:03 P.M., the IP said he/she has completed the IP training and is certified to be the infection preventionist. The IP said he/she helps gather and document in the facility's Infection/Antibiotic control log the antibiotic usage in the facility. The IP said he/she does not do anything else with that information it is given to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) and they implement whatever is needed. He/She said the log isn't fully completed because he/she did not know what information is required. The IP said he/she has been in this role for a year. During an interview on 02/26/26 at 1:15 P.M., the DON said the IP is responsible for maintaining the information in infection/antibiotic log and for tracking and trending infections and use of antibiotics in the facility. During an interview on 02/26/26 at 1:16 P.M., the ADON said the IP is responsible for the antibiotic stewardship program. During an interview on 02/26/26 at 4:53 P.M., the administrator said she was not aware the antibiotic stewardship was not being completed. She said she is aware of the importance and the risks are for not having the antibiotic stewardship program in place.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, facility staff failed to provide appropriate care to meet basic hygiene needs for three dependent residents (Resident #8, #34 and #35), to include appropriate incontinent care, out of sampled residents. The facility census was 53.1.Review of the facility's policies showed staff did not provide a policy that addressed toileting/ incontinent care of dependent residents. 2. Review of Resident #8's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 12/12/25, showed staff assessed the resident as follows: -Moderately impaired cognition; -Required mobility device - wheelchair; -Required substantial/maximal assistance with toilet transfer. toilet hygiene, both upper and lower body dressing and with putting on/taking off footwear; -Frequently incontinent of urine. -Diagnosed with Chronic Obstructive Pulmonary Disease, Constipation, Type II Diabetes Mellitus with hyperglycemia, Emphysema, Diabetes Mellitus due to underlying condition with diabetic chronic kidney disease, Essential (primary) hypertension, Presence of artificial eye-prosthetic right eye, Schizophrenia. Review of the resident's plan of care, dated 12/10/25, showed staff assessed the resident required the assistance of one staff with toileting. Did not contain an intervention for frequency of checking and/or changing incontinent resident or intervention for agitated behaviors or refusals of care. Review of the resident's Treatment Administration Records (TAR), dated 09/01/25 – 02/26/26, showed the record did not contain documentation of behaviors or interventions for the resident. Observation on 02/24/26 at 11:54 A.M., showed the resident in a wheelchair at the dining room table with a strong urine odor, a large wet area on the front of his/her pants and down each pant leg, and with puddling on the floor. Observation showed three staff members in the dining room preparing residents for lunch. Observation showed the resident ate lunch while he/she sat in wet pants. Observation on 02/25/26 at 12:02 P.M., showed the resident in a wheelchair at the dining room table with a strong urine odor. Observation on 02/25/26 at 2:45 P.M., showed the resident in a wheelchair at the dining room table with a strong urine odor. Observation on 02/25/26 at 3:34 P.M., showed the resident left the dining room via self-propelled wheelchair with a large wet area on the front of his/her pants. Observation on 02/25/26 at 3:41 P.M., showed the resident in a wheelchair at the entrance to his/her room. The resident yelled out, Can someone bring me a brief. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/25/26 at 3:45 P.M., showed the Director of Nursing (DON) brought the resident a brief as requested. Observation showed no toileting assistance was provided. Observation on 02/25/26 at 4:04 P.M., showed the resident self-propelled to the dining room. A strong urine odor still present. During an interview on 02/25/26 at 4:05 P.M., the resident said, I had to change clothing and I'm wore out. The resident said no body helped with going to the bathroom or changing clothing. Observation on 02/26/26 at 12:49 P.M., showed the resident in a wheelchair at the dining room table with strong urine odor. During an interview on 02/26/26 at 12:51 P.M., Certified Nurse Assistant (CNA) H said he/she checks incontinent residents at least every two hours. The CNA said the resident will get agitated if the CNA's ask if he/she needs to go the bathroom and because of that some CNA's don't check on the resident often enough. During an interview on 02/26/26 at 1:15 P.M., the resident said staff only ask some of the time if he/she needs to go to the bathroom. The resident said, It makes me feel pretty bad when I'm left wet for too long. During an interview on 02/26/26 at 3:51 P.M., Registered Nurse (RN) I said staff should check on incontinent residents at least every two hours, and they should follow the care plan. The RN said the care plan should include interventions for checking incontinent residents, and staff should follow the care plan for ADL's of toileting. For residents needing behavior monitoring, the staff should document in the TAR any behaviors that were seen, what intervention was done and the result of the intervention. During an interview on 02/26/26 at 4:37 P.M., the DON said staff should check on incontinent residents every two hours. The DON said care plans should include interventions for checking incontinent residents every two hours, and staff should follow the care plan for ADL's of toileting. Staff should always document in the TAR any resident behaviors that were seen, what intervention was performed and the result of the intervention. During an interview on 02/26/26 at 5:10 P.M., the Administrator said that all incontinent residents should be checked at least every two hours. The administrator said the care plans should have an intervention for two-hour checks, and staff should be following the care plan for ADL's of toileting. Staff should document in the TAR any behaviors that are observed, what intervention they did, and the result of the intervention. 3.Review of Resident #34's Quarterly MDS, dated [DATE] , showed staff assessed the resident as: -admitted to facility on 01/25/24; -Frequently incontinent; -The resident did not reject care; (continued on next page)

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Eldon Nursing & Rehab	1001 East North Street Eldon, MO 65026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent with toilet assist and transfer. Review of the resident's care plan, dated 02/12/25, showed staff are directed to assist the resident with peri-care and transfer to/from the toilet every two hours. The staff will check for incontinent episodes, change every two hours and as needed. Review of the resident's functional assessment ability, dated 02/04/26, showed, the resident is dependent with all toilet transfers as a two person assist. Observation on 02/24/26 at 1:47 P.M., showed the resident sat in the dining room with small puddle of wet substance under the resident's wheelchair, strong smell of urine and the resident's pants were wet. Observation on 02/24/26 at 2:04 P.M., showed the Activity Director (AD) pushed the resident to activity table. The resident's pants were wet, and a wet substance dripped from the resident's wheelchair. Observation on 02/25/26 at 11:01 A.M., showed the resident sat in his/her wheelchair in the dining room, with a wet substance on the floor under his/her wheelchair. The wet substance dripped from the resident's wheelchair as Certified Medication Technician L (CMT) administered his/her medications. Observation on 2/25/26 at 11:31 A.M., showed the resident spoke with Nurse Aide E (NA) while he/she sat in his/her wheelchair in the dining room with a large puddle under his/her chair. Observation on 02/25/26 at 11:50 A.M., showed staff served the resident lunch. Observation showed a large wet puddle under the resident's chair and strong smell of urine. During an interview on 02/25/26 at 12:32 P.M., the resident said he/she has been sitting in the dining room since about 8:00 A.M. The resident said he/she is unable to tell when he/she urinates. The resident said he/she feels bad and embarrassed because he/she is not able to help it. The resident said the staff usually change him/her when he/she wakes up, after lunch and at bedtime. The resident said staff are aware he/she is not able to control his/her bladder because the staff will let the resident know when he/she has urine under the dining room table. The resident said he/she is not able to transfer by themselves. He/She said the staff assist him/her to the toilet and change him/her. The resident said the staff usually do not ask him/her throughout the day if he/she needs changed. Observation on 02/26/26 11:59 A.M., showed the resident in the dining room with a large wet puddle under his/her wheelchair. During an interview on 02/26/26 at 12:19 P.M., CNA D said he/she does not know how often the resident is changed. He/She assumed the resident would tell him/her if he/she needed to use the bathroom. CNA D said he/she is unaware of the specifics related to the resident's assistive needs. CNA D said they usually change the resident after lunch. He/She does not check the resident every couple hours. During an interview on 02/26/26 at 3:55 P.M., CMT L said the staff try and change the resident every couple of hours at least, because CMT said he/she is aware, but he/she will not tell you. CMT said if (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he/she sees a resident's pants wet then he/she will take and change them if they are a one person assist. The CMT said the CNAs are responsible to ensure the residents are clean and dry. The CMT said the DON would monitor a residents' change in conditions. The staff tell the charge nurse of a resident's change in condition. The CMT said he/she is aware of the residents' incontinent issues as the resident is often wet. The CMT said he/she did not realize the resident was wet when he/she administered his/her medications. The CMT said he/she was aware the resident, at times, has puddles of urine under his/her wheelchair in the dining room. The CMT said the staff is not consistent with cares. The CMT said he/she expects the CNA's to check/monitor the resident every couple of hours. During an interview on 02/26/2026 4:24 P.M., RN I, said he/she expects CNA's to check on the resident's incontinence. RN said he/she notices the resident 34's urine on the floor in the dining room and he/she expects his/her staff to change him/her. Staff is expected to check on the residents every two hours or in between activities. RN said the CNA's should help the resident change his/her clothes. He/She said if the resident sat in his/her urine for several hours, the resident has potential to develop sores and skin breakdown on his/her bottom. RN said the charge nurses have oversight to ensure the resident's Activities of Daily Living ADL's are carried out and followed properly. During an interview on 02/26/26 at 5:11 P.M., the DON said he/she expects staff to follow resident's care plans/ADL's for toilet cares. The DON said he/she expects staff to check the resident every two hours. The DON said the resident is not aware when he/she is incontinent of bladder. The DON expects his/her staff to check or offer to take the resident to the restroom every two hours. The DON said staff remind the resident to shower. The DON said the CNA's check the residents to ensure they are clean, dry and smell good every two hours. The DON said he/she is responsible to ensure the ADL's are followed. 4.Review of Resident #35's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -The resident admitted on [DATE]; -The resident required substantial/maximum assistance from staff to maintain perineal hygiene, toileting and bathe; -The resident did not reject care.Review of the resident's care plan, dated 02/17/26, showed: - Diagnosis of incontinence without sensory awareness; -The resident to remain clean and dry after each incontinent episode; -The staff to reminds the resident to use the restroom regularly; -The staff assists the resident with dressing; -The staff assists the resident during incontinent episodes and toileting; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The staff assists the resident with showers once a week. Observation on 02/23/26 at 11:27 A.M., the resident sat in the dining room with wet pants and a large puddle under his/her [NAME] Observation on 02/24/26 at 10:01 A.M., the resident sat in a common chair near the exit door corridor of the courtyard. The resident wore the same pants, shirt, and jacket from yesterday. There was a strong odor present. During an interview on 02/24/26 10:02 AM., the resident said the staff help him/her shower. The resident said he/she feels embarrassed after he/she has an accident and is not aware when he/she is incontinent. The resident said he/she needs help with his/her pants, shoes and socks. The resident said he/she needs help with showers and is unsure how often he/she showers. The resident said he/she depends on the staff to help him change and shower. The resident said he/she did not refuse cares. Observation on 02/25/26 at 11:50 A.M., the resident sat in the dining room, with the grey t-shirt, blue sweatpants that exposed his/her bottom and smell of urine odor. The resident had small puddles under his/her chair. During an interview on 02/26/26 at 3:55 P.M., CMT L said he/she is unaware of any incontinent issues with the resident. CMT said he/she never provided hygiene or perineal cares for the resident. CMT said he/she reviews care plans at least every morning. CMT said he/she was unaware of the resident's overactive bladder diagnosis. During an interview on 02/26/2026 4:24 PM Registered Nurse (RN) I said he/she is not familiar with the resident and is not aware if staff check on him/her for incontinent cares. He/She said if the resident sat in his/her urine for several hours, the resident has potential to develop sores and skin breakdown on his/her bottom. 5.During an interview on 02/26/26 at 4:59 P.M., the Administrator said he/she expects his/her staff to follow all resident's ADL's. The administrator said he/she does not expect residents to set in his/her wet clothes for long periods. The administrator said if there is urine on the floor, he/she expects his/her staff to place a wet floor sign and change the resident. The Administrator said the resident's care plans match the ADL's and toileting/hygiene interventions. The Administrator said the DON is responsible to ensure the ADL's are followed

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, facility staff failed to meet professional standards when staff failed to obtain proper Against Medical Advice (AMA) documentation for one resident (Resident #60) of one sampled discharge close record. The facility census was 53.1.Review of the facility's Leaving the Facility against Medical Advice policy (AMA) Release, undated, showed staff are directed when a resident or resident's legal representative expresses the desire to leave the facility before the attending physician has discharged the resident staff will: --Notify the physician; --Notify the administrator; --Notify the Director of Nursing (DON); -Document completion of leaving Facility Against Medical Advice release form; -Present form to resident or legal representative regardless of whether it is believed it is the resident or legal representative will sign it. The release should be offered for signature in the presence of witnesses: --If the resident refuses to sign: i.In the space provided for the resident's signature, write the words, Resident refused to sign. Beneath this line, sign your name and exact time, date, and give a brief notation concerning the circumstances of the refusal. ii.Place a summary of facts leading up to the incident and what occurred in the resident's medical record. 2. Review of Resident #60's Comprehensive Minimum Data Set Assessment (MDS), a federally mandated assessment tool, dated 12/10/25, showed staff assessed the resident as: -admission date of 12/10/25; -Cognitively intact; -Did not exhibit behaviors towards others physical, verbal, or other; -Did not refuse care. Review of the resident's nurse's notes, dated 12/11/25, showed: -At 12:33 P.M., the resident is upset about being at the facility and has clothes packed on his/her bed; -At 3:48 P.M., resident was upset about being at the facility and left against medical advice with his/her family member; -At 3:54 P.M., the physician and administrator were notified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's electronic medical record (EMAR) showed the record did not contain documentation an AMA release form was completed. During an interview on 2/25/26 at 2:42 P.M., the Social Services Director (SSD) said he/she was not working the day the resident left AMA. He/She does not have any documentation an AMA form was filled out. He/She said any time a resident wants to leave AMA a form should be filled out and signed by the resident. He/She said if the resident refuses to sign the form, staff should indicate that on the form. He/she does not know why the form was not signed. He/She was not notified the form was not signed. During an interview on 2/26/26 at 4:28 P.M., the DON said the resident didn't want to stay at the facility and left AMA. He/She said an AMA form should have been fileld out, he/she is not sure why it was not done. He/She said he/she is not sure what their policy says about resident refusals to sign. He/She said he/she would expect there to be notes in the system regarding why the form was not signed/filled out. During an interview on 2/26/26 at 4:36 P.M., the administrator said it is his/her expectation when a resident wants to sign out AMA that the physician and family are notified right away, and that the AMA form is followed and filled out. He/She said the AMA is important documentation because it contains all the steps of what staff should do in the event a resident wants to sign out AMA and documents important information. He/She was made aware of the situation during survey and was not aware before.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, facility staff failed to ensure a medication error rate of less than five percent (%). Out of 34 opportunities observed, three errors occurred, resulting in a 9.68% error rate, which affected one resident (Resident #24) of eleven sampled residents. The facility census was 53. 1.Review of the facility's Medication Errors and Drug Reactions policy, undated, showed staff are directed to report all medication errors immediately to the physician, Director of Nursing (DON) and administrator. The policy did not contain a definition of a medication error. Review of the facility's Medication Administration Guidelines policy, undated, showed the physician's order must be verified before the medication is administered. The policy did not contain a definition of a medication error. Review of the facility's Medication Administration policy, undated, showed the policy did not contain a definition of a medication error. 2. Review of Resident #24's physician order sheet (POS), dated 2/26/26, showed the order sheet did not contain an order to crush medications. Observation on 2/26/26 at 8:05 A.M., showed certified medication technician (CMT) J administered nine of twelve pills to the resident, walked back to the medication cart and then crushed the remaining three pills before administering them to the resident. During an interview on 2/26/26 at 8:16 A.M., CMT J said the resident was having trouble getting all his/her pills down, so he/she crushed his/her medications to help. He/She said the resident sometimes has problems swallowing, so he/she crushes his/her medications before giving them. He/She said he/she thought the resident had an order for crushing medication as needed. He/She said he/she should not have crushed the medications. He/She said he/she is not supposed to crush medications without an order. During an interview on 2/26/26 at 4:28 P.M., the Director of Nursing (DON) said it is his/her expectation CMT and nurses have orders before administering medications. He/She said staff should not crush medications without an order. He/She said he/she would consider it a medication error because it is not administered according to the physician order. He/She said he/she would expect staff to notify the charge nurse and contact the physician and/or pharmacy if a medication error was made. He/She said he/she was not made aware of any medication errors during survey. During an interview on 2/26/26 at 4:36 P.M., the administrator said it is his/her expectation staff follow physician orders when administering medications. He/She said staff need an order to crush medications and should not crush them without an order. He/She said if an error is made, he/she would expect his/her staff to notify the charge nurse and DON right away so they could assess the resident and call the physician/pharmacy. He/She said he/she was not made aware of any medication errors during survey.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Many	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 review and revise the plan of care for three residents (Resident #1, #2, and #23) out of 14 sampled residents. The facility census was 53.1. Review of the facility's Care Plan Comprehensive, undated, showed the assessment of each resident is 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 the care plans as follows: -When a significant change in the resident's condition has occurred; -At least quarterly; -When changes occur that impact the residents' care (i.e., change in diet, discontinuation of therapy, changes in care areas that do not require a significant change assessment). 2. Review of Resident #1's Quarterly Minimum Data Set Assessment (MDS), a federally mandated assessment tool, dated 02/06/26, showed staff assessed the resident as: -Cognition not assessed; -Impairment on one side of upper extremity, impairment on both sides of lower extremity; -Dependent on staff for toileting, and shower/bathe; -Diagnosis of Paraplegia (impairment or loss of motor and sensory function in the lower half of the body), Monoplegia of upper limb affecting right dominant side (a form of paralysis affecting only on arm or leg). Review of the resident's care plan, dated 02/10/26, showed the plan did not contain documentation or interventions of the resident's contracture. Observation on 02/24/26 at 9:20 A.M., showed the resident in bed with his/her right hand contracted. Observation on 02/25/26 at 11:30 A.M., showed the resident in the dining room with his/her right hand contracted. Observation on 02/26/26 at 12:50 P.M., showed the resident in the common area with his/her right hand contracted. During an interview on 02/26/26 at 1:09 P.M., the Care plan coordinator said specific interventions for contractures should be on the care plan, and he/she was not aware the resident's contractures were not acknowledged on the care plan. During an interview on 2/26/26 at 4:07 P.M., Licensed Nurse Practitioner (LPN) C said the resident does have a right-hand contraction. He/She said he/she would expect to see the resident have an order for an intervention as well as see it documented on the care plan with interventions. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 2/26/26 at 4:36 P.M., the administrator said he/she would expect the resident's contractures to be addressed on the resident's care plan. 3. Review of Resident #2's comprehensive MDS, dated [DATE], showed staff assessed the resident as: -Moderate Cognitive impairment; -Had a pressure injury. Review of the resident's wound care note, dated 02/02/26, showed wound care for a wound to his/her right-side sacrum, left lateral foot, left lateral foot near 5th digit, and right heel. Review of the resident's care plan, dated 12/09/26, showed the plan did not contain interventions for the wounds or wound prevention. During an interview on 02/26/26 at 1:01 P.M., the Care plan coordinator said the resident's wounds should be addressed on the care plan with interventions. He/She said sometimes the information or changes are not communicated. He/She there were no orders or documentation of interventions that he/she is aware of and he/she believes that is why interventions were not addressed for the residents wound. During an interview on 02/26/26 at 4:04 P.M., Registered Nurse (RN) I said the resident has multiple wounds. He/She said he/she would expect the care plan to have interventions for the current wounds and for prevention of any further wounds. During an interview on 02/26/26 at 4:28 P.M., the Director of Nursing (DON) said the resident does have wounds. He/She said he/she would expect the wounds and interventions to be addressed on the care plan. He/She was not aware interventions were not addressed. During an interview on 2/26/26 at 4:36 P.M., the Administrator said he/she would expect the resident's wounds to be addressed on the care plan with interventions. He/She said interventions are important for the prevention of wounds. 4. Review of Resident #23's comprehensive MDS, dated [DATE], showed staff assessed the resident as: -Moderate cognitive impairment; -At risk for pressure ulcer/injury; -Diagnosis of peripheral vascular disease, chronic venous insufficiency (occurs when leg vein valves are damaged or weak, preventing efficient blood return to the heart, causing blood to pool in legs). Review of the resident's care plan, dated 01/09/26, showed the plan did not contain direction on how to care for the resident's lower leg edema and did not have interventions in place. Review of the Physician Order Sheet (POS), dated 02/18/26, showed an order to cleanse lower left calf wound with soap and water, pat dry, apply Gentamicin ointment to wound base, cover with an (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Many	abdominal pad, and apply tubi-grip (a brand of elasticated, tubular, multi-purpose bandage used to provide, comfortable, and lasting, compression support for strains, sprains, and soft tissue injuries) size G to hold in place, three times daily and to place a gel foam cushion in his/her wheelchair. Observation on 02/23/26 at 11:09 A.M., showed the resident in his/her wheelchair with bilateral swollen and red legs. Observation on 02/24/26 at 11:19 A.M., showed the resident in his/her wheelchair with bilateral tubi-grips on his/her swollen lower legs. Observation on 02/25/2026 at 12:30 P.M., showed the resident in his/her wheelchair with bilateral swollen and red legs. Observation on 02/26/26 at 9:25 A.M., showed the resident in his/her wheelchair with bilateral swollen and red legs. During an interview on 02/26/26 at 1:01 P.M., the Care plan coordinator said edema should be addressed on the care plan. He/She said there should be interventions to keep legs elevated. He/She is not sure why it is not addressed on the care plan. He/She said sometimes resident changes get overlooked due to documentation or lack of communication. During an interview on 02/26/26 at 4:04 P.M., RN I said he/she would expect the care plans to include a continuous issue of edema. He/She said the resident does have issues with edema and he/she believes it should be addressed with interventions on the care plan. He/She said if there are frequent refusals of care or interventions those should also be addressed on the care plan. During an interview on 02/26/26 at 4:28 P.M., the DON said he/she would expect the resident's edema concerns to be addressed on the care plan with relevant interventions. He/She wasn't aware the care plan did not address the edema. During an interview on 02/26/26 at 4:36 P.M., the Administrator said he/she would expect the resident's edema to be addressed on the care plan. He/She said he/she would expect the care plan coordinator to have interventions in place for edema prevention and for it to address any refusals/behaviors associated.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, facility staff failed to update the Facility Assessment at least annually, failure to review the assessment within 12 months may result in the facility failing to identify a factor that would require a change to the assessment. The facility census was 53.1. Review of the Facility's Assessment, dated 12/04/24, showed the assessment did not contain documentation the assessment was reviewed for 2025 During an interview on 02/26/26 at 1:37 P.M., the administrator said she does not know why the facility assessment has not been reviewed and updated since 2024. The administrator said she is aware the assessment needs to be completed at least annually. During an interview on 03/04/26 at 9:50 A.M., the Director of Nursing (DON) said he/she was not aware the facility assessment had not been updated since 2024. The DON said the administrator would be responsible and he/she is not familiar with the facility assessment process.