STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265836	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nodaway Healthcare	22371 State Highway 46 Maryville, MO 64468

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to treat one sampled resident, Resident #1 with dignity and respect when a staff member transferred the resident from a chair to bed without securing the assistance of another staff member or use a gait belt, as directed in the residents plan of care, and put the resident to bed when the resident was not ready to go to bed. This affected one of four sampled residents (Resident #1). The facility census was 20. On 4/21/2026, the Administrator was notified of the past noncompliance which occurred on 4/5/26. On 04/05/2026, facility administration was notified of the incident, an investigation immediately began, and corrective actions were implemented to include a facility wide in-service that included abuse, resident rights, compliance and ethics policy, elder abuse hotline Number, gait belts, and call lights. Additionally, nursing staff completed a full physical assessment of the resident, implemented close monitored for any outcome, and the staff member involved in the incident was suspended and later terminated. The noncompliance was corrected on 4/6/26. Review of facility policy, Safe Lifting and Movement of Residents, revised 2013, showed:- Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents.- Manual lifting of residents shall be eliminated when feasible.- Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.Review of facility policy, Resident Rights, undated, showed:Resident Rights include: - A dignified existence;- Treated with respect, kindness, and dignity;- Self-determination;- Be supported by the facility in exercising his or her rights;Review of facility training records, dated 4/5/26, showed an employee in-service education was conducted and included Resident Rights, Compliance and Ethics, Hotline Number, Gait Belts, and Call Lights.Review of Resident #1's Quarterly Minimum Data Sheet, (MDS, a federally mandated assessment tool completed by facility staff), dated 3/3/26, showed:- Resident was moderately cognitively impaired;- Resident needed substantial or maximal assistance from staff for lower body dressing;- Resident was dependent on staff for footwear assistance;- Resident had independent mobility for rolling left or right;- Resident needed staff supervisor or touching for sitting to lying and lying to sitting mobility;- Resident needed partial or moderate assistance staff assistance for mobility sit to stand, transfer from chair to bed, toilet and shower transfers;- Diagnoses: Coronary Artery Disease, Hypertension, Kidney Disease, Hip Fracture, Dementia, Psychotic Disorder, Asthma, Acute Pain due to Trauma;Review of Resident's Care Plan, revised 4/7/26, showed:- Resident required psychoactive medications for diagnosis of adjustment disorder with mixed disturbance of emotions and conduct. Resident requires two assist to transfer to the bed. Resident is able to stand and pivot transfer with two assist if medicated. - The resident had an Activities of Daily Living self-care performance deficit related to activity intolerance. Resident had a healed fracture of right femur and fractured vertebrae in his/her back. Resident was required to have two assist with transfer from chair to bed and bed to chair. Resident had a history of having difficulty with asking for assistance due to his/her strong sense of independence. - Resident had two falls on 4/2/26 with pain in the left hip and left shoulder;Review of the facility abuse investigation, dated 4/7/26, showed:- Incident occurred on 4/5/26 at 8:15 P.M.- Resident stated she told Certified (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Assistant (CNA) (A) that he/she did not want to go to bed. - Nursing Assistant (NA) (A) and Certified Medical Technician (CMT) (A) reported that they saw CNA (A) being aggressive with the resident. They heard CNA (A) not give the resident a choice about going to bed. Resident was transferred from his/her wheelchair to the bed by CNA (A) and the resident said the transfer hurt his/her body and that his/her shoulder was in pain. CNA (A) had held him/her under the arms and roughly tossed him/her onto the bed. The resident also stated that his/her legs hurt after CNA (A) grabbed and pushed the resident's legs onto the bed. - Medical evaluation and statements from the resident showed no indication of harm or pain experienced by the resident when evaluated by nursing staff after the incident on 4/5/26. - Interventions implemented by the facility included in-service education for staff on abuse and neglect, abuse prevention, gait belts, resident rights, and cares in pairs. Specific guidance was provided to staff on the resident's needs regarding assistance.During an interview on 4/16/25 at 10:40 A.M., the Director of Nursing (DON) said:- The resident is a poor historian and is currently on hospice care. Immediately after the incident involving staff and the resident, the facility did in-service training on various topics including abuse, transfers, and resident rights. The staff are well educated and can identify abuse or neglect when they observe it and they are not hesitant about reporting these incidents. - After the incident, the Administrator did interviews to determine causes and issues related to the resident's treatment. CNA (A) should have asked for assistance from the other staff members present to assist with providing a safe transfer. A gait belt should have been used during a two-person transfer of the resident. During an interview on 4/16/25 at 2:15 P.M., CNA (A) said: - He/she was working with CMT (A) and NA (A) on the evening shift on 4/5/26 and they were helping the resident to his/her room. The resident was sitting on the edge of his/her wheelchair so he/she felt it was imperative that he/she immediately transfer the resident to the bed so he/she would not fall. He/she knew that a gait belt should have been used but he/she did not have time to use one. - He/she transferred the resident to the bed by doing a face-to-face transfer. He/she placed his/her arms under the resident's rib area and moved the resident in one fluid motion to the bed. The resident said that his/her shoulder was hurting after the transfer. - The resident protested about going to bed, but he/she educated him/her on why it was beneficial for him/her to go to bed right now. During an interview on 4/16/26 at 1:15 P.M., the Administrator said based on the investigation, she determined the incident was not abuse and CNA (A) was rough with the resident and denied the resident his/her right of choice by putting him/her to bed when he/she didn't want to go to bed. The resident said the next morning that he/she was not hurt and that no one was abusive towards him/her the evening before. The Administrator waited to interview the resident until the next morning since the resident was sleeping when the Administrator arrived at the facility on the evening of 4/5/26. After reviewing all of the statements, CNA (A) was terminated for not using a gait belt and performing a one-person transfer and violating the resident's right to be treated with dignity and respect when she put the resident in bed when the resident was not ready to go to bed. During an interview on 4/16/26 at 4:25 P.M., CMT (A) said his/her recollection of the incident was all contained in the statement that he/she submitted to the Administrator. His/her statement showed that CNA (A) was aggressive with the resident and performed a one person transfer without a gait belt from the resident's wheelchair to the bed. The resident was not given a choice about going to bed. During an interview on 4/17/26 at 2:25 P.M., NA (A) said he/she was working with CMT (A) and CNA (A) on 4/5/26 during the evening shift. CNA (A) forced the resident to go to bed and did a one person transfer without a gait belt. The resident's transfer was done roughly, and CNA (A) was verbally harsh to the resident. Overall CNA (A) did not treat the resident with dignity or respect during the incident. The transfer of the resident was not an emergency and could have been done with a two-person assist. At no time did he/she feel that the resident was going to fall out of his/her wheelchair and required immediate intervention to prevent an accident. Intake 2973932