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	08/07/2025

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

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for eight consecutive hours per day seven days a week. This had the potential to affect all residents. The facility census was 30. The facility did not provide a policy for RN coverage. Review of the facility's Payroll Based Journal data (PBJ - a report that provides staffing data set information submitted by nursing homes on a quarterly basis) for Quarter 2 2025 (January 1 - March 31) showed no RN coverage hours on 2/23, 3/2, 3/16, 3/29 and 3/ 30. Review of staffing schedule for February 2025 showed no RN on the day: 2/23. Review of the staffing schedules for March 2025 showed no RN on the following days: 3/2, 3/16, 3/29 and 3/30.During an interview on 8/5/25 at 9:52 A.M., the Regional Nurse said she knew something was not right with the PBJ and did not think it had been filled out correctly. During an interview on 8/7/25 at 11:53 A.M., the Assistant Director of Nursing (ADON) said:- The Administrator had been there since July of this year;- He/She had been at the facility since November of last year;- The MDS/Care Plan Coordinator took over as the DON about three months ago;- He/She was unable to find any documentation to show their was RN coverage on those dates;- They had a rough time with staffing early in the year but it was better now. During an interview on 8/7/25 at 2:20 P.M., the Administrator said:- The PBJ should be filled out correctly;- They should have an RN working eight hours a day, seven days a week.

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	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to complete Tuberculosis (TB) skin testing for three out of ten employees. The facility additionally failed to establish and maintain an effective water management program to aide in identifying and reducing the risk of Legionella and other waterborne pathogens that can grow and spread and lead to Legionnaires' disease (a type of serious pneumonia caused by a type of bacteria called Legionella.) The facility census was 30. Review of the facility's Employee TB Screening and interpretation of Results Policy, Revised July 2010 showed: All employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) prior to beginning employment. The need for annual testing shall be determined by the annual TB risk classification or as per State regulations. The facility will administer and interpret TB skin test in accordance with recognized guidelines and pertinent regulations. A qualified nurse or health practitioner interprets the TB skin test 48-72 hours (2-3 days) after administration. Initial testing will be a two-step procedure with the first dose give before beginning work and the second booster dose to be given 7-21 days after the first dose: New employees will not be allowed to work until the Tuberculin Skin Test (TST), or chest x-ray results are known. Employees who will be receiving the two-step TST may begin work after the first step results are negative. The facility did not provide a water management plan or policy regarding prevention of water borne pathogens. 1. Review of employee records on 08/06/25, showed: CMT A, hire date 11/04/24, showed no 2 step TB in employee file. CNA A, hire date 11/11/24, showed no 2 step TB in employee file. CNA B, hire date 03/14/25, showed no 2 step TB in employee file. During an interview on 08/07/25 at 9:51 A.M., the Director of Nursing/Infection Preventionist, said that all new hire employees are to have a 2 step TB skin test upon being hired and documentation is kept in a binder in her office. She also stated that there are times that staff may need to a copy of their results and the originals get taken out and never returned. She was not able to explain where the missing TB skin testing results were. 2. During an interview on 8/7/25 at 11:08 A.M., the Maintenance Supervisor said: - There currently was no established program to address prevention of legionella in the water system at the facility; - Testing for legionella at the facility had not been done; During an interview on 8/7/25 at 2:30 P.M., the DON said there was currently no water management plan or program in place for legionella prevention at this facility;

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure two of the 12 sampled residents reviewed for unnecessary medications, (Resident #3 and #33) and/or their representative were informed of the risks and benefits of a physician ordered antipsychotic medication. This failure prevented the resident and/or their representative from knowing the risks and the benefits of using psychotropic medications. The facility census was 30. Review of the facility's policy for antipsychotic medication use, revised December 2016, showed: - Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. - Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review; - Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective; - The Attending Physician and facility staff will identify acute psychiatric episodes, and will differentiate them from enduring psychiatric conditions; - Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident; - Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders: Schizophrenia, Schizo-affective disorder, Schizophreniform disorder, delusional disorder, mood disorders (bipolar disorder, depression with psychotic features, and treatment refractory major depression), Psychosisi in the absence of dementia, medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania, Tourette's Disorder, Huntington Disease, Hiccups or nausea and vomiting associated with cancer or chemotherapy; - Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: the behavioral symptoms present a danger to the resident or to others AND: the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or behavioral interventions have been attempted and included in the plan of care, except in an emergency; - For enduring psychiatric conditions, antipsychotic medications will not be used unless behavioral symptoms are: not due to a medical conditions or problem that can be expected to improve or resolve as the underlying condition is treated or the offending medication are discontinued; and persistent or likely to reoccur without continued treatment; and not sufficiently relieved by non-pharmacological interventions; and not due to environmental stressors that can be addressed to improve the psychotic symptoms or maintain safety; and not due to psychological stressors or anxiety or fear stemming from misunderstanding related to his/her cognitive impairment that can be expected to improve or resolve as the situation is addressed; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Antipsychotic medications will not be used if the only symptoms are one or more of the following: wandering; poor self-care; restlessness; impaired memory; mild anxiety; insomnia; inattention or indifference to surroundings; sadness or crying alone that is not related to depression or other psychiatric disorders; fidgeting; nervousness; or uncooperativeness; - The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications; - Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician: general/anticholinergic : constipation, blurred vision, dry mouth, urinary retention, sedation; cardiovascular: orthostatic hypotension, arrhythmias; Metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain: or Neurologic: Akathisia, dystonia, extrapyramidal effects akinesia; or tardive dyskinesia, stroke or mini strokes; - The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected of confirmed adverse consequences. 1. Review of Resident #3's Significant Change in Status Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 7/22/25 showed: - Long term and short term memory problems; - No behaviors; - Dependent on the assistance of staff for eating, oral care, toilet use, showers, dressing and personal hygiene; - Required substantial/maximum assistance with transfers; - Frequently incontinent of bowel and bladder; - Had two or more falls with no injury noted; one fall with minor injury; - Diagnoses included Non traumatic brain dysfunction, cancer, anxiety, high blood pressure, arthritis, dementia, TBI, malnutrition, and anxiety; - In the last seven days the resident had seven antipsychotic medications, antidepressant medications and anticoagulant medications; - Antipsychotic medications were used on a routine basis; - No gradual dose reduction was attempted. Review of the resident's care plan, revised 7/24/25 showed: - The resident used psychotropic medications. Depakote, trazodone and Haldol related to behavior management, depression, and anxiety with delusions. Administer psychotropic medications as ordered (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by the physician. Monitor for side effects and effectiveness every shift. Consult with pharmacy to consider dosage reduction when clinically appropriate at least quarterly; - Discuss with the physician, family for ongoing need for use of medications. Review behaviors/interventions and alternate therapies attempted and their effectiveness. Educate the resident, family, caregivers about risks, benefits and the side effects and/or toxic symptoms. Monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the resident. Review of the resident's Medication Administration Record (MAR), dated July 2025 showed: - Haldol 5 mg. by mouth in the evening for behavioral disturbance, mood disorder. Review of the resident's medication regimen review (MRR) dated July, 2025 showed: - The resident was admitted [DATE]; - July 2025- no pharmacy recommendations. Review of the resident's Physician Order Sheet (POS), dated August 2025 showed: - Start date: 7/31/25 - Haldol 5 mg. by mouth in the evening for behavioral disturbance, mood disorder. Review of the resident's MAR, dated August 2025 showed: - Haldol 5 mg. by mouth in the evening for behavioral disturbance, mood disorder. Review of the resident's medical records, dated 8/6/25 showed: - No consents or education of risks and benefits for psychotropic medication use were found from 7/1/25 through 8/6/25. During an interview on 8/7/25 at 2:20 P.M., the Director of Nursing (DON) said staff should have obtained a written consent from the resident or responsible party prior to the resident starting on antipsychotic medications. 2. Review of Resident #33's Quarterly MDS, dated [DATE], showed:- Resident was moderately cognitively impaired;- Resident required substantial assistance for eating;- Resident was dependent on staff assistance for oral hygiene, toileting hygiene, showering, dressing, and personal hygiene;- Resident was taking antipsychotic, antidepressant, and opioid medications;- Diagnosis: neurogenic bladder, dementia, paraplegia, multiple sclerosis, depression, and psychotic disorder; Review of Resident's Care Plan, revised 7/22/25, showed;- Resident was prescribed an anti-psychotic medication; - Resident was prescribed psychotropic medications (Aripiprazole, Topamax, and Citalopram) for depression and anxiety disorder. Monitor/document/report as needed (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any adverse reactions from these medications; Review of Resident's Order Recap Report, dated 8/5/25, showed:- Aripiprazole oral tablet 5mg, one tablet daily for depression related to delusional disorders. Started 6/27/24 – Discontinued 7/22/25;- Aripiprazole oral tablet 5mg, one tablet daily for delusions and major depressive disorder related to delusional disorders, started 7/22/25; Review of Resident's Medication Administration Record, dated 8/1/25 – 8/5/25, showed:- Aripiprazole 5mg tablet 1x daily administered for delusions and major depressive disorder;- Citalopram hydrobromide 10mg tablet 1x daily administered for depression;- Hydrocodone-Acetaminophen 7.5-325 mg tablet administered two times daily for pain; Review of Resident's Medication Administration Record, dated 7/1/25 – 7/31/25, showed:- Aripiprazole 5mg tablet 1x daily administered for delusions and major depressive disorder;- Citalopram hydrobromide 10mg tablet 1x daily administered for depression;- Hydrocodone-Acetaminophen 7.5-325 mg tablet administered two times daily for pain; Record Review of Resident's medical record showed:- No documentation showing the facility fully informed the resident in advance of the risks and benefits to taking anti-psychotic, psychotropic, or anti-depressant medications;

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation and interview the facility failed to promote an environment respectful of the rights of each resident to make choices, when six out of six residents in a group interview were concerned about specific aspects of their life when staff did not offer a bedtime snack to the residents. This potentially affected all residents who would like a snack. The facility census was 30. Review of facility Resident Nutrition Services Policy, dated November 2015, showed snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snacks may be scheduled between meals to accommodate the resident's typical eating patterns. Review of facility Resident Rights Policy, undated policy included federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to exercise his or her rights as a resident of the facility and as a resident or citizen of the United States, be supported by the facility in exercising his or her rights, exercise hir or her rights without interferences, coercion, discrimination or reprisal from the facility.During a group interview on 08/05/2025 at 2:08 P.M., the residents said no bedtime snacks were brought to residents. Five of six residents said that they would take a snack at bedtime if it was offered. During an interview on 08/07/2025 at 10:36 A.M. Resident #31 said no snacks are passed out before bedtime and would take a snack at bedtime if offered.During an interview on 08/06/2025 at 8:11 A.M., CNA B said: - Drinks and snacks are set on a cart by nursing station at 10:00 A.M. - There is supposed to be a snack cart after supper also. - He/she only works on the dayshift, so he/she is unsure of time that snack cart arrives after supper. During an interview on 08/06/2025 at 8:58 A.M., CNA A said:- No one goes room to room to pass snacks. - The snacks sit out by the nurse's station. - Staff will bring the residents a snack if they say they are hungry. - He/she stated that times vary for when snacks arrive at the nurse's desk, and it depends on who is working in the kitchen. During an interview on 08/06/2025 at 10:03 A.M. LPN A said: - It depends on who is working in the kitchen on what time snacks arrive. - Residents can ask any time for a snack and staff will get them one. - There is a snack cart on evening shift and night shift, not on day shift. CNAs pass out snacks and leave the cart by the nurse's station for the residents at night. During an interview on 08/06/2025 at 11:16 A.M., [NAME] B said: - Kitchen staff gets the snacks ready. - A snack cart is made after dinner and left in the hallway by the nurse's station. - CNAs pass out snacks or if residents want a snack, they can ask for one and the CNAs will get a snack for them. During an interview on 08/07/2025 at 9:30 A.M. The Dietary Manager said:- CNAs are supposed to pass out snacks, then bring the snack cart back to the kitchen. -He/she is not sure if snacks get passed out every day. -He/she said that as of yesterday (8/6/25) the snack cart was sent out three times. -Before yesterday the snack cart was only sent to the nurse's station at 6:30P.M. (night shift). -The snack cart typically consists of- baked goods, crackers, chips, bananas, and peanut butter and jelly sandwiches. Food that is gluten free is marked indicating that it is gluten free. - He/she recently informed staff that the snack cart needs to go behind the nurse's station so snacks will get passed and residents cannot grab a food item that they are not supposed to have. During an interview on 08/07/2025 at 9:50 A.M., CMT B said snacks are available at nighttime. The snack cart is left by the nurse's station for residents to get snacks.During an interview on 08/07/2025 at 10:05 A.M. The DON (Director of Nursing) said the snack cart is refilled after the noon meal, and snacks are usually passed after the evening meal. Residents can ask for snacks during the day if they want one. The CNAs asks the residents before bedtime if they want a snack.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observation and interview, during a group interview six out of six participants said the facility failed to protect resident rights when the facility did not prominently display information on how to file a grievance or how to call or contact the Missouri Adult Abuse & Neglect hotline in the facility for its residents. The facility census was 30. Review of facility policy, Resident and Family Concerns and Grievances Policy and Procedure, dated 2020, showed the facility will notify residents, individually or through posting in prominent locations throughout the facility, of the right to file a grievance. The notification must include the following information: Contact information for the relevant state agency or Ombudsman program for filing a complaint. Review of facility policy, Resident Rights, not dated, showed; - Federal and state laws guarantee certain basic rights to all residents of this facility. -These rights include the resident's right to: communicate with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protections or advocacy organizations, etc.) regarding any matter.During a group interview on 8/5/25 at 2:15 P.M., the residents said six of six residents did not know where the State Agency contact information for filing a complaint was displayed in the building;-Six is six residents did not have knowledge of the phone number to the State Agency for filing a complaint; -Six of six residents did not know how to file a grievance. During observation on 08/05/2025 at 11:00 A.M., showed no sign posted in the facility with information to contact the State Agency to file a complaint. During an interview on 08/06/2025 at 8:11 A.M., CNA B said the hotline number is on the wall. No resident had asked him/her for the State phone number, so he/she had not looked for it. He/she was unable to locate the phone number for the adult abuse and neglect hotline. During an interview on 08/06/2025 at 8:58 A.M., CNA A said he/she was not sure where the telephone number for the State abuse hotline was located.During an interview on 08/06/2025 at 10:03 A.M., LPN A said if a resident wanted to make a phone call to state hotline, he/she would take resident into the office so the business manager could give the resident the phone number. He/she is not sure where the phone number would be posted. During an interview on 08/07/2025 at 10:05 A.M., The DON (Director of Nursing) said she was not sure if the State phone number was posted anywhere currently. The State phone number used to be posted in the dayroom. During an interview on 08/07/2025 at 10:52 A.M., The Administrator said: She was not sure if State abuse hotline phone number was posted. During observation on 08/07/2025 at 11:00 A.M., showed no sign posted in the facility with information to contact the State Agency to file a complaint.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to maintain the privacy of three of the 12 sampled residents (Resident #15, #2 and #30), when staff failed to post signage at the front door, and outside each sampled residents room to indicate 24 hour camera surveillance was in progress and failed to obtain consents from (#15) and (#30)'s responsible party. The facility census was 30.The facility failed to provide a policy for video surveillance with or without audio.Interview, observation and record review of resident #15, on 08/05/25 at 1:45 P.M. showed: Resident is alert and orientated to self and place, uses a walker with ambulation and wants to be as independent as possible. Resident is his/her own person and able to make his/her own decisions. Resident has diagnosis of: Sequelae following Cerebrovascular disease, Foot drop,(Left), Muscle weakness, Gastro-Esophageal Reflux Disease, Conversion Disorder with Seizures, Restless Leg Syndrome, Abnormalities of gait and mobility, Pain in Left Ankle and Joints of Left Foot and History of Falls. Last fall being 07/17/25, in the hall.Review of the resident's Physician Order Sheet. (POS), dated 07/01/25-08/31/25, did not include an order for video surveillance with audio.Observation on 08/06/25 at 9:40 A.M., showed: The resident was on his/her side of the room getting dressed, video//audio surveillance on his/her roommates side of room but had to pass by when leaving room or using the BR.Did not have a sign outside the resident's room to indicate video monitoring with audio was in use;No signage was posted at the entrance to the facility to indicate video monitoring with audio was in use.The video monitor was at nurse's station and the volume was turned down at time so you were unable to hear what was being said in the resident's room. Review of Resident #15's progress notes for last 7 days and care plans, revised 6/27/25, on 08/6/25 at 9:50 A.M., showed: Care plan did not address the use of video/audio surveillance in residents room. Progress notes did not address receiving consent from resident for the use of video/audio surveillance in room. On 08/07/25 at 11:00 A.M., the audio from video was noted to be turned on at nurses station and you could hear the TV. On 08/07/25 at 2:30 P.M., Review of the residents medical record showed he/she did not have a consent signed by her for 24 hour camera surveillance. 2. Review of Resident #2's care plan, Revised on 06/17/25, on 08/04/25 at 2:53 P.M., showed:Resident has a BIMs of 10, he/she is alert to Person, Place and Time. Resident uses a wheelchair for mobility and is able to ambulate with walker in room but has a note in room to remind him/her to ask for assistance. Resident is unsteady at times and is unaware of limitations.Resident is on hospice for heart failure and is noted to have 2+ edema in bilateral lower extremities with ace wraps applied in the morning and removed at night. Residents diagnosis's are Heart disease, Non-Hodgkin's Lymphoma, Chronic Kidney disease(stage 4), Hypertension, Major Depressive Disorder, History of Transient Ischemic Attack, Cellulites to Bilateral lower limbs. The resident was a high risk for falls related to deconditioning, incontinence, psychoactive drug use, osteoarthritis and knee pain and I have poor safety awareness. The resident has had several falls since his/her admission, last one dated 6/17/25. Interventions include, anticipate and meet residents needs. Be sure call light is within reach and encourage the resident to use it for assistance as needed. A sign has been placed in residents room to remind him/her to ask for assistance to get to the bathroom. Ensure resident is wearing appropriate footwear such as non-skid socks when up ambulating or mobilizing in wheelchair; The care plan did not address the use of video surveillance.Did not have a sign outside the resident's room to indicate video monitoring with audio was in use;No signage was posted at the entrance to the facility to indicate video monitoring with audio was in use.Review of resident #2's progress notes for last 7 days (7/28/25-8/4/25) showed, residents POA(Power of Attorney) has given verbal consent on 7/31/25 at 4:20 P.M., for video surveillance in residents room [ROOM NUMBER]/7 monitoring.On 08/07/25 at 11:00 A.M., the audio from video was noted to be turned on at nurses station and you could hear the TV. On 08/07/25 at 2:15 P.M., Review of the residents medical record showed he/she did not have a consent signed by her POA for 24 hour (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	camera surveillance. 3. Review of Resident #30's Significant Change in Status MDS, dated [DATE] showed;- Long term and short term memory problems;- Dependent on the assistance of staff for eating, toilet use, dressing, showers, and personal hygiene;- Required substantial to maximum assistance with transfers;- Frequently incontinent of bowel and bladder;- Had two or more falls with no injury noted. Had one fall with a minor injury;- Diagnoses included non traumatic brain dysfunction, cancer, anxiety, arthritis, and dementia. Review of the resident's care plan, revised 7/24/25 showed:- The resident was at a high risk for falls related to confusion deconditioning, gait/balance problems, incontinence, poor communication/comprehension, and unaware of safety needs. The resident has had falls since his/her admission. Interventions include anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure the resident is wearing appropriate footwear such as non-skid socks when ambulating or mobilizing in wheelchair;- The care plan did not address the use of video surveillance. Review of the resident's medical record showed it did not have a consent signed by the responsible party for 24 hour camera surveillance. Observation on 08/04/2025 at 10:15 A.M., showed:- The resident sat in his/her recliner;- There was a video monitor on the resident's bedside table aimed at where he/she sat;- There was not a sign outside the resident's room to indicate there was camera surveillance. During an interview on 08/04/2025 at 2:15 P.M., Family Member A said:- He/She noticed about a week ago staff had placed a video monitor in the resident's room;- He/She was not for sure if there was audio capabilities or not because no one had discussed it with him/her;- He/She was not asked to sign any kind of a consent for the video monitor;- He/She did not know if it was linked to anyone's phone;- He/She would have expected to have been informed about it prior to the staff setting it up. Observation on 08/04/2025 at 2:58 P.M., showed:- A VTECH video monitor at the nurse's station and showed the resident in his/her room;- The volume on the monitor was able to be adjusted and you could hear staff talking in the resident's room. During an interview on 08/06/2025 at 3:22 P.M., the Assistant Director of Nursing (ADON) said:- He/She thought the resident has had the camera surveillance since he/she was readmitted ;- The resident has had multiple falls in his/her room;- He/she was under the impression that whomever put the monitor in the resident's room had obtained a verbal consent;- There should have been a written consent obtained, a physician's order and it should have been care planned;- A sign should be posted outside the resident's room and at the front entrance. During an interview on 08/07/2025 at 2:20 P.M., the Director of Nursing said:- The family should be made aware of the video surveillance and a consent signed.- Should have a physician's order and it should be care planned.- Should have signage posted outside the resident's room and at the front entrance.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility staff failed to check the Certified Nurses Assistant (CNA) Registry for nine of 10 sampled staff to ensure they did not have a Federal Indicator (a marker given by the federal government to individuals who have committed abuse/neglect). this affected 10 of 10 sampled staff (Licensed Practical Nurse(LPN) B, Certified Medication Technician (CMT) A, Social Service Designee (SSD), Nursing A, Nursing B, and Nursing C, [NAME] A, Nursing Assistant (NA) A, Care Partner (CP)A, and Administrator 2. The facility also failed to have a criminal record check on file prior to employee's first date working for two of 10 sampled staff: CMT A and Nurse A. The facility census was 30.Review of facility policy, Abuse and Neglect Procedure, revised [DATE], showed pre-employment screening will be completed on all employees, to include:- Criminal History Check, Background Check, Reference check from previous employers, Professional licensure, certification, or registry check as applicable, Registry and OIG.- The facility will not hire or retain any employee with a history of abuse or neglect if that information is known to the home.1.Review of SSD's employee file showed: - Hire date on 04/06/2025;- No CNA registry check found.2. Review of LPN B's employee file showed:- Hire date on 06/01/25- No CNA registry check found.3. Review of CMT A's employee file showed:- Hire date on 11/04/24;- No Criminal Background Check prior to first working day or on file;- CNA registry check on file.4. Review of NA A's employee file showed:- Hire date 07/02/25;- No CNA registry check on file.5. Review of CP's employee file showed:-Hire date 05/23/25; -No CNA registry check on file.6. Review of [NAME] A's employee file showed:- Hire date 07/09/25;- No CNA registry check on file.7. Review of Nurse A's employee file showed:- Hire date 11/11/24- No Criminal Background Check prior to first working day or on file;- No CNA registry check on file.8. Review of Nurse B's employee file showed:-Hire date 03/14/25;- No CNA registry check on file.9. Review of Nurse C's employee filed showed: - Hire date 03/31/25;- No CNA registry check on file.10. Review of Administrator 2 employee file showed:-Hire date 01/16/25;-No CNA registry check on file.During an interview on 08/07/25 at 9:58 A.M. the BOM said:- She was able to provide 8 out of 10 of CBC, 10 of 10 EDL's and one of 10 Certified Nurse Registry's. - The 2 CBC that she failed to supply were done but not uploaded to the system. - Every new employee should have a background check completed before they start work, but she was unable to provide all documentation.In an interview on 08/07/25 at 2:48 P.M the Administrator said CBC and EDL's are to be completed prior to staff being able to start work.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the bed hold policy, a discharge summary regarding Resident #8, and the reason for discharge to the resident's representative in writing, including the statement of appeal rights or the name, address, or telephone number of the Office of the State Long Term Care Ombudsman (advocates for the residents in long-term care facilities) for (Resident #1, #4, #6 and #12) and failed to notify the Ombudsman of the discharge. This affected five of 12 residents sampled. The facility census was 30.Review of facility policy Transfer or Discharge Notice, revised 12/2016, showed:- The facility shall provide a resident and/or resident's representative with a thirty-day written notice of an impending transfer or discharge;- A notice will be given for the following reasons: transfer is necessary for the resident's welfare and their needs cannot be met in the facility, resident no longer needs the services provided by the facility, the safety of individuals in the facility is endangered, failure to pay by the resident, or immediate transfer or discharge is required due to urgent medical needs;- The resident and/or representative will be notified in writing with the following information: reason for the transfer or discharge, effective date, location to which the resident is being sent, a statement of the resident's rights to appeal the transfer or discharge including where to send the appeal and obtain the appeal form, facility bed hold policy, Ombudsman contact information;- A copy of the notice will be sent to the Office of the State Long-Term Ombudsman;- The reasons for the transfer or discharge will be documented in the resident's medical record; Review of facility policy Transfer or Discharge, Preparing a Resident for, revised December 2016, showed:- When a resident is scheduled for transfer or discharge nursing services will complete a discharge note in the medical record;- When a resident is scheduled for transfer or discharge the business office will inform the resident or his/her representative of the facility's readmission appeal rights and bed hold policy; 1. Review of Resident #1 closed medical record on 08/06/2025 showed:- Resident #1 was admitted to the facility on [DATE] after receiving a bowel resection. - Diagnosis include Crohn's Disease, Kidney disease, Respiratory failure, anemia and sepsis. - On 06/09/25, resident was sent to the hospital due to shortness of breath.- Nurses' notes showed the resident was in the hospital from [DATE]-[DATE]. The record did not include documentation regarding why the resident did not return to the facility, if the residents personal belongings were picked up or not, and where resident was discharged to.- The record did not show a bed hold notice was provided or the Ombudsman was notified of the discharge. 2. Review of Resident #6 closed record on 08/06/25 showed; - Resident #6 was admitted on [DATE] with diagnosis of Adult Failure to Thrive, Anorexia, Heart Disease, Hypertension and Type 2 Diabetes. - On 07/29/25 this resident was given the choice to go to hospice or to be sent to hospital due to failure to thrive and weight loss, by Physician. The resident chose to go to the hospital instead of going to on hospice and was sent out for possible admission. Notes in the chart did not indicate the DPOA was notified of the resident being transferred nor was she notified the resident was able to return to facility after discharge from hospital. - No documentation that the Ombudsman was notified of discharge. - After the resident was discharged , the charting noted: Not coming back over the next 5 days. - Documentation did not indicate how the nurse was notified that resident was coming back nor who notified him/her that the resident was not coming back. - Documentation in chart did not indicate the family came to facility and picked up resident's personal belongings.- Charting does not state what happened to this resident after discharge or reason for not returning to facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/6/25 at 11:15 A.M., LPN A said when a resident is transferred out of the facility the nurse is to send with the resident, a copy of the medication list, medication administration record, diagnosis list, face sheet, code status, notice of emergency discharge, bed hold agreement, all go in the packet and are sent with the resident to the hospital. Documentation should include where the resident is sent, why the resident was sent, how they were sent, and who was notified of the transfer. During an interview on 08/06/25 at 10:33 A.M., DON was asked what paperwork is sent in regard to records regarding transfer and discharge and said staff are to send a discharge packet for each resident and the packet is at the nurse's station in a binder for each individual resident. When a resident is discharged out of facility, their individual packet is copied and sent with resident. The packet contains a medication list, MAR, diagnosis list, face sheet, DNR (purple sheet) and if applicable, a notice of emergency transfer or discharge and bed hold. Paperwork in placed in transfer packet and should be sent with the resident. During an interview on 08/07/25 at 2:48 P.M., ADON said:- When a transfer/discharge of a resident is completed, she would expect the discharge paperwork to be uploaded into the medical records.- He/she said the Ombudsman is to be contacted when a resident is transferred out of the facility. - He/she said there should be a physician's order in the system for discharge or emergency transport, and the charting should indicate what time the physician was notified. - He/she said that when the resident does not return back to facility, charting should indicate who notified the nurse.- Documentation should be in the chart that showed when a resident's personal property is picked up. 3. Review of Resident #4's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/25, showed:- Resident was severely cognitively impaired;- Diagnosis: deep venous thrombosis (blood clot formation), kidney disease, obstructive uropathy (blockage of urine flow), hip fracture, epilepsy, and down syndrome;- MDS updated with a change of status due caused by hip fracture; Record review of Resident's medical progress notes, showed:- Resident was hospitalized on [DATE] due to leg pain and an order for an x-ray was given; Record Review of Resident's medical records showed:- There was no documentation that the bed hold policy or discharge summary was provided to the resident their representative; Record Review of the Admission/Discharge Report, dated June 2025, showed:- No record of resident being discharged on 6/17/25 to the hospital or date when resident was re-admitted back into the facility;During an interview on 8/7/25 at 2:15 P.M., the Ombudsman said:- Before August 2025 she did not receive any documentation from the facility on admissions, transfers, or discharges from the facility;- She has not received in the past any notifications or reasons why residents have been discharged or transferred; 4. Review of Resident #12's progress notes, dated 4/23/25 R 5:17 P.M., showed:- The resident was observed sweating and vomited. The resident stated he/she did not feel good. Vital signs within normal limits (WNL). Alert and oriented at baseline. Primary Care Physician (PCP) was contacted and said to sent the resident out for further evaluation. Family contacted. EMS in route.- There was no documentation to indicate when the resident returned to the facility and no documentation to indicate the transfer discharge paperwork and bed hold had been discussed with the resident's responsible party or signed. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Quarterly MDS, dated [DATE] showed:- Cognitive skills severely impaired;- Upper and lower extremities impaired on one side;- Dependent on the assistance of staff with toilet use and lower extremity dressing;- Required substantial to maximum assistance with upper extremity dressing, personal hygiene and transfers;- Always incontinent of urine;- Frequently incontinent of bowel;- Diagnoses included non-traumatic brain dysfunction, stroke and hemiplegia. During an interview on 8/5/25 at 11:39 A.M., LPN D said:- When a resident is sent out to the hospital, the staff sent the face sheet, Medication Administration Record (MAR), transfer/discharge report, bed hold, order summary and the advance directives;- The facility did not keep a copy of the paperwork for the resident's chart, it was sent to the hospital with the resident; During an interview on 8/7/25 at 7:56 A.M., the Social Services Designee said he/she was not aware the Ombudsman had to be notified monthly of any transfers or discharges. During an interview on 8/7/25 at 2:20 P.M., the Assistant Director of Nursing (ADON) said:- Staff should keep a copy of the transfer form and the bed hold;- The Ombudsman should be notified monthly of the transfers and discharges;- Staff should document in the resident's chart why the resident was being transferred out, who was notified, and when the resident returned to the facility or if they did not return to the facility; 5. Review of Resident #8's face sheet showed:-The resident had a diagnosis of type two diabetes (a chronic condition where the body does not use insulin effectively); -Unspecified abnormalities of gait and mobility;-Repeated falls. Review of resident discharge summary showed:-Discharge summary report was not filled out;-No charting was completed to indicate that the Ombudsman had been notified of the resident's discharge. Review of the resident's electronic medical record showed there was no discharge summary to include continuance of care at time of discharge. Interview on 08/06/2025 at 3:31 P.M. The DON said:-The resident was admitted to the facility for therapy;-The resident had been admitted to this facility in the past and had gone home with his/her spouse when he/she was discharged the first time;-The last time the resident was discharged the discharge summary was completed but it was not complete during the most recent discharge.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure staff developed and implement a person-centered comprehensive care plan to meet preferences and goals, and address the resident's medical, physical, mental and psychosocial needs for three of 12 sampled residents when the facility failed to update a (Resident #3) care plan after a significant change, and when the facility failed to include the use of oxygen therapy in the care plans for (Resident #30 and Resident #31). The facility census was 30. Review of the facilities Comprehensive Person-Centered Care Plans policy showed: -The Interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment; -Each resident's comprehensive person-centered care plan will be consistent with the resident's right to participate in the development and implementation of his or her plan of care; -The comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 1.Review of resident #31's face sheet showed: -Resident had a diagnosis of chronic obstructive pulmonary disease (COPD); -Resident had mild cognitive impairment; -Resident had acute respiratory failure with hypoxia. Record review of physician order summary report for July and August 2025 showed: -Resident had an order to titrate oxygen up to six liters per minute via nasal cannula to maintain SpO2 (a noninvasive method of measuring the oxygen saturation in a person's blood to indicate how well the lungs are delivering oxygen to the body) greater than 91% as needed; -Resident had an order to change oxygen humidifier weekly-every night shift on Wednesday; -Resident had an order to change/date oxygen tubing and storage bag weekly on Wednesday nights. Review of resident's current care plan showed: -Staff did not care plan the use of oxygen as needed to maintain SpO2 above 91%. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #3's Significant Change in Status MDS, dated [DATE] showed; - Long term and short term memory problems; - Dependent on the assistance of staff for eating, toilet use, dressing, showers, and personal hygiene; - Required substantial to maximum assistance with transfers; - Frequently incontinent of bowel and bladder; - Had two or more falls with no injury noted. Had one fall with a minor injury; - Diagnoses included non traumatic brain dysfunction, cancer, anxiety, arthritis, and dementia. Review of the resident's care plan, revised 7/24/25 showed: - The resident was at a high risk for falls related to confusion deconditioning, gait/balance problems, incontinence, poor communication/comprehension, and unaware of safety needs. The resident has had falls since his/her admission. Interventions include anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure the resident is wearing appropriate footwear such as non-skid socks when ambulating or mobilizing in wheelchair; - The staff did not update the resident's care plan with each new fall. Review of the resident's medical records showed the resident had a fall on the following dates: - 5/24/25, 5/25/25, 5/27/25 and 5/31/25; - 6/1/25, 6/2/25, 6/4/25 and 6/5/25; - 7/2/25, 7/8/25, and 7/11/25. . 3. Review of Resident #30's Quarterly MDS dated [DATE], showed:- Resident was severely cognitively impaired;- Resident currently on oxygen therapy and hospice care;- Diagnosis: cancer, kidney disease, coronary artery disease, pneumonia, and malnutrition; Review of Resident's Care Plan, revised 6/30/25, showed:- No documentation regarding end-of-life care from Hospice;- No care planning for condition of colon cancer;- No care planning for the use of oxygen for identified condition of shortness of breath; Review of Resident's Face Sheet dated 8/5/25, showed:- Primary Payer is Hospice Medicaid;- Diagnosis Information shows Malignant Neoplasm of Ascending Colon (cancerous tumor growth a type of colorectal cancer); Review of Resident's Hospice Physician's Orders, dated 4/25/25, showed:- Resident admitted to hospice care with terminal diagnosis of colon cancer;- Morphine concentrate 20mg/ml every four (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hours as needed for shortness of breath or pain;- Levsin 0.125 mg 1 tablet every four hours as needed for secretions; Observation on 8/4/25 at 11:00 A.M. showed:- Resident lying in his/her bed using an oxygen concentrator; During an interview on 8/4/25 at 11:03 A.M., the Resident said:- He/she thinks they are on hospice but not sure if they are getting care still from them;- He/she utilizes the oxygen concentrator most of the time during the day, he/she is able to leave the room without it but his/her preference is to use it at all times to prevent getting dizzy; During an interview on 8/4/25 at 1:57 P.M., RN (A) said:- Resident is on hospice care for terminal colon cancer;- He/she was not able to identify specifically what extra care hospice would provide the resident;- Hospice care and oxygen therapy should be in a resident's care plan; During an interview on 08/06/2025 at 11:22 A.M., the DON said:- He/she did the MDS, care plans and infection control;- The care plans can be updated by any nurse;- He/She tried to go through the care plans daily;- The care plans should be updated with new interventions with each new fall a resident had.

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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** Base on observation, interview, and record review the facility failed to ensure that residents who are unable to carry out activities of daily living received the necessary services to maintain good, grooming, personal hygiene, when the facility failed to provide proper peri care for four of the 12 sampled residents, (Resident #3, #12 and #28), and when the facility failed to provide proper catheter care for resident #16. The facility census was 30. Review of facility Perineal Care policy, dated February 2018, showed: -For a female resident wash perineal area, wiping from front to back, separate labia and wash area downward from front to back; -If the resident has an indwelling catheter, gently was the juncture of the tubing from the urethra down the catheter about three inches. Gently rinse and dry the area; -For a male resident wash perineal area starting with urethra and working outward. 1.Review of Resident #28's Care Plan dated 06/26/2025 showed: -Resident was limited physical mobility related to neurological deficits and inability to use legs; -Resident was incontinent of bowel and had a catheter inserted into bladder to drain urine; Observation on 08/06/2025 at 11:24 A.M. showed: -CNA A and CNA B assisted resident to get up for lunch and the resident was soiled with urine; -CNA B used the same area of the wipe and wiped front to back multiple times; -CNA B did not change gloves after providing perineal care and placed a new incontinent brief on the resident; -CNA B took off gloves, did not perform hand hygiene; During an interview on 8/6/25 at 11:30 A.M., CNA B said he/she should have used a clean wipe with each swipe and not re-use the same wipe 2.Review of Resident #16's Care Plan showed: -The resident has activity intolerance related to Chronic Obstructive Pulmonary Disease (COPD); -The resident has episodes of shortness of breath with and without activity; -The resident is incontinent of bowel and has a urinary catheter. Observation on 08/06/2025 at 11:48 A.M. showed: -CNA A donned gown and gloves due to resident being on enhanced barrier precautions (EBP); (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA A assisted resident to the toilet from his/her wheelchair; -CNA A wiped the residents catheter from insertion site down the catheter tubing approximately three inches using the same wipe multiple times; -CNA A wiped the residents perineal area from front to back using the same wipe twice; -CNA A placed new incontinent brief on the resident without changing gloves or performing hand hygiene; During an interview on 08/07/2025 at 9:50 A.M. CNA A said: -He/She should have wiped down on the catheter with a new wipe each time when providing catheter care; During an interview on 08/07/2025 at 10:20 A.M. LPN D said: -When providing peri care wipe front to back; -Use one wipe for each swipe; -Always wipe clean to dirty. -Always wipe away from urinary opening. 3. Review of Resident #3's Significant Change in Status MDS, dated [DATE] showed; - Long term and short term memory problems; - Dependent on the assistance of staff for eating, toilet use, dressing, showers, and personal hygiene; - Required substantial to maximum assistance with transfers; - Frequently incontinent of bowel and bladder; - Diagnoses included non traumatic brain dysfunction, cancer, anxiety, arthritis, and dementia. Review of the resident's care plan, revised 7/24/25 showed:- The resident had mixed bladder incontinence related to confusion, disease process with behavioral disturbances and impaired mobility. The resident used disposable briefs and should be changed every two hours and as needed. Clean the peri area thoroughly with each incontinence episode. Observation on 8/6/25 at 7:37 A.M., showed: - CNA B wiped down one side of the resident's groin and with the same area of the wipe, went under the skin folds and back up the other side of the groin. CNA B used a new wipe and with the same area of the wipe cleaned different areas of the front skin folds; - CNA A and CNA B turned the resident on his/her side. CNA B wiped from front to back with fecal (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	material noted on the wipe, folded the wipe and wiped again from front to back with fecal material on the wipe. CNA B used three new wipes and each time wiped from front to back with fecal material on each wipe and folded each wipe and wiped again with fecal material on each wipe; - CNA A and B and place a clean incontinent brief on the resident and dress him/her for the day; - CNA B propelled the resident to the dining room in his/her wheelchair; - CNA A and CNA B did not offer or provide oral care and did not wash the resident's face and hands or comb his/her hair; - CNA B did not separate and clean all the skin folds and did not clean the resident's buttocks. 4. Review of Resident #12's care plan revised 5/21/25 showed: - The resident had functional bladder incontinence related to recent brain injury from non-traumatic bleed, and impaired mobility to non-dominant side. The resident used disposable briefs and changed as needed. Clean the peri area with each incontinent episode. Review of the resident's Quarterly MDS, dated [DATE] showed: - Cognitive skills severely impaired; - Upper and lower extremities impaired on one side; - Dependent on the assistance of staff with toilet use and lower extremity dressing; - Required substantial to maximum assistance with upper extremity dressing, personal hygiene and transfers; - Always incontinent of urine; - Frequently incontinent of bowel; - Diagnoses included non-traumatic brain dysfunction, stroke and hemiplegia. Observation on 8/6/25 at 6:59 A.M., showed: - CNA B unfastened the resident's incontinent brief and said the resident was dry; - CNA A and CNA B turned the resident on his/her side; - CNA A wiped from front to back with fecal material on the wipe, folded the wipe and wiped again from front to back with fecal material on the wipe. folded the wipe and wiped again front to back with smear of fecal material on the wipe. CNA A used a new wipe and with the same area of the wipe and cleaned both sides of the buttocks, folded the wipe and wiped both sides of the buttocks again. CNA A used a new wipe and wiped back and forth on both sides of the buttocks, folded the wipe and wiped the rectal area, folded the wipe again and wiped the rectal area; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- CNA A and CNA B placed a clean incontinent brief on the resident and dressed the resident for the day. - CNA A and CNA B did not clean the front perineal folds and did not brush or comb the resident's hair, wash his/her face and hands and did not provide oral care. During an interview on 08/06/2025 at 10:30 A.M., CNA B said: - He/She thought it should have been one swipe with one wipe; - He/She should not have used the same area of the wipe to clean different areas of the skin and should have separated and cleaned all the skin folds; - He/She should not have folded the wipe with fecal material on the wipe; - HeShe should have washed the resident's face and hands, offered or provided oral care and combed the resident's hair before the resident went to breakfast. During an interview on 08/07/2025 at 11:14 A.M., CNA A said: - Should use a new wipe with each swipe and should not fold the wipe with fecal material on it; - Should separate and clean all the skin where urine or feces had touched; - Should have cleaned the buttocks and the front skin folds; - Should have brushed or combed the resident's hair, washed the resident's face and hands and provided oral care before the resident went to the dining room for breakfast. During an interview on 08/07/2025 at 2:20 P.M., the DON and the Assistant Director of Nursing said: - Staff should separate and clean all areas of the skin folds where urine or feces had touched. If the resident was dry, the staff still should provide incontinent care to the front perineal folds; - Staff should not fold the wipe, it should be one wipe, one swipe; - Staff should not use the same area of the wipe to clean different areas of the skin; - Staff should wash the resident's face and hands, comb or brush the resident's hair and should provide oral care before they took the resident to the dining room for breakfast.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed provide proper respiratory care when staff failed to date the oxygen tubing for two residents (Resident #7 and #30), failed to clean the oxygen concentrator filters for one resident (Resident #7), failed to have an oxygen filter installed for one resident (Resident #5), and failed to obtain an order for oxygen prior to administering to a resident (Resident #30). This affected three of 12 sampled residents. The facility census was 30. Review of the facility's Oxygen Administration policy, revised October 2010, showed:- Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration;- Review the resident's care plan to assess for any special needs of the resident;- Equipment and supplies: Portable oxygen cylinder strapped to the stand, nasal cannula, nasal catheter, mask (as ordered), humidifier bottle, No Smoking/Oxygen in Use signs, regulator, and PPE as needed;- Check the mask, tank, humidifying jar to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through;- Periodically re-check water level I humidifying jar;- Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record (Date and time procedure performed, name of staff member performing procedure, rate of oxygen flow, frequency of treatment); 1. Review of Resident #7's Annual MDS, dated [DATE] showed;- Cognitive skills intact; - Lower extremity impaired on one side; - Diagnoses included depression, schizophrenia, and COPD. Review of the resident's nurse treatment administration record (TAR), dated July 2025 showed: - Change oxygen tubing and date new bag monthly every night shift every four weeks on Wednesday; - Cleanse and change oxygen concentrator filter monthly every night shift every four weeks on Wednesday; - Staff documented it was completed on 7/23/25. Review of the resident's care plan, revised 7/30/25 showed: - The resident required assistance with his/her activities of daily living (ADLs). The resident wore oxygen at all times at two liters per nasal cannual (2L/NC); - The resident had altered respiratory status/difficulty breathing related to anxiety, sleep disorder related to morbid obesity and difficulty lying down to sleep. Elevate the head of the bed to at least 45 degrees at bedtime. The resident used oxygen at three liters per nasal cannula (3L/NC) at bedtime to assist with oxygenation during sleep cycle. Observation on 8/4/25 at 10:46 A.M., showed: - The oxygen was set on 2L/NC; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The oxygen tubing was dated 5/23/25; - The humidified water bottle was dated 5/23/25; - The filters were covered in gray lint. Review of the resident's POS dated August 2025 showed: - Start date: 5/3/25 - Change oxygen tubing and date new bag monthly every night shift every four weeks on Wednesday; - Start date: 5/3/25 - Cleanse and change oxygen concentrator filter monthly every night shift every four weeks on Wednesday. During an interview on 8/5/25 at 11:51 A.M., Licensed Practical Nurse (LPN) D said: - The oxygen tubing should be changed and dated every Sunday on the night shift; - The whole set up should be changed (tubing, humidified water bottle and the filters cleaned) every Sunday night. During an interview on 8/7/25 at 2:20 P.M., the Assistant Director of Nursing (ADON) and the DON said: - The Charge Nurse (CN) was supposed to change the oxygen tubing every Sunday on the night shift. Staff should date the tubing and the filters should also be cleaned every Sunday night on the night shift. 2. Review of Resident #30's Quarterly MDS dated [DATE], showed:- Resident was severely cognitively impaired;- Resident was experiencing shortness of breath or trouble breathing when sitting at rest, during exertion, and when lying flat;- Resident was on oxygen therapy;- Diagnosis: cancer, kidney disease, coronary artery disease, pneumonia, and malnutrition; Review of Resident's Care Plan, revised 6/30/25, showed:- Resident has limited physical mobility related to weakness and shortness of breath;- No documentation regarding oxygen therapy for the resident; Review of physician's orders for July and August 2025., showed no physician order for oxygen in the medical record. Observation on 8/4/25 at 11:00 A.M. showed:- Resident breathing with an oxygen concentrator operating in the room;- Date on the tubing going into the oxygen concentrator showed 7/14/25 as the last date cleaned and changed; During an interview on 8/4/25 at 11:03 A.M., the Resident said:- He/she uses the oxygen concentrator all the time to help him/her from becoming dizzy. He/she used a walker and since the machine is so bulky he/she doesn't leave the room very often because it's hard to ambulate with a walker and that machine;- Resident can't recall how long he/she had been using oxygen but thinks he/she started using it as soon being admitted to the facility a few months ago; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/7/25 at 8:30 A.M., the DON said:- Oxygen orders are required to be in a resident's medical record to get oxygen therapy or use of the oxygen concentrator;- Oxygen also needs to be care planned and orders for cleaning and changing of tubing included;- The resident would have oxygen orders if they are using oxygen; 3. Review of Resident #5's Care Plan showed: -Diagnosis of Chronic Obstructive Pulmonary Disease (COPD); -The resident is dependent on supplemental oxygen; Review of Resident #5's order summary report showed: -Staff are to cleans and change oxygen concentrator filter weekly- at bedtime every Wednesday; -Change oxygen humidifier weekly- at bedtime every Sunday; -Change/date oxygen tubing and storage bag weekly on Sunday nights; Observation on 08/06/2025 at 10:33 A.M. showed: No filter on the oxygen concentrator for the resident. Observation on 08/07/2025 at 9:48 A.M. showed: No filter on his/her oxygen concentrator for the resident. During an Interview on 08/07/2025 at 10:05 A.M., the DON said: -Oxygen and nebulizer tubing was to be changed every Sunday night; -Oxygen concentrators have filters that are changed on a weekly scheduled basis. During Interview on 08/07/2025 at 10:52 A.M. the Administrator said: Oxygen concentrator filters and oxygen tubing are to be changed on Sunday's during the night shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews and record review, the failed to ensure staff discarded expired medications and biologicals stored in the medication room and in the nurse's medication cart. The facility census was 30. Review of the facility's undated policy for Storage of Medications, showed:- The facility shall store all drugs and biologicals in a safe, secure, and orderly manner;- Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers;- Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing;- The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 1. Observation and interview on 8/5/25 at 2:37 P.M., of the medication room showed:- One opened vial of Tuberculin, purified protein derivative,0.1 ml., dated 6/13/25. The label on the box said it was good for 30 days after opening;- 11 Influenza vaccine Fluzone HIgh Dose prefilled syringes expired 6/25;- Certified Medication Technician (CMT) A said he/she did not know how long the TB vial was good for after opening and was not for sure when the flu vaccine expired. All CMTs and nurses had a color coded chart when the medication rooms and medication carts are supposed to be checked. 2. Observation and interview on 8/5/25 at 3:05 P.M., of the South CMT/Nurse medication cart showed:Latanoprost 0.005% eye drops (Xalatan) - bag with label said 11/25/24, discard after 11/24/25; no date when it was opened. CMT C said it was good for 30 days after it was opened;A plastic bag with the label torn off which indicated who it belonged to had two 4 mg. tabs of Ondansetron. CMT C said he/she did not know who it belonged to and all medications should have a pharmacy label to indicate who they belonged to;Resident #23 had an opened bottle of Lidocaine Viscous solution 2%., expired June 2025;An albuterol sulfate inhalation aerosol, opened date 11/24/23, did not have a pharmacy label to indicate who it belonged to and was in a box with a pharmacy label for Resident #31, but had a piece of tape on the top of the box and staff hand wrote Resident #32's name in a red marker. CMT C said he/she did not know who it belonged to. It had been in the medication cart since he/she started a year ago'An opened bottle of MOM expired 5/25CMT C expired medications should not be used and should be destroyed. All medications should have a date when they were opened, During an interview on 8/5/25 at 11:51 A.M., Licensed Practical Nurse (LPN) D said:The Nurses and CMTs are supposed to check the medication room and medication carts per the schedule. Staff should not use expired medications. Medications should be dated when opened;He/She was not for sure how long TB was good for after it had been opened;If a label has been removed from the medication, it should not be used.During an interview on 8/7/25 at 2:20 P.M., the Assistant Director of Nursing (ADON) said:Expired medications should not be used, they should be removed and discarded;TB should be discarded after 30 days;All medications should have a date when opened.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interviews, the facility failed to store, prepare and serve food in accordance with professional standards of food service safety when staff failed to discard expired leftovers in the refrigerator, failed to maintain proper standards of cleanliness and storage in the kitchen area, and failed to use proper handwashing hygiene in the kitchen. This affected all residents by putting them at risk for a food borne illness. The facility census was 30.Review of facility policy Bare Hand Contact with Food and Use of Plastic Gloves, undated, showed:- Single-use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from the food handler' hands to the food product being served;- Hands are to be washed when entering the kitchen and before putting on the single-use gloves and after removing single use gloves;- Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed;Review of facility policy Food Receiving and Storage, revised July 2014, showed:- Food services, or other designated staff, will maintain clean food storage areas at all times;- When food is delivered to the facility it will be inspected for safe transport and quality before being accepted; - Food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents;- Dry food that are stored in bins will be removed from original packaging, labeled and dated (use by date); - All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date);- Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat-foods;- Refrigerators must have working thermometers and be monitored for temperature according to state specific guidelines;Review of facility policy Sanitization, revised October 2008, showed:- All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish;- All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils;- The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas; Observation of the dining room on 8/4/25 at 9:30 A.M., showed:- Food stains on the inside shelving of the resident refrigerator;- Ice Machine cleaning log showed last cleaning date as 4/26/24;Observation of the kitchen on 8/4/24 at 9:35 A.M., showed:- Ice machine had dirt build up on the inside lip directly above the dispensed ice;Observation of the Dry Storeroom on 8/4/25 at 9:40 A.M., showed:- Marshmallows on the floor in the corner under the shelving;- Cup cart had moldlike substance along the interior edges of the bottom tray near the wheels;- Right forward corner had heavy moldlike substance on the floor covering a 48 square inch area;- Karo Syrup container had moldlike growth on cap and bottle;- Moldlike growth throughout forward wall near the floor under the racks covering a 8' by 3' area;- Beef flavor soup base not sealed;- 2nd and 3rd racks from the floor on back wall had shelving that was rusted throughout covering an 8' area;- Beans stored in an unsealed container, container is sticky and has food debris on top. The container is unlabeled and undated;- Breadcrumbs dated 3/21/24 expired;- All-purpose flour (2 bags) dated 7/17 without indication what year it was stored;- Rust on forward shelving racking;- Ventilation duct against forward wall near overhead had moldlike substance covering a 16 x 8 area;- Cereal unlabeled and dated 2/20;- Lemon Gelatin mix single package had no date and moldlike growth on packaging;- Cherry pie filling can had rust on both ends of #10 can;- Debris and pepper shaker lying on floor near full bait trap underneath the bread rack;- Yeast resealed 4/5/25;- Trash can against storeroom wall had an unsealed, unlabeled, undated grain in an open bag with a scoop in it;- Heavy dirt on top of hash browns 2.125oz cardboard container;- Moving cart 1.5' in height underneath the shelving was covered in moldlike substance;During an interview on 8/4/25 at 10:00 A.M., Dietary [NAME] (B) said:- He/she had been working in the kitchen since February 2025;- He/she had not seen any mold in the storeroom or anywhere else in the kitchen;- Sometimes there's condensation build up in the storeroom which might cause mold;- He/she had not seen the mold on the products on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the shelves since he/she doesn't go to that area very often; - If he/she saw mold he/she would tell the Dietary Manager (DM) and then clean it up;- The moisture from the food trucks causes the cans to rust out;- When opening a can he/she will inspect the contents to make sure it had not spiled and any dented cans are automatically rejected;- The staff do not use the pinto beans that are in the unlabeled and undated container anymore, they use a substitute item instead;Observation of the dishwashing area on 8/4/25 at 10:10 A.M., showed:- Vent duct covered in grime;- Heavy grime and food build up under the dishwasher;Observation of the walk-in refrigerator on 8/4/25 at 10:15 A.M., showed:- Two rotten vegetables on the floor in the back corner of the refrigerator; - Dried milk stain on floor covering a one foot area under the shelving where milk is stored;- Defrosting beef on the first shelf, not dated; - Cottage Cheese (2) 5lb containers dated 7/20/25 expired; - Sour Cream 5lb container dated 8/1/25 expired;- Condensation puddles on floor in front of racks;- One box of mighty milk shakes stored directly on the floor;- Apple crisp on rack no dates;- (4) packs of hot dog buns expired 5/22/24;- English muffins (2) packages expired 1/8/25;- Two of five raw cucumbers stored in cardboard box was moldy;- Coffee cake dated 7/31 as leftover was expired;Observation of the walk-in freezer on 8/4/25 at 10:25 A.M., showed:- Condenser leak resulted in ice buildup on floor six inches high and chunks of ice on the floor;Observation of the dining room on 8/4/25 at 12:15 P.M., showed:- CP A did not sanitize hands in between serving resident trays in the dining room;- Dietary Aide A did not sanitize hands in between serving resident trays in the dining room;Continuous Observation of the kitchen on 8/5/25 starting at 10:54 A.M., showed:- Raw beef in walk-in refrigerator from 8/4/25 still defrosting in a tub with no dates;- Boneless ham and unlabeled meat in walk-in refrigerator defrosting together in a tub with no dates;- CP B entered the kitchen and did not wash hands but instead put on gloves and started working on food items for the meal;- At 11:10 A.M. CP B removed gloves after working with frozen strawberries and put on a new pair of gloves without washing hands;During an interview on 8/5/25 at 11:12 A.M., CP (B) said:- He/she changed gloves because he/she got strawberries on them and normally he/she would wash his/her hands between glove changes but he/she was just going to go over and work with the dessert bowls by pouring strawberries over the shortcake;Observation on 8/6/25 at 8:21 A.M., showed:Dietary Aide (B) did not sanitize hands between serving breakfast hall trays for resident rooms on the 200 hall;During an interview on 8/7/25 at 9:45 A.M, the DM said:- The ice machines should be cleaned every other day on the outside by kitchen staff and maintenance will sanitize the inside components every four months;- Log in the dining room for cleaning the ice machines was not being kept up, the process had just been changed to one log in the kitchen that covers all the ice machines;- The DM is responsible for checking the cleaning of the ice machines and it should not have dirt and bacterial buildup;- There should be no raw moldy food items on the floor;- Carts in the storeroom should be free of mold and dirt;- There should not be black moldlike growth along the walls and floor of the storeroom. It would be expected that kitchen staff would see this and bring it to the DM's attention;- There should be no moldlike growth on packaging. If there is, it should be reported to the DM, then clean the product and check the integrity of the packaging and the expiration date;- Opened containers should be tightly resealed;- Containers should be free of sticky substances on the containers;- There should not be heavy rust on the storage racks;- Breadcrumbs that have been opened should not be stored for more than a year;- When dating products the year should be added to maintain clarity and avoid confusion;- There should not be built up dirt around the ventilation ducting and maintenance would be notified if there was an issue;- Cans should not be rusted in the storeroom;- Packages should be free of dirt and dust buildup in the storeroom;-Liquid spills in the refrigerator should be cleaned up immediately;- A date should be placed on all meat being defrosted and a label attached showing what is being defrosted;- Expired products should be discarded as soon as they are expired;- There should not be condensation puddles in the walk-in refrigerator;- Items should never be stored directly on the floor;- Leftovers can be kept for three days before they must be discarded;- There should not be ice chunks on the freezer floor and maintenance has been informed, the issue had been going on for a while;- Staff should wash their (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hands immediately upon entering the kitchen;During an interview on 8/7/25 at 2:30 P.M., the Administrator said:- The ice machine should be free of dirt and/or bacterial growth;- Raw food items should not be on the floor of the storeroom;- Carts in the dry storeroom should be free of mold and dirt;- There should be no black moldlike growth along the walls and floor of the dry storeroom;- There should be no moldlike growth on the food packaging in the dry storeroom;- Containers should be free of sticky substances on the surface of the containers;- There should not be heavy rust on the storage racks;- Cans should not be rusted in the storeroom;- Liquid spills in the refrigerator should be cleaned up;- Expired products should be discarded as soon as they are expired;- There should not be condensation puddles in the walk-in refrigerator;- Items should not be stored directly on the floor in the storeroom;- There should not be ice chunks on the freezer floor or icicles formed on the floor from water leaks;- Staff entering the kitchen should wash their hands immediately;

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to submit the Payroll Based Journal (PBJ) data (a mandatory submission by nursing facilities to the Centers for Medicare & Medicaid Services detailing facility staffing levels, including staff identification, hours worked, and job titles, on a quarterly basis correctly for Quarter 2 2025 (January 1 to March 31). The facility census was 30 The facility did not provide a policy for PBJ. Review of the facility's Payroll Based Journal data (PBJ - a report that provides staffing data set information submitted by nursing homes on a quarterly basis) for Quarter 2 2025 (January 1 - March 31) showed no RN coverage hours on 2/23, 3/2, 3/16, 3/29, and 3/ 30 and no licensed nurse on 1/25, 2/11, 3/13 and 3/29. Review of staffing schedule for February 2025 showed no RN on the day: 2/23. Review of the staffing schedules for March 2025 showed no RN on the following days: 3/2, 3/16, 3/29 and 3/30.During an interview on 8/5/25 at 9:52 A.M., the Regional Nurse said:- He/She knew something was not right with the PBJ and did not think it had been filled out correctly. During an interview on 8/7/25 at 11:53 A.M., the Assistant Director of Nursing (ADON) said:- The Administrator had been there since July of this year;- He/She had been at the facility since November of last year;- The MDS/Care Plan Coordinator took over as the DON about three months ago;- He/She was unable to find any documentation to show there was RN coverage on those dates;- He/She provided documentation to show there was a licensed nurse on the dates indicated;- They had a rough time with staffing early in the year but it was better now. During an interview on 8/7/25 at 2:20 P.M., the Administrator said:- The PBJ report should be filled out correctly;- They should have an RN working eight hours a day, seven days a week.

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	265836	A. Building B. Wing	08/07/2025

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

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to follow care plan directions for maintaining and using hearing aids for one resident of 12 sampled (Resident #30). The facility census was 30. Review of facility policy Care Plans, Comprehensive Person-Centered, revised September 2013, showed the care plan will include measurable objectives and timeframes and describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;Review of facility policy Activities of Daily Living (ADL), Supporting, revised March 2018, showed:- Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry ot activities of daily living (ADLs);- Appropriate care and services will be provided for residents including appropriate support and assistance with communication (speech, language, and any functional communication systems;1. Review of Resident #30's Quarterly MDS dated [DATE], showed:- Resident was severely cognitively impaired;- Resident has moderate difficulty in the ability to hear without a hearing aid;- Resident usually understands verbal content but misses some part or intent of message;- Diagnosis: cancer, kidney disease, coronary artery disease, pneumonia, and malnutrition; Review of Resident's Care Plan, revised 6/30/25, showed:- Resident has a communication problem related to a hearing deficit;- Resident requires bilateral hearing aides to communicate, ensure availability and functioning of adaptive communication equipment;- Ensure hearing aids are fully charged and in place;Observation on 8/4/25 at 11:00 A.M. showed the Resident as very hard of hearing, staff must speak directly and loudly to resident in order for him/her to understand the message. During an interview on 8/4/25 at 11:03 A.M., the Resident said:- He/she should have two hearing aids, and they are somewhere around their room, but he/she did not know where they were;- He/she would like to have both hearing aids to hear better hear but is unsure now if they have any hearing aids at all;During an interview on 8/4/25 at 1:40 P.M., CNA (A) said the resident doesn't have hearing aids and sometimes can get a bit moody but if staff speak louder and directly to him/her they can be better understood;During an interview on 8/4/25 at 1:57 P.M., RN (A) said the resident doesn't have hearing aids and even after searching the room he/she could not find any for the resident;During an interview on 8/7/25 at 8:45 A.M., the DON said:- The resident does not like his/her hearing aids and we've had trouble getting the resident to wear them;- The ADON knows exactly what happened to the resident's hearing aids;- Hearing aids and any changes to their use should be reflected in the care plan;During an interview on 8/7/25 at 9:12 A.M., the ADON said she was not familiar with the resident's hearing aids and if he had them or not;During an interview on 8/7/25 at 2:30 P.M., the Administrator said she would expect hearing aids to be care planned and directions pertaining to them followed by staff and updated when needed;

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide an environment free from accident hazards when staff did not implement new interventions to prevent falls for one of the 12 sampled residents, (Resident #3), who was at risk for falls and who had experienced multiple falls and failed to update the resident's fall risk assessment with each new fall. The facility census was 30. 1. Review of Resident #3's medical record showed the resident was admitted on [DATE] at 12:15 P.M. Review of the resident's progress notes showed:- 5/24/25 at 12:30 P.M., the resident was found on the right side of the bed on the floor. No injury noted;- 5/25/25 at 1:15 P.m., the resident had an unwitnessed fall. The resident was found on the floor, no injury noted. Review of the resident's fall risk assessment, dated 5/25/25 showed the resident scored 20 (indicated the resident was at risk for falls). Review of the resident's progress notes showed:- 5/27/25 at 6:50 A.M., a Certified Nurse Aide (CNA) noticed the resident stumbling over his/her feet and fell backwards. The resident did not hit his/her head. No injury noted;- 5/31/25 at 5:16 A.M., the resident was seen trying to get up on patient camera. It appeared the resident slipped out of bed onto the floor next to the bed. No injury noted'- 6/1/25 at 4:00 P.M., the resident had a fall. No injury noted;- 6/2/25 at 7:30 P.M., the resident had a fall. Resident was observed by CNA laying on the floor on his/her right side. No injury noted. - 6/4/25 at 4:53 A.M., the resident was assisted by two staff off the ground into a standing position to walker and assisted to the bathroom. No injury noted;- 6/5/25 at 9:27 A.M., the resident was found laying on his/her right hp next to the recliner with his/her food knocked onto the floor. The resident had a red area on his/her left side of the head and on the right side of his/her head, right knee and down the leg was swollen and the resident was unable to bear weight. Also had a purplish, yellowish bruise on his/her right hip from a previous fall. The resident was confused, lethargic, and complained of his/her head hurting. The resident was transferred to the local hospital. Review of the resident's fall risk assessment dated [DATE] showed the resident scored a nine (indicated the resident was a low risk for falls). Review of the resident's progress notes showed:- 7/2/25 at 9:28 P.M., the resident sat on the floor in-between the bed and was incontinent of bowel. No injury was noted;- 7/5/25 at 8:00 A.M., the resident had a fall. No injury noted;- 7/8/25 at 11:50 P.M., the resident was observed by the nurse aide (NA) on the floor with his/her back against the bed with his/her legs out straight. No injury noted;- 7/11/25 at 2:33 P.M., the resident was observed on the floor on his/her left side in between the bed and the wheelchair. No injury noted. Review of the resident's Significant Change in Status Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/22/25 showed;- Long term and short-term memory problems;- Dependent on the assistance of staff for eating, toilet use, dressing, showers, and personal hygiene;- Required substantial to maximum assistance with transfers;- Frequently incontinent of bowel and bladder;- Had two or more falls with no injury noted. Had one fall with a minor injury;- Diagnoses included non-traumatic brain dysfunction, cancer, anxiety, arthritis, and dementia. Review of the resident's care plan, revised 7/24/25 showed:- The resident was at a high risk for falls related to confusion deconditioning, gait/balance problems, incontinence, poor communication/comprehension, and unaware of safety needs. The resident has had falls since his/her admission. Interventions include anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure the resident is wearing appropriate footwear such as non-skid socks when ambulating or mobilizing in wheelchair. Follow facility fall protocol. Physical therapy to evaluate and treat as ordered and as needed. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident, family, care givers, interdisciplinary team (IDT) as to causes;- The care plan was not updated with new interventions after each fall. Review of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's fall risk assessment, dated 7/28/25 showed the resident scored a 20 (indicated the resident was at risk for falls). During an interview on 8/7/25 at 2:20 P.M., the Director of Nursing (DON) said fall interventions should be developed and added to the care plan. In addition, after each new fall the fall risk should also be updated.