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	265266	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES NEOSHO	400 LYON DRIVE NEOSHO, MO 64850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to promote self-determination of all residents when staff failed to work with one resident (Resident #27) who requested a room change due to conflict with a roommate. A sample of 16 residents was reviewed in a facility with a census of 50.	F 561		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 5/24/24

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.

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F 561	Continued From page 1 Review of the facility form titled, "Resident Rights," undated, showed the following: -The facility shall ensure that each resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility shall protect and promote the rights of each resident as set forth in the following standards; -The sharing of personal space will only be by agreement of each resident. When this is not acceptable, each resident will be given the choice of another person with whom to share space, if available, or a private room at established private room rates. 1. Review of Resident # 27's current face sheet showed: -Admission date of 09/19/19; -Readmission date of 02/16/22; -Diagnoses included depression. Review of the resident's care plan, dated 03/12/21, showed the following: -The resident had mood/behavior and psychosocial problems. He/she can be manipulative, passive/aggressive, and attention seeking at times; -Resident has been known to make grandiose statements and false accusations at times due to fluctuations in his/her cognition; -Resident has been known to make inappropriate sexual comments towards staff at times; -Staff to monitor behavior episodes and attempt to determine underlying cause.	F 561		

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Review of the resident's quarterly Minimum Data Set (MDS - a federally-mandated assessment tool completed by facility staff), dated 02/10/24, showed the following:

-Cognitively intact;
-No verbal or physical behavioral symptoms directed toward others;
-No hallucinations or delusions.

Review of the resident's social service progress note dated 02/20/24, at 2:53 P.M., showed the Social Service Designee (SSD) documented the following:

-The SSD called the resident's responsible party on 02/20/24 to ask if it was okay to move the resident to a different room for now. If the resident liked the move, staff might leave the resident in the room. The resident's move was due to his/her roommate having a lot of family coming and going. The resident's responsible party said he/she was good with the room change, if the resident was good with the move. Staff asked the resident, and he/she was good with changing rooms as long as his/her television would also be moved.

Review of the resident's room census showed:

-On 02/22/24, staff moved the resident into a room with Resident #39;
-On 02/26/24, staff moved the resident to a different room;
-On 03/04/24, staff moved the resident back into the room with Resident #39.

Review of a resident's behavior note dated

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F 561	Continued From page 3 03/12/24, at 3:06 A.M., showed Licensed Practical Nurse (LPN) F documented the following: -Resident yelling at roommate calling him/her, "A bitch"; -Resident angry over the temperature in the room and the bedroom door being shut; -Unit turned down and the door cracked. Review of the resident's behavior note dated 03/17/24, at 1:09 P.M., showed LPN F documented the following: -Resident hit his/her light and when this nurse answered it. The resident told this nurse that he/she wanted everything in the room turned off. The resident's roommate was still awake watching television. This nurse asked the roommate if he/she could turn the television down a little bit. The roommate said that was fine. The nurse turned the television down and the resident started screaming, "That's not what I want I want it all shut the fuck off so I can go to sleep." The nurse explained he/she could not turn the roommate's things off until the roommate was ready to go to bed. The resident began screaming and cursing at the roommate, initiating the roommate to start screaming and cursing at the resident; -Resident is requesting to move to another room. During interviews on 04/16/24, at 2:25 P.M., and on 04/18/24, at 8:54 A.M., the resident said the following: -He/she does not get along with his/her roommate, Resident #39; -They argue with one another daily;	F 561		

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-Resident #39 is bossy with the resident;
-He/she has been telling staff of wanting to move away from his/her current roommate (Resident #39) because the roommate tries to control everything and butts into Resident #27's conversations;
-The two residents argue with one another and do not get along with one another.

During an interview on 04/17/24, at 8:54 A.M., the resident's responsible party said the following:

-The resident was very set in his/her ways;
-The resident and his/her roommate, Resident #39, did not get along with one another;
-They mostly just aggravated one another;
-The facility decided the resident and Resident #39 were so much alike, they would just keep them together in the same room;
-The responsible party said he/she did not necessarily think that was a good idea, but he/she went along with the facility's plan to place the two residents back in the same room together.

2. Review of the Resident #39's face sheet showed the following:

-Admission date of 05/18/23;
-Diagnoses included severe dementia and depression.

Review of the resident's care plan, revised on 02/05/24, showed the following:

-Behaviors included crying, sadness, self-isolation, anxiety, yelling, physical aggression, delusions (misconceptions or beliefs that are firmly held, contrary to reality), disorganized thinking, and inattention;

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F 561	Continued From page 5 -Deficit in cognitive functioning characterized by deficit in memory, judgement, decision making, and thought process related to dementia; -Report to the nurse and/or physician of any note changes in the resident's behavior/cognitive status. Review of the resident's quarterly MDS, dated 02/17/24, showed the following: -Mildly impaired cognitive function; -No verbal or physical behavioral symptoms directed toward others; -No hallucinations or delusions. Review of the resident's social service progress note dated 02/20/24, at 2:25 P.M., showed the following: -SSD called the resident's responsible party and asked if he/she was okay with moving another resident into the room with the resident and the responsible party said it was good with him/her. Review of the resident's behavior note dated 03/12/24, at 3:09 A.M., showed LPN F documented the following: -Resident yelling at roommate calling him/her "A bitch"; -Resident angry about roommate not wanting the room too warm and the door to be shut, so resident screaming at the roommate; -Temperature turned down a little and door cracked. Review of the resident's behavior note dated 03/12/24, at 10:25 P.M., showed LPN F documented the following:	F 561		

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F 561	Continued From page 6 -Resident screaming and cursing at roommate because roommate stated it was too hot in the room and requested the nurse to turn the heat down a little bit. When the nurse went to turn the heat down, the heat was at 82 degrees Fahrenheit (F). The nurse turned the heat down a few degrees and the resident started screaming at the roommate, calling the roommate, "a fucking dumb bitch" telling the roommate to, "Shut the fuck up about the temp in the room." 3. During an interview on 04/17/24, at 11:40 A.M., LPN C said the following: -Resident #27 and Resident #39 do not get along well with one another; -Their biggest issue is the television volume. The facility had provided both residents with headsets, but the residents refuse to wear these headsets; -When the resident had issues with one another, he/she usually assisted the residents in working out a compromise; -He/she never heard the two residents curse one another, but other nurses have reported the residents cursing and yelling at one another; -If he/she observed cursing and yelling, he/she would separate the residents, notify the Director of Nursing (DON), and call the residents' responsible parties; -In the past, on the night shift, Resident #27 and Resident #39 were reportedly arguing with one another and LPN F moved Resident #27 into a different room, but the DON had staff move Resident #27 back into the room with Resident #39 a few days later; -He/she was unsure why the DON had staff move the residents back in together.	F 561		

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4. During an interview on 04/17/24, at 2:13 P.M., LPN F said the following:

-He/she worked full time on the night shift (7:00 P.M. - 7:00 A.M.);
-Resident #27 and Resident #39 had verbal issues with one another, just "heated arguments";
-The residents curse at one another over the heat and air conditioner, the television, the curtains, and the lights;
-At one point, the residents had a "heated" argument and LPN F contacted the DON and moved Resident #27 to the next room at the resident's request;
-Within a few days, the facility moved Resident #27 back in with Resident #39 after discussing the decision with each resident's responsible party;
-He/she asked the day shift staff why the two residents were moved back in together and the day shift staff said the residents were moved back in together because they were not able to physically abuse one another.

5. During an interview on 04/17/24, at 3:15 P.M., Certified Nurse Assistant (CNA) H said the following:

-Resident #27 and Resident #39 had days they argued in raised voices. The arguments were generally over the television volume, but he/she had not heard the residents cursing at one another.

6. During an interview on 04/18/24, at 11:49 A.M., CNA I said the following:

-Resident #27 and Resident #39 disagree over the room temperature and occasionally curse and

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yell at one another, but neither resident are upset by the disagreements.

7. During an interview on 04/18/24, at 9:20 A.M., SSD said the following:

-In the past, Resident #39 frequently cursed and yelled at Resident #27 when Resident #27 turned the television on in the room;
-SSD talked with the residents when they had issues with one another and the SSD could generally resolve their arguments;
-The residents cursed and yelled at one another in the very beginning when the two first became roommates;
-Since the two were temporarily separated and then placed back together, they no longer argue with one another;
-The DON wanted to move the two residents back together, because Resident #27's other roommate passed away and the DON wanted to keep the other resident room vacant for possible admissions.

8. During an interview on 04/18/24, at 1:02 P.M., Nurse Practitioner (NP) G said the following:

-If two residents were not getting along with one another, the facility staff need to talk to the residents and move them to different rooms;
-In the past when roommates had issues, the residents tell staff and staff move the residents to separate rooms.

9. During interviews on 04/17/24, at 8:44 A.M., and on 04/18/24, at 9:59 A.M. and 3:20 P.M., the DON said the following:

-Resident #27 and Resident #39 were having

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issues getting along over room temperature and the television, so one of the nurses moved Resident #27 into another room;
-The DON subsequently met with both residents' responsible party, and the responsible parties for each resident spoke with their respective resident;
-Staff then moved Resident #27 back in the room with Resident #39 because Resident #27's other roommate discharged from the facility and Resident #27 could not afford a private room;
-The residents started getting along better, once they realized they needed to get along with each other;
-The residents agreed to move back in together;
-Neither of the residents are the nicest, but the facility tried different roommates in the past and Resident #39 did not get along with anyone;
-The DON said there was no reason not to move the residents back in together because they act like siblings and will eventually get along with each other;
-The DON said he/she thought the responsible parties for both residents knew that neither resident really wanted a roommate, but either would not or could not pay for a private room. The families said if he residents were not going to get along with anyone to put the two back together in the same room;
-The nurse did not notify the DON the residents were cursing and yelling at one another. The nurse told the DON the resident was yelling at the nurse;
-If the nurse notified the DON the residents were cursing and yelling at one another, the DON would have instructed the nurse to separate the residents;
-He/she could offer another available room to Resident #27 at this time.

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F 561	Continued From page 10 During an interview on 04/18/24, at 4:03 P.M., the Administrator said the following: -Resident #27 and Resident #39 both have a negative attitude, in general, and have had disagreements with each other over the television; -Neither of the residents wanted a roommate, but neither can afford a private room; -The Administrator was told at a morning meeting of the department heads that neither of the residents wanted a roommate; -The Administrator was not aware Resident #27 and Resident #39 were yelling at and cursing one another; -Nursing staff told the Administrator the residents were mad at nursing staff and the yelling was directed at the staff; -If the residents were yelling and cursing at one another, he/she expected staff to immediately de-escalate the situation, remove one of the residents from the room, and notify the DON and the Administrator; -The Administrator would then contact the Regional Director for further guidance; -The Administrator said the common sense approach would be find different roommates for the residents.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		

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results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to immediately notify the physician and responsible party of a fall with injury for one resident (Resident #41) out of 16 sampled residents in a facility with a census of 50.

Review of the facility policy titled, "Falls Management," revised December 2022, showed the following:

-After a fall occurs the licensed nurse is to initiate the risk management event reporting process. The process is to include a physical assessment;
-Physician and responsible party are to be notified following a fall;
-Physician and responsible party are to be notified following a fall occurrence with documentation of notification present in the clinical record.

1. Review of Resident #41's face sheet showed:

-Admission date of 12/30/22;
-Readmission date of 03/15/24;
-A legal guardian listed as the responsible party/emergency contact #1;
-Two additional emergency contacts listed with phone numbers.

Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/30/23, showed the following:

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F 580	Continued From page 13 -Moderate cognitive impairment; -Resident ambulated without the use of an assistive device; -Resident had no falls; -Resident had no pain. Review of the resident's fall note dated 03/10/24, at 1:00 A.M., showed Licensed Practical Nurse (LPN) N documented the following: -While answering a call light, a certified nurse assistant (CNA) found the resident on the floor, midway into the bathroom. Resident was lying on his/her right side with his/her torso on the floor in the bathroom and his/her legs in the bedroom. Resident immediately reported left hip pain before being moved off the floor. CNA and nurse were able to lift resident off the floor and into a wheelchair. Resident was taken to the nurses' station for assessment. Resident was not able to stand long enough to remove his/her jeans for staff to view his skin due to the pain; -The resident was not able to bear weight well or walk far on his/her left leg. The resident was not able to stand long enough to remove his/her jeans for staff to view his/her skin due to the pain; -The resident reported pain at a seven out of ten in his/her left hip; -Within 30 minutes of Tylenol administration, the resident reported pain of three out of ten; -The resident declined being taken to the emergency room (ER) on three different occasions; -Physician notification and response: via communication folder; -Responsible party notification and response: Will contact at a more appropriate time; -Administrator and Director of Nursing (DON) notification: per protocol.	F 580		

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F 580	Continued From page 14 (Staff did not document immediate notification of the resident's physician and responsible party of the fall with injury.) Review of the resident's nurse note dated 03/10/24, at 10:33 A.M., showed LPN M documented the following: -At 7:15 A.M., the nurse went down to the resident's room to evaluate the resident; -The resident was unable to bend his/her left leg due to too much pain; -The resident was able to move and bend his/her right leg; -The nurse explained to the resident he/she needed to go get checked out at the hospital to evaluate his/her left leg and to get X-rays. The resident said, "Okay;" -At 7:20 A.M., the nurse placed a call to the resident's responsible party to give an update and to notify the facility was sending the resident to the emergency room for evaluation and X-rays of the left hip. The responsible party said he/he would meet the resident at the emergency room; -At 7:40 A.M., the ambulance arrived to transport the resident to the emergency room. (Staff did not document physician notification of the fall with injury. Staff notified the resident's responsible party over six hours after the fall occurred.) Review of the resident's progress note dated 03/15/24, at 9:56 A.M., showed the Director of Nursing (DON) documented the following: -Resident reviewed due to a fall in his/her room on 03/10/24 at 12:50 A.M.; -The CNA went to answer the resident's resident call light and upon entering the room, the CNA	F 580		

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noted resident to be sitting on the floor partially into his/her bathroom;
-The CNA called for the charge nurse. Upon assessment by the charge nurse, the resident complained of left hip pain however, he/she adamantly refused to be sent to hospital for evaluation/treatment;
-Staff administered pain medication administered as ordered with good effect for pain control;
-The charge nurse attempted to talk the resident into going to the hospital multiple times, however the resident adamantly refused;
-Staff attempted to complete a head-to-toe skin assessment, however it was limited due to the resident's pain;
-After shift change, the day shift nurse went to assess the resident and was able to convince him/her to go to hospital for further evaluation and treatment of possible left hip fracture;
-The facility notified the resident's responsible party of the incident and of the resident being transferred to the hospital on 03/10/24 at 7:20 A.M. (over six hours after the fall with injury occurred);
-The facility notified the physician on 03/10/24 and the physician agreed with the resident being sent to the hospital.

Review of Nurse Practitioner (NP) G's visit note, dated 03/21/24, showed the following:

-The resident had a recent left hip surgery at the hospital for a broken hip after a fall on 03/10/24;
-The resident returned to the facility on 03/15/24.

During an interview on 04/18/24, at 12:14 P.M., LPN N said the following:

-After the resident fell on 3/10/24, the resident

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F 580	Continued From page 16 expressed pain and guarding (behavior that is aimed at preventing or alleviating pain) of his/her left side. The resident would not bear weight on his/her left leg or move his/her left leg; -The resident showed no obvious deformities or shortening of his/her legs, so staff assisted the resident up into a wheelchair and brought the resident out to nurse's desk due to the resident insistence on getting up and drinking coffee; -The nurse administered Tylenol and the resident showed some improvement in pain; -The nurse planned to send the resident out to the emergency room due to concerns of the resident guarding and not wanting to move his/her left leg; -The nurse asked, but the resident refused to go to the emergency room three times; -The nurse did not call the physician about the resident's fall and assessment; -The next morning, the day shift nurse came in and the day shift nurse notified the resident's family of the fall and injury and the resident agreed to go to the emergency room for evaluation; -It is normally the responsibility of the on-call RN to notify the resident's physician; -He/she did not speak to the physician; -On the morning of 3/10/24, the day nurse assessed the resident, and he/she did not want to bear weight on his/her right leg and did not want to move his/her right leg, so the day nurse notified the resident's responsible party and the resident agreed to go to the hospital; -The nurse (LPN N) said he/she thought the day nurse or on-call RN notified the resident's physician, but the nurse was unsure. During an interview on 04/17/24, at 11:40 A.M., LPN C said the following:	F 580		

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F 580	Continued From page 17 -If a resident fell, he/she would perform a head-to-toe assessment for injuries; -If the resident did not complain of hip pain, he/she would check for any abnormal internal or external rotation or shortening of the legs and see if the resident was able to move the extremity; -If he/she observed any issues or complaints of hip pain, he/she would immediately contact the resident's physician to notify of the resident fall, condition, and ask about an X-ray order. During an interview on 04/25/24, at 9:25 A.M., the Assistant Director of Nursing (ADON) said the following: -He/she was the RN on-call for the facility on the night of 03/09/24 to 03/10/24; -The night nurse, LPN N, did not contact the ADON immediately after the resident's fall, as was the expectation of the facility; -The night nurse waited to contact the ADON until approximately 6:00 A.M., via text message and the message did not name a resident. The message read a resident slipped on the floor due to sick slippers and his/her left hip was sore and he was refusing to go to the hospital; -The ADON arrived at work within an hour, obtained report, and went to the resident's room along with LPN M, the day nurse, to assess the resident. The resident could not move his/her left leg at all and complained of pain to the leg. The nurse told the resident he/she needed to go to the hospital because the nurse suspected the resident cold have fractured a bone in his/her leg/hip. The resident agreed to go to the hospital; -The LPN needed to contact the RN on-call and the resident's responsible party immediately after a fall, if the nurse suspected serious	F 580		

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injury/fracture;
-The facility physician preferred not to be contacted during the night, if the facility RN determined a resident needed to go to the hospital. The facility would typically send a resident to the hospital and notify the physician the following morning. This was not written policy, but was the physician's preference.

During an interview on 04/18/24, at 1:02 P.M., the resident's Nurse Practitioner (NP) G said he/she would expect the facility to call the resident's physician after a fall with hip pain and limited range of motion to that extremity as soon as possible after the fall.

During interviews on 04/18/24, at 9:59 A.M. and 3:20 P.M., the DON said the following:

-The resident was able to walk prior to the fall on 03/10/24;
-If a resident had a fall with injury, the nurse on duty should have immediately notified the physician and the resident's responsible party or next of kin;
-According to the resident's fall report, the facility notified the resident's responsible party and 7:20 A.M. of the resident's fall;
-The DON spoke with the resident's physician and the physician recalled the DON notified him/her of the resident's fall on 03/10/24, sometime after staff sent the resident out to the hospital, but could not recall an exact time;
-The charge nurses should contact the on-call registered nurse (RN), and then the RN directs the charge nurse on what they need to do after a fall, before they contact the resident's physician;
-If the charge nurse working the night of the fall had contacted the DON, he/she would have

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F 580	Continued From page 19 instructed the charge nurse to call and notify the resident's physician; -The physician's expectation was for the facility to contact him within 24 hours after a fall; -In this situation, the night nurse or the on-call RN should have notified the resident's physician and family. During an interview on 04/18/24, at 4:03 P.M., the Administrator said the following: -The nurse should notify a resident's physician of a resident fall within 24 hours per the physician's protocol, but some of it is a case-by-case basis; -The night nurse should have called the DON, if he/she suspected a resident injury and then go from there; -The night nurse probably should have called the resident's physician before sending the resident out to the hospital; -The night nurse should have notified the resident's responsible party and the earliest possible time.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		

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receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure a clean and homelike environment for all residents when when staff failed to clean/maintain the toilet riser in one resident's (Resident #29) bathroom. The facility census was 50.

Review of the facility's policy titled, "Housekeeping, Laundry and Maintenance," undated, showed staff to clean all resident

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bathrooms daily and provide emergency cleaning as need arises.

1. Review of Resident #29's face sheet (admission data), dated 04/18/24, showed an admission date of 12/14/19.

Review of the resident's Care Plan, dated 03/31/24, showed the following:

-Cognitive skills intact;
-Independent with decision making;
-Required staff assistance with activities of daily living (ADL) due to limitations.

Observations on 04/14/24, at 4:28 P.M., and on 04/16/24, at 10:08 A.M., of the resident's bathroom showed the resident's toilet riser over the facility stool with six layers of curling non-adhered duct tape and a brown fecal-like substance on or around the duct tape. The adhered duct tape attached a clear sheet of plastic from the riser and allowed the end of the plastic to fall into the toilet bowl water. There was a brown fecal like substance on the clear sheet of plastic. A brown fecal-like substance was present on the back of the riser in the center of the circular opening to the riser.

During interviews on 04/16/24, at 10:00 A.M., and on 04/17/24, at 9:00 A.M., Housekeeper A said the following:

-Staff clean the residents' rooms daily. The cleaning included the floors, toilets, and sinks. If a toilet riser is present, they should move it out and clean behind it and the toilet riser;
-The duct tape is removed daily and adhesive scraped off daily with a scraping tool.

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F 584	Continued From page 22 Replacement duct tape and plastic are in the storage closet; -Housekeeper B clean's the resident's room at the resident's request. During an interview on 04/17/24, at 9:30 A.M., Housekeeper B said that the resident will not allow him/her to change the duct tape or the plastic in the bathroom. He/she sprays it with a cleaning solution and wipes it down the best he/she can. The Housekeeping Supervisor was aware of the resident not allowing the riser to be cleaned correctly. They have never changed the duct tape or the plastic sheeting when cleaning the bathroom. During an interview on 04/17/24, at 10:00 A.M., the Housekeeping Supervisor said she is aware of the resident not allowing the staff to remove the duct tape or plastic sheeting so they can clean the riser properly. She instructed her staff to spray it with a disinfectant and do the best that they can. During an interview on 04/18/24, at 10:20 A.M. the Administrator said he has spoken to resident # 29 on multiple occasions about how the staff need to change the duct tape and plastic regularly, but that he/she is not responsive to it.	F 584		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination	F 644		

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F 644	Continued From page 23 includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify and coordinate with the State-designated authority following newly evident or serious mental illness for one resident (Resident #51) who had a negative Level I Preadmission Screening and Resident Review (PASARR - Level I is administered to determine if a PASARR Level II (an in-depth evaluation and determination of an individual by a Medicaid-certified nursing facility, evaluation is needed prior to admission for possible serious mental disorders, intellectual disabilities and related conditions to ensure that residents identified receive care and services in the most integrated setting appropriate to their needs)). The facility census was 50. Review showed the facility did not provide a policy regarding PASARR requirements. Review of the Missouri Department of Health and Senior Services web-site showed the following: -The PASARR is a federally mandated screening	F 644		

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process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis who apply or reside in Medicaid Certified beds in a nursing facility regardless of the source of payment. The screening assures appropriate placement of persons known or suspected of having a mental impairment(s) and also that the individual needs of mentally impaired persons can be and are being met in the appropriate placement environment.

1. Review of DHSS Licensure Records show all the facility beds are dually certified for Medicaid and Medicare.

Review of Resident #51's Level I Nursing Facility PASARR, dated 02/02/24, showed the following information:

-Does not show any signs of symptoms of major mental disorder;
-Had not been diagnosed as having a major mental disorder;
-Primary reason for nursing facility placement not due to a mental illness;
-Does not have any areas of impairment due to serious mental illness;
-Had not received intensive psychiatric treatment in the past two years;
-Not known or suspected to have mental retardation that originated prior to age 18;
-Not known or suspected to have a special admission condition.

Review of resident's current face sheet (gives basic profile information at a glance) showed the following information:

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-Admission date of 02/05/24;
-Admission diagnoses included recurrent depressive disorders, nicotine dependence, and psychosis not due to a substance or known physical condition;
-Diagnosis, dated 02/05/24, of schizophrenia (mental disorder including symptoms of delusions, hallucinations, and disorganized thinking/speech);
-Diagnosis, dated 02/07/24, of cognitive communication deficit.

Review of the resident's medical record showed staff did not refer the resident after a significant change in status for additional PASARR review.

During an interview on 04/18/24, at 12:20 P.M., the Business Office Manager (BOM) said nursing staff screen any potential residents for admission and placement at the facility. Review will be completed of the PASARR Level I screening by the referring agency. The nursing staff will add any additional diagnoses or clarification of resident care needs to the extended portion of the screening form. The nursing staff should request a new PASARR screening only if resident has Medicaid as a payor source. If a resident does not have Medicaid as a payor source, the nursing staff complete the screening form, but do not summit the form for further determination is needed. The screening form will remain in the resident's file if there is a question of benefits. Based on the screening conducted prior to admission with the diagnosis of schizophrenia with behaviors the the resident should have been resubmitted for further review of their PASARR Level I screen.

During an interview on 04/18/24, at 2:40 P.M., the

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Infection Control Nurse said the facility nursing staff review all Level I PASARR screens received for any possible facility admission. She completes the nursing facility portion of the form and places it the resident file. Re-submission of the PASARR is only done if the BOM requests for payment source. She has no knowledge of who is required to have the Level II screen, but completes the skill level screening to determine additional care needs and provide a skill level score if one is required to be submitted. She stated that the resident's diagnosis of schizophrenia and increased level of care was not indicated on the screen received prior to admission and would indicate changes on the resident's care needs.

During an interview on 04/18/24, at 3:22 P.M., the Director of Nursing (DON) said all residents are screened for the Level I PASARR prior to admission. The BOM is provided a confirmation code of the resident's submission and determines if the form should be resubmitted based on their payment source. The Infection Prevention Nurse completes the additional nursing facility portion of the application and keeps this in the resident's file. It is only submitted if it was requested. The resident's Level I screen was missing screening information and should have been submitted based on his/her schizophrenia diagnosis and increase level of care needs. This should have been completed due to the resident being admitted to a certified nursing bed and not due the residents payor source.

During an interview on 04/18/24, at 06:05 P.M., the Administrator said he was not familiar with the PASARR screening requirements until the current certification survey. Based on discovery of

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F 644	Continued From page 27 incomplete resident information submitted on the prior screening form, the facility staff should have resubmitted the Level I screen for determination of eligibility regardless of payor source for a certified facility admission.	F 644		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		

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F 656	Continued From page 28 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans for four residents (Residents #5, Resident #12, Resident #26 and Resident #47) that addressed side rails usage. The facility census was 50. Review of the facility's policy titled, "Electronic Care Plan," dated 12/2018, showed the following: -The facility is to develop a plan of care to attain and maintain the highest practical level of physical, psychological, emotional and social well-being for each resident in the facility. Review of the facility's policy titled, "Side Rail Use and Assessment," undated, showed the following: -To ensure the automatic use of side rails of any size or shape is avoided, a decision to use, reduce or remove side rails occurs within the framework of an individual resident assessment	F 656		

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F 656	Continued From page 29	F 656		

and is clearly documented, and the use of side rails for either positioning and mobility or for the treatment of a medical/psychological symptom or condition is accompanied by an individualized care plan;
-Use of side rails and interventions to ensure safe use will be included in the resident's care plan.

1. Review of Resident #5's face sheet (a brief resident profile) showed the following:

-Admission date of 11/14/19;
-Diagnoses included Alzheimer's disease.

Review of the resident's electronic record showed a Side Rail Consent Form was signed by the resident on 02/22/24, indicating information regarding the risks and benefits of using a side rail of any sort was received, and the resident chose to utilize a transfer bar,1/4 rail, or 1/2 rail.

Observations on 04/16/24, at 9:21 A.M. and 1:35 P.M., on 04/17/24, at 10:26 A.M., and on 04/18/24, at 11:25 A.M., showed the resident had a raised u-shaped grab bar on the right side of the bed against the wall.

Review of the resident's care plan, last revised 02/19/24, showed staff did not care plan the use of side rails/u-shaped grab bar.

2. Review of Resident #12's face sheet showed the following:

-Admission date of 01/24/24;
-Diagnoses included cognitive communication deficit, other abnormalities of gait and mobility, mild cognitive impairment of unknown cause, and delusional disorders.

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F 656	Continued From page 30 Review of the resident's electronic record showed a Side Rail Consent Form was signed by the resident's representative on 01/24/24, indicating information regarding the risks and benefits of using a side rail of any sort was received, and the resident chose to utilize a transfer bar,1/4 rail, or 1/2 rail. Interview and observation on 04/15/24, at 11:07 A.M., showed the following: -The resident had bilateral quarter side rails in raised position on the bed; -The resident said the side rails were put on when he/she fell out of bed. Observation on 04/16/24, at 1:33 P.M., showed bilateral quarter side rails in raised position. Interview and observation on 04/17/24, at 2:11 P.M., showed the following: -Bilateral quarter side rails were in raised position on the resident's bed; -The resident said he/she used the side rails for bed mobility. Observation on 04/18/24, at 11:25 A.M., showed resident lying in bed with eyes closed, bilateral quarter side rails in lowered position. Review of the resident's care plan, last revised on 02/03/24, showed staff did not address the use of side rails on the care plan. During an interview on 04/18/24, at 2:16 P.M., Licensed Practical Nurse (LPN) C said the resident had side rails and used them for mobility	F 656		

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F 656	Continued From page 31 and transfer during cares provided by staff. 3. Review of Resident #26's face sheet showed the following: -Admission date of 06/26/19; -Diagnoses included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), and unspecified dementia. Review of the resident's electronic record showed a Side Rail Consent Form was signed by the resident's representative on 09/08/22, indicating information regarding the risks and benefits of using a side rail of any sort was received, and the resident chose to utilize a transfer bar,1/4 rail, or 1/2 rail. Observation on 04/16/24, at 1:27 P.M., showed bilateral u-shaped grab bars in raised position on the resident's bed. Observation on 04/17/24, at 10:26 A.M., showed the resident in bed with eyes closed with bilateral u-shaped grab bars in raised position. Observation on 04/18/24, at 11:25 A.M., showed the resident in bed with bilateral u-shaped grab bars in raised position. Interview and observation on 04/18/2024, at 2:07 P.M., showed the following: -Resident in bed with bilateral u-shaped grab bars in raised position; -The resident said he/she does not use the grab	F 656		

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F 656	Continued From page 32 bars. Review of the resident's care plan, last revised 04/01/24, showed staff did not address the use side rails on the resident's care plan. During an interview on 04/18/24, at 2:16 P.M., LPN C said the resident had side rails and used them for mobility and transfer during cares provided by staff. 4. Review of Resident #47's face sheet showed the following: -Admission date of 02/22/24; -Diagnoses included cognitive communication deficit, presence of left artificial hip joint, and fracture of left femur. Review of the resident's electronic record showed a Side Rail Consent Form was signed by the resident's representative on 02/22/24, indicating information regarding the risks and benefits of using a side rail of any sort was received, and the resident chose to utilize a transfer bar,1/4 rail, or 1/2 rail. Interview and observation on 04/15/24, at 2:57 P.M., showed the following: -U-shaped grab bar in raised position on the left side of the bed; -The resident said he/she used the grab bar for transfer and bed mobility. Observations on 04/16/24, at 1:34 P.M., on 04/17/24, at 10:26 A.M., and on 04/18/14, at 11:25 A.M., showed the u-shaped grab bar in raised position on left side of the bed.	F 656		

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F 656	Continued From page 33 Interview and observation on 04/18/24, at 2:05 P.M., showed the following: -U-shaped raised side grab bar on left side of the bed; -He/she uses the grab bar to get in and out of bed. Review of the resident's care plan, initiated on 02/22/24, showed staff did not care plan the use of the side rails/grab bars. 5. During an interview on 04/18/24, at 2:16 P.M., LPN C said staff should care plan all side rails. 6. During an interview 04/18/24, at 2:29 P.M., Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff) Coordinator E said staff should include residents with full side rails in the care plan. He/she was unsure and needed to verify if grab bars and quarter rails should be included in the care plan. 7. During an interview on 04/18/24, at 4:22 P.M., the Director of Nursing (DON) said staff should care plan all side rails. 8. During an interview on 04/18/24, at 5:46 P.M., the Administrator said side rails should be included in the care plan.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		

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F 684	Continued From page 34	F 684		

assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to timely notify the physician, responsible party, and registered nurse on-call of a fall for one resident (Resident #41) who complained of pain and decreased mobility to his/her left hip/leg, potentially contributing to a delay in the treatment of this resident's fractured femur, out of 16 sampled residents in a facility with a census of 50.

Review of the facility policy titled, "Falls Management," revised December 2022, showed the following:

-The facility strives to minimize the risk for resident falls and to reduce injuries associated with resident falls;
-After a fall occurs the licensed nurse is to initiate the risk management event reporting process. The process is to include a physical assessment including injuries sustained including description, location, measurements, and treatment, vital signs, pain, neurological checks, are to be completed when the head comes in contact with another surface of when the fall is unwitnessed;
-Fall occurrences are to be documented in the clinical record including environmental, situational, or psychological factors, location, time found, position, adaptive equipment, actions taken, and new interventions implemented;
-Physician and responsible party are to be notified following a fall;

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F 684	Continued From page 35 -Witness statements are to be obtained including time last seen, care provided prior to fall, and resident location prior to fall -Resident statements are to be obtained, when possible; -Physician and responsible party are to be notified following a fall occurrence with documentation of notification present in the clinical record. 1. Review of Resident #41's face sheet showed: -Admission date of 12/30/22; -Readmission date of 03/15/24; -A legal guardian listed as the responsible party/emergency contact #1; -Two additional emergency contacts listed with phone numbers. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/30/23, showed the following: -Moderate cognitive impairment; -Resident independent with all activities of daily living (ADL), except required substantial to maximum staff assistance with showers; -Resident ambulated without the use of an assistive device; -Resident always continent of bowel and bladder; -Resident had no falls; -Resident had no pain. Review of the resident's fall note dated 03/10/24, at 1:00 A.M., showed Licensed Practical Nurse (LPN) N documented the following: -Description of fall: While answering a call light, a	F 684		

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F 684	Continued From page 36 certified nurse assistant (CNA) found the resident on the floor, midway into the bathroom. Resident was lying on his/her right side with his/her torso on the floor in the bathroom and his/her legs in the bedroom. Resident immediately reported left hip pain before being moved off the floor. CNA and nurse were able to lift resident off the floor and into a wheelchair. Resident was taken to the nurses' station for assessment. Resident was not able to stand long enough to remove his/her jeans for staff to view his skin due to the pain; -Resident description of fall: Resident reported he/she was going to the bathroom, and he/she slipped because, "These slippers are slick;" -Description of environment: Resident's room and floor were clean, clear, and unobstructed in the living quarters and bathroom; -Resident assessment: Head to toe assessment completed, range of motion (ROM) of right upper extremity (RUE), left upper extremity (LUE), and right lower extremity (RLE) was within normal limits (WNL) for the resident. The resident was not able to bear weight well or walk far on his/her left leg. The resident was not able to stand long enough to remove his/her jeans for staff to view his/her skin due to the pain. Neurological checks (an assessment conducted to determine if any neurological changes have occurred) started and were WNL. Two staff assisted the resident into a wheelchair; -Vital Signs (VS - temperature, pulse rate, blood pressure, and respiratory rate) and neurological checks stable. No new injuries or bruises noted upon assessment. The resident was not able to stand long enough to remove his/her jeans for us to view his/her skin due to the pain. The resident reported pain at a 7/10 in his/her left hip; -Injuries and interventions: The resident reported pain at 7/10 in his/her left hip. Tylenol 1000	F 684		

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milligram (mg) was administered to the resident. Within 30 minutes of Tylenol administration, the resident reported his pain being 3/10;
-Pain and intervention: The resident reported pain at 7/10 in left hip. Tylenol 1000 milligrams (mg) was administered to resident. Within 30 minutes of Tylenol administration, resident reported his pain being 3/10. The resident declined being taken to the emergency room (ER) on three different occasions;
-Fall interventions: After observing the resident at the nurse station for more than an hour, staff assisted resident to his room and helped him into his recliner. Call light was given to the resident. The resident's walker was placed in front of recliner;
-Physician notification and response: via communication folder;
-Responsible party notification and response: Will contact at a more appropriate time;
-Administrator and Director of Nursing (DON) notification: per protocol.

Review of the resident's medication administration record (MAR) note, dated 03/10/24 at 1:07 A.M., showed LPN N documented the following:

-Order for Tylenol extra strength 500 mg, give 1000 mg by mouth every 6 hours as needed for unspecified pain;
-Nurse administered Tylenol extra strength 500 mg two tablets to equal 1000 mg for left hip pain after fall;
-Pain rating of 7 out of 10 (on a scale of 0-10, with 10 being the worst pain).

Review of the resident's medication administration record (MAR) note, dated 3/10/24

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at 3:25 A.M., showed LPN N documented the following:

-Tylenol administration was effective;
-Follow up pain scale was 3.

Review of the resident's nurse note, dated 03/10/24 at 10:33 A.M. showed LPN M documented the following:

-At 7:15 A.M., the nurse went down to the resident's room to evaluate the resident;
-The resident was unable to bend his/her left leg at all, due to too much pain;
-The resident was able to move and bend his/her right leg;
-The nurse explained to the resident he/she needed to go get checked out at the hospital to evaluate his/her left leg and to get X-rays. The resident said, "Okay;"
-At 7:20 A.M., the nurse placed a call to the resident's responsible party to give an update and to notify the facility was sending the resident to the emergency room for evaluation and X-rays of the left hip. Responsible party said he/he would meet the resident at the emergency room;
At 7:40 A.M., the ambulance arrived to transport the resident to the emergency room.

Review of the resident's progress note, dated 03/15/24 at 9:56 A.M., showed Director of Nursing (DON) documented the following:

-Resident reviewed due to a fall in his/her room on 03/10/24 at 12:50 A.M.;
-The CNA went to answer the resident's resident call light and upon entering the room, the CNA noted resident to be sitting on the floor partially into his/her bathroom;

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F 684	Continued From page 39 -The CNA called for the charge nurse. Upon assessment by the charge nurse, the resident complained of left hip pain however, he/she adamantly refused to be sent to hospital for evaluation/treatment; -The CNA and nurse assisted the resident up from the floor and into a wheelchair where he/she remained one-on-one with staff immediately following the fall; -The staff obtained vital signs and initiated neurological checks; -Staff administered pain medication administered as ordered with good effect for pain control; -The charge nurse attempted to talk the resident into going to the hospital multiple times, however the resident adamantly refused, therefore resident was assisted into his/her recliner per his/her request; -Staff attempted to complete a head-to-toe skin assessment, however it was limited due to the resident's pain; -Range of motion (ROM) were within normal limits for the resident in all areas except the left hip, which was noted with limited ROM WNL during the assessment, hence the reason the charge nurse tried diligently to get the resident to agree to a hospital visit; -The resident remained in his/her recliner until the day shift nurse arrived on shift; -After shift change, the day shift nurse went to assess the resident and was able to convince him/her to go to hospital for further evaluation and treatment of possible left hip fracture; -The facility notified the resident's responsible party of the incident and of the resident being transferred to the hospital on 03/10/24 at 7:20 A.M.; -The facility notified the physician on 03/10/24 and the physician agreed with the resident being	F 684		

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	265266	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES NEOSHO	400 LYON DRIVE NEOSHO, MO 64850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40	F 684		

sent to the hospital;
-It was noted during the initial assessment, the resident was wearing slippers on his/her feet with minimal traction on the bottom, when asked where the slippers came from the resident was unable to tell staff;
-Staff removed the resident's slippers from his/her room and provided education to the family related to proper footwear for added safety during transfers/ambulation.

Review of Nurse Practitioner (NP) G's visit note, dated 03/21/24, showed, in part, the following:

-The resident had a recent left hip surgery at the hospital for a broken hip after a fall on 03/10/24;
-The resident returned to the facility on 03/15/24.

Review of the resident's quarterly MDS, dated 03/21/24, showed:

-Diagnosis of non-displaced intertrochanteric (directly below the hip joint) fracture of left femur (upper leg bone) with subsequent encounter for closed fracture with routine healing;
-Dependent on staff for toileting hygiene, lower body dressing;
-Required substantial or maximum assistance with transfers;
-Used a wheelchair for mobility device;
-Occasionally incontinent of bowel and bladder;
-Sustained 2 falls since admission, non-injury.

Review of the resident's care plan, revised on 03/28/24, showed:

-Resident at risk for falls;
-Staff to encourage the resident to change positions slowly;

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F 684	Continued From page 41 -Education provided to staff to offer to assist the resident to bed after dinner for added safety; -Resident had limitations on his/her left side, please place items on the right side of his/her bed/chair; -Staff to place commonly used items within the resident's reach; -Resident to use handrails to assist with ambulation; -Resident to wear appropriate shoes and non-slip footwear; -Resident to use a walker to assist with walking; -Ensure the call light is within reach and encourage the resident to use it to ask for assistance; -Please inform the resident's family and physician of changes in his/her status; -Please make sure the pathway in the resident's room remains clean and unobstructed. Observation on 04/16/24 at 10:20 A.M. and at 2:25 P.M., showed: -The resident sat in a recliner in his/her room, watching television; -The resident wore a pair of tennis shoes on his feet; -The resident showed no obvious signs of distress. During an interview on 04/17/24 at 11:40 A.M., LPN C said the following: -If a resident fell, he/she would perform a head-to-toe assessment for injuries; -If the resident did not complain of hip pain, he/she would check for any abnormal internal or external rotation or shortening of the legs and see if the resident was able to move the extremity;	F 684		

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F 684	Continued From page 42 -If he/she observed any issues or complaints of hip pain, he/she would immediately contact the resident's physician to notify of the resident fall, condition, ask about an X-ray order. During an interview on 04/17/24 at 1:32 P.M., Certified Medication Technician (CMT) J said the following: -On 3/10/24, he/she arrived to work at approximately 6:00 A.M.; -When the day nurse arrived, he/she immediately went to the resident's room, assessed the resident, and sent the resident out via ambulance to the emergency room for evaluation. During a phone interview on 04/17/24 at 2:26 P.M., Licensed Practical Nurse (LPN) M said the following: -He/she worked day shift (7:00 A.M. to 7:00 P.M.) at the facility as the charge nurse; -He/she worked on the morning of 03/10/24, upon arrival to work, the night nurse reported the resident fell during the night; -The night nurse reported after assessing the resident, he/she refused to go to the emergency room; -Both nurses went to the resident's room; -The day nurse asked the resident if he/she could lift his/her leg, but he/she could not; -The day nurse told the resident he/she needed to go to the hospital and the resident agreed to go. During an interview on 04/18/24 at 9:59 A.M., Director of Nursing (DON) said the following: -The resident was able to walk prior to the fall on	F 684		

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F 684	Continued From page 43 3/10/24; -If a resident had a fall with injury, the nurse on duty should have immediately notified the physician and the resident's responsible party or next of kin; -According to the resident's fall report, the facility notified the resident's responsible party and 7:20 A.M. of the resident's fall. During a phone interview on 04/18/24 at 12:14 P.M., LPN N said the following: -After the resident fell on 3/10/24, the resident expressed pain and guarding (behavior that is aimed at preventing or alleviating pain) of his/her left side. The resident would not bear weight on his/her left leg or move his/her left leg; -Staff assessed the resident's vital signs (VS, temperature, pulse rate, blood pressure, and respiratory rate) and the nurse performed a quick visual assessment of the resident; -The resident showed no obvious deformities or shortening of his/her legs, so staff assisted the resident up into a wheelchair and brought the resident out to nurse's desk due to the resident insistence on getting up and drinking coffee; -The nurse administered Tylenol and the resident showed some improvement in pain; -The nurse planned to send the resident out to the emergency room due to concerns of the resident guarding and not wanting to move his/her left leg; -The nurse asked, but the resident refused to go to the emergency room three times; -The nurse did not call the physician about the resident's fall and assessment, but he/she did contact the on-call registered nurse (RN). The nurse (LPN N) said he/she was unsure who that on-call RN was that night;	F 684		

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F 684	Continued From page 44 -The next morning, the day shift nurse came in and the day shift nurse notified the resident's family of the fall and injury and the resident agreed to go to the emergency room for evaluation; -It is normally the responsibility of the on-call RN to notify the resident's physician; -He/she did not speak to the physician; -On the morning of 3/10/24, the day nurse assessed the resident, and he/she did not want to bear weight on his/her right leg and did not want to move his/her right leg, so the day nurse notified the resident's responsible party and the resident agreed to go to the hospital; -The nurse (LPN N) said he/she thought the day nurse or on-call RN notified the resident's physician, but the nurse was unsure. During an interview on 04/18/24 at 1:02 P.M., the resident's nurse practitioner (NP) G said the following: -He/she would expect the facility to call the resident's physician after a fall with hip pain and limited range of motion to that extremity as soon as possible after the fall. During an interview on 04/18/24 at 3:20 P.M., the DON said the following: -The DON spoke with the resident's physician and the physician recalled the DON notified him/her of the resident's fall on 03/10/24, sometime after staff sent the resident out to the hospital, but could not recall an exact time; -The charge nurses should contact the on-call registered nurse (RN), and then the RN directs the charge nurse on what they need to do after a fall, before they contact the resident's physician; -If the charge nurse working the night of the fall had contacted the DON, he/she would have	F 684		

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F 684	Continued From page 45	F 684		

instructed the charge nurse to call and notify the resident's physician;
-The physician's expectation was for the facility to contact him within 24 hours after a fall;
-In this situation, the night nurse or the on-call RN should have notified the resident's physician and family.
The DON did not feel the way in which the nurse handled the fall follow-up was an issue and therefore he/she did not conduct an investigation after the fall;
-He/she assumed the on-call RN, which was the ADON, educated the night nurse about not contacting the resident's physician;
-The DON did not follow-up with the ADON to ensure he/she provided education to the night nurse regarding not notifying the resident's physician or responsible party;
-The DON should have followed up with the ADON to ensure he/she educated the night nurse on the need to timely notify the resident's physician and responsible party;
-The ADON and the day shift charge nurse sent the resident out to the hospital that morning after the fall.

During an interview on 04/18/24 at 4:03 P.M., Administrator said the following:

-The nurse should notify a resident's physician of a resident fall within 24 hours per the physician's protocol, but some of it is a case-by-case basis;
-The night nurse should have called the DON, if he/she suspected a resident injury and then go from there;
-The night nurse probably should have called the resident's physician before sending the resident out to the hospital;
-The night nurse should have notified the

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F 684	Continued From page 46	F 684		

resident's responsible party and the earliest possible time.

During an interview on 4/25/24 at 9:25 A.M., Assistant Director of Nursing (ADON) said the following:

-He/she was the RN on-call for the facility on the night of 03/09/24-03/10/24;
-The night nurse, LPN N, did not contact the ADON immediately after the resident's fall, as was the expectation of the facility;
-The night nurse waited to contact the ADON until approximately 6:00 A.M., via text message and the message did not name a resident. The message read a resident slipped on the floor due to sick slippers and his/her left hip was sore and he was refusing to go to the hospital;
-The ADON arrived at work within an hour, obtained report, and went to the resident's room along with LPN M, the day nurse, to assess the resident. The resident could not move his/her left leg at all and complained of pain to the leg. The nurse told the resident he/she needed to go to the hospital because the nurse suspected the resident cold have fractured a bone in his/her leg/hip. The resident agreed to go to the hospital;
-Afterwards, the ADON educated the night nurse, LPN N, regarding the need to contact the RN on-call and the resident's responsible party immediately after a fall, if the nurse suspected serious injury/fracture;
-The ADON said he/she asked why staff assisted the resident into a wheelchair and brought the resident to the nurse station after the fall and LPN N said for closer monitoring and assessment of the resident;
-The facility physician preferred not to be contacted during the night, if the facility RN

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F 684	Continued From page 47 determined a resident needed to go to the hospital. The facility would typically send a resident to the hospital and notify the physician the following morning. This was not written policy, but was the physician's preference.	F 684		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05383	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES NEOSHO	400 LYON DRIVE NEOSHO, MO 64850

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A4087	19 CSR 30-85.042(78) Dr Notification-Change in Condition In the event of accident, injury, or significant change in the resident's condition, facility staff shall notify the resident's physician in accordance with the facility's emergency treatment policies which have been approved by the supervising physician. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F580.	A4087		
A4088	19 CSR 30-85.042(79) Notify Responsible Party-Change in Condition In the event of accident, injury, or significant change in the resident's conditions, facility staff shall immediately notify the person designated in the resident's record as the designee or responsible party. III This regulation is not met as evidenced by: 1. Please refer to F580.	A4088		
A6041	19 CSR 30-87.020(41) Toilet Room Requirements Toilet rooms shall be conveniently located and easily accessible to residents and employees. Toilet rooms shall be completely enclosed. Toilet fixtures shall be kept clean and in good repair. A supply of toilet tissue shall be provided at each toilet at all times. Easily cleanable receptacles shall be provided for waste materials. Toilet rooms used by women employees shall have at least one (1) covered waste receptacle. III	A6041		

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A6041	Continued From page 1 This regulation is not met as evidenced by: 1. Please refer to F584.	A6041		
A8019	19 CSR 30-88.010(19) Resident Room Transfer A room transfer of a resident within a facility, except in an emergency situation, requires consultation with the resident as far ahead of time as possible and shall not be permitted where this transfer would result in any avoidable detriment to the resident's physical, mental or emotional condition. II/III This regulation is not met as evidenced by: Class III 1. Please refer to F561.	A8019		

PLAN OF CORRECTION

Provider/Supplier Name:	Medicalodge Neosho
Street Address, City, Zip:	400 W. Lyon Drive Neosho MO 64850
Date of Survey:	4/18/24

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265266

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction constitutes a written allegation of substantial compliance with requirements of the Department of Health and Human Services Centers for Medicare and Medicaid Services. This plan of correction is being submitted pursuant to the applicable federal and state regulations and nothing contained herein shall be construed as an admission that this facility violated any federal or state regulations. A copy of this annual survey and a Plan of Correction will be submitted to the Quality Assurance Committee for review and monitoring at their next scheduled meeting. The facility will be in substantial compliance by	
F561 CFR: 483.10	For resident # 27 and all other potentially affected residents, the facility will promote and facilitate resident self-determination through support of resident choice by offering to move resident to a different available room as needed/indicated. Resident agreed and was moved to a different room in a different hall 4/19/24. SSD and/or designee will follow up with resident weekly x 4 weeks to monitor psychosocial wellbeing. SSD and/or designee will review room choice with each resident quarterly during Wellness review and will report findings and continued compliance to facility QAPI committee monthly. Compliance by 5/19/24.	5/19/24
F580 CFR: 483.10	For resident #27, #39, #41 and all other potentially affected residents in the facility. The facility completed in person inservice on 5/8/24 where policy/procedure r/t doctor/family/DON/Administrator notification was reviewed with all nursing staff. IDT team (Interdisciplinary Team-Administrator/DON/ADON/SSD/MDS) will conduct routine audits of nursing documentation during Daily Clinical Excellence (M-F) and will report findings and continued compliance to the facility QAPI committee monthly. Compliance by 5/30/24	5/30/24

F584 CFR: 483.10	For resident # 29, the facility will ensure that we have provided a safe clean home by removing the makeshift "splash guard" on the toilet riser and placing an appropriately fitting "splash guard" on the toilet riser in the residents bathroom in room 304 so that it may be properly cleaned and sanitized. An audit by housekeeping was done to ensure risers in other resident rooms were clean and sanitized appropriately. Administrator and housekeeping supervisor and/or designee will monitor cleaning weekly of toilet and riser/splash guard in room 304 as well as all other risers/splash guards used in other resident rooms and report continued compliance through the QAPI committee. Compliance by 5/31/24.	5/31/24
F644 CFR: 483.20	For resident #51 and all other potentially affected residents in the facility. The PASSAR will be resubmitted for Res #51 and other outstanding resident PASSAR's. The facility will ensure proper education has been provided to all administrative staff and business office staff in relation to completing and submitting PASSAR for all new residents admitted into a certified bed in the facility. The Business office Manager audited resident charts and all current outstanding PASSAR that have not been submitted will be reviewed and submitted. Will be Audited by the Administrator when completing the admission packet. Administrator and/or designee will review and report continued compliance through the QAPI committee. Compliance by 5/1/24.	5/1/24
F656 CFR: 483.21	For resident #5, #12, #26, #47 and all other potentially affected residents in the facility. The MDS coordinator and/or designee will complete an audit of all current residents requiring/utilizing bed rails of any kind and update care plans to reflect appropriately. MDS coordinator and/or designee will monitor assessments/care plans quarterly with wellness and report completion and continued compliance to facility QAPI committee monthly. Compliance by 5/31/24.	5/31/24
F684 CFR: 483.25	For resident #41, and all other potentially affected residents in the facility. The DON and/or designee will complete an audit of all current active RISK Event Assessment/Progress notes and the DON will provide education to all nurses during inservice on 5/29/24 and/or prior to next scheduled shift regarding Risk Management process and notification expectations for all falls, changes in condition and new skin issues. DON and/or designee will report continued compliance through the facility QAPI committee monthly. Compliance by 5/29/24	5/29/24

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider/Supplier Name:	Medicalodges Neosho
Street Address, City, Zip:	400 Lyon Drive Neosho, MO 64850
Date of Survey:	4/18/24

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	05383

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction constitutes a written allegation of substantial compliance with requirements of the Department of Health and Human Services Centers for Medicare and Medicaid Services. The plan of correction is being submitted pursuant to the applicable federal and state regulations and nothing contained herein shall be construed as an admission that this facility violated any federal or state regulations. A copy of this complaint survey and a Plan of Correction will be submitted to the Quality Assurance Committee for review and monitoring at their next scheduled meeting. The facility will be in substantial compliance by	
A4087 CSR: 30-85.042	For resident #27, #39, #41 and all other potentially affected residents in the facility. The facility completed in person inservice on 5/8/24 where policy/procedure r/t doctor/family/DON/Administrator notification was reviewed with all nursing staff. IDT team (Interdisciplinary Team-Administrator/DON/ADON/SSD/MDS) will conduct routine audits of nursing documentation during Daily Clinical Excellence (M-F) and will report findings and continued compliance to the facility QAPI committee monthly. Compliance by 5/30/24	5/30/24
A4088 CSR: 30-85.042	For resident #27, #39, #41 and all other potentially affected residents in the facility. The facility completed in person inservice on 5/8/24 where policy/procedure r/t doctor/family/DON/Administrator notification was reviewed with all nursing staff. IDT team (Interdisciplinary Team-Administrator/DON/ADON/SSD/MDS) will conduct routine audits of nursing documentation during Daily Clinical Excellence (M-F) and will report findings and continued compliance to the facility QAPI committee monthly. Compliance by 5/30/24	5/30/24

A6041 CSR: 30-87.020	For resident # 29, the facility will ensure that we have provided a safe clean home by removing the makeshift "splash guard" on the toilet riser and placing an appropriately fitting "splash guard" on the toilet riser in the residents bathroom in room 304 so that it may be properly cleaned and sanitized. An audit by housekeeping was done to ensure risers in other resident rooms were clean and sanitized appropriately. Administrator and housekeeping supervisor and/or designee will monitor cleaning weekly of toilet and riser/splash guard in room 304 as well as all other risers/splash guards used in other resident rooms and report continued compliance through the QAPI committee. Compliance by 5/31/24.	5/31/24
A8019 CSR: 30-88.010	For resident # 27 and all other potentially affected residents, the facility will promote and facilitate resident self-determination through support of resident choice by offering to move resident to a different available room as needed/indicated. Resident agreed and was moved to a different room in a different hall 4/19/24. SSD and/or designee will follow up with resident weekly x 4 weeks to monitor psychosocial wellbeing. SSD and/or designee will review room choice with each resident quarterly during Wellness review and will report findings and continued compliance to facility QAPI committee monthly. Compliance by 5/19/24.	5/19/24

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