STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265493	A. BUILDING _____ B. WING _____	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES NEVADA	1210 WEST ASHLAND NEVADA, MO 64772

(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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of abuse and neglect were reported immediately to facility management and to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required two-hour time frame when staff failed to immediately report an	F 609	Past noncompliance: no plan of correction required.	

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

K Shuey | Executive Director | 1/17/25

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 609	Continued From page 1 allegation of employee to resident abuse of involving three residents (Resident #1, #2 and #3). The facility census was 31. The Administrator was notified on the morning of 12/17/24 of the Past Non-Compliance which occurred on 12/15/24 between 3:00 A.M. and 5:00 A.M. The accused certified nurse aide was suspended on 12/17/24. Staff assessed both residents for injuries and none were found. On 12/17/24, in-service of all staff was started. Staff began the full investigation on 12/17/24 and completed interviews on 12/17/24. The facility implemented monitoring, including once a week for four weeks or as needed for psychosocial support. The noncompliance was corrected on 12/17/24. Review of the facility's policy titled, "Abuse, Neglect, and Exploitation," revised 10/2022, showed the following: -The resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. It is the policy of Medicalodges, Inc., to treat each resident with respect, kindness, dignity and care, to keep them free from abuse and neglect and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect; -All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source are to be reported immediately to the Administrator and/or their designated representative, the appropriate state agency and when applicable, law enforcement, not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury.	F 609		

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F 609	Continued From page 2 1. Review of Resident #1's face sheet (resident information at a quick glance) showed the following: -Admission date of 10/18/21; -Diagnoses included cerebral palsy (a group of disorders that affect a person's ability to move, maintain balance, and control posture), muscle weakness, and depression. Review of the resident's annual Minimum Data Set (MDS - federally mandated assessment tool completed by facility staff), dated 12/05/24, showed the following: -The resident was cognitively intact; -The resident used a wheelchair to ambulate; -The resident was dependent on others for assistance in completing the Activities of Daily Living (ADL's - dressing, grooming, bathing, eating, and toileting). Review of the resident's care plan, updated 12/18/24, showed the following: -The resident yells out at night because he/she is hungry; -The resident frequently screams. Staff to redirect him/her to use his/her words; -The resident needed to develop a trusting, therapeutic relationship with others; -Allow the resident to express his/her emotions without judgement or criticism; -The resident needed staff to follow up on his/her needs and concerns in a timely manner. 2. Review of Resident #2's face sheet showed the following:	F 609		

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F 609	Continued From page 3 -Admission date of 07/31/24; -Diagnoses included major depressive disorder (mood disorder that is characterized by a low mood and negative emotions), muscle weakness, and dementia (a general term for a number of neurological conditions that cause a decline in cognitive abilities). Review of the resident's quarterly MDS, dated 10/31/24, showed the following: -The resident had severe cognitive impairment; -The resident was dependent on others for assistance in completing his/her ADL's, -The resident used a wheelchair to ambulate; -The resident was dependent on others to push his/her wheelchair. Review of the resident's care plan, updated 12/18/24, showed the following: -The resident needed staff to wheel him/her around his/her home. The resident was unable to do so on his/her own; -Monitor the residents verbal and nonverbal cues for pain. 3. Review of the facility's Investigation Summary, dated 12/17/24, showed the following: -The Administrator was notified on 12/17/24, at 8:30 A.M., of an allegation of employee to resident verbal and physical abuse, that had occurred on 12/16/24 between 3:00 A.M. and 5:00 A.M.; -The staff reported the allegations of abuse to DHSS on 12/17/24 at 9:21 A.M.	F 609		

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F 609	Continued From page 4 Review of a written statement, dated 12/17/24, showed Certified Nurse Aide (CNA) E noted the following: -On 12/15/24, at around 3:30 A.M., the CNA heard Resident #1 screaming and then heard a staff tell the resident to "Shut-up! You are fine!" -On 12/15/24, at around 4:40 A.M., Resident #2 was yelling for help and CNA F came up behind the resident in a wheelchair, grabbed the wheelchair, and roughly began pushed the resident forward hard enough to cause the resident's legs to bend back under the wheelchair. -CNA F then walked over to Resident #3 and without saying anything, "ripped the blankets off of the resident." The resident began screaming. The CNA sid "hey, I'm chaingng you!" and "yanked" the resident's brief down being rough with the resident. The resident was continued to scream. 4. Review of DHSS's intake information dated 12/17/24, at 9:33 A.M., showed the facility self-reported a verbal allegation of abuse by a CNA. 5. During an interview on 12/23/24, at 1:29 A.M., CNA A said the following: -If he/she witnessed, or if a resident reported, any abuse or neglect to him/her, he/she would immediately report the allegations to the charge nurse; -The state required allegations of abuse and neglect to be reported to the state within two hours; -Before moving a resident in a wheelchair staff should make sure the resident's feet were on the	F 609		

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F 609	Continued From page 5 foot pedals and the resident's arms were in their lap; -Verbal abuse was considered abuse and should be reported to the state. 6. During an interview on 12/23/24, at 1:37 A.M., CNA B said the following: -If a resident reported abuse or neglect to him/her CNA B would report it to the charge nurse; -The state required allegations of abuse and neglect to be reported to the state with in two hours; -Prior to pushing a resident in a wheelchair staff should make sure the resident's feet are on the foot pedals and the resident's arm/hands are on their lap; -If a resident does not have pedals on their wheelchair staff should not push that resident. 7. During an interview on 12/23/24, at 1:40 A.M., CNA C said the following: -All allegations of abuse and neglect should be reported to the charge nurse immediately; -The state required all allegations of abuse and neglect to be reported within two hours; -The residents should not be pushed in a wheelchair that did not have foot pedals; -The resident's feet should be on the foot pedals prior to pushing; -The resident should be sitting all the way to the back of the wheelchair; -Being rough with a resident and telling a resident to shut up was abuse and should be reported to upper management. 8. During an interview on 12/23/24, at 10:36 A.M., CNA E said the following:	F 609		

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F 609	Continued From page 6 -If he/she witnessed any abuse towards a resident he/she would report it immediately to the charge nurse; -The state required all allegations of abuse and/or neglect to be reported within two hours; -On 12/15/24, around 3:00 A.M., Resident #1 had yelled for help and CNA F responded by saying "Shut up, you're fine." -CNA E did not feel that what CNA F said to the resident was appropriate; -The same night CNA F walked up behind Resident #2's wheelchair and started pushing it. CNA F did not make sure the resident's feet were on the foot pedals. Resident #2 started screaming because his/her leg was being bent as his/her foot was on the ground while CNA F was pushing the wheelchair; -CNA E did not tell the charge nurse working about CNA F telling Resident #1 to "shut up" or about CNA F pushing Resident #2 in the wheelchair roughly; -CNA E contacted the Administrator two days after the incidents with CNA F to report his/her concerns. 9. During an interview on 12/23/24, at 1:45 A.M., Licensed Practical Nurse (LPN) D said the following: -LPN D would report all allegations of abuse and neglect to the Director of Nursing (DON) and the Administrator; -The Administrator should start an investigation and report the allegations to the responsible state agency within two hours; -Staff are trained in the proper way to assist residents in wheelchairs; -The resident's feet should be on the foot pedals	F 609		

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F 609	Continued From page 7	F 609		

of the wheelchair prior to moving the wheelchair;
-No staff reported to him/her that CNA F verbally or physically abused or was rough with a resident;
-Staff telling a resident to shut up is an allegation of verbal abuse and should be reported immediately.

10. During an interview on 12/23/24, at 12:25 P.M., the DON said the following:

-CNA E called the Administrator regarding the incident with CNA F;
-No residents have reported any abuse or issues with CNA F to the DON.

During interviews on 12/23/24, at 1:55 A.M. and 12:30 P.M., the Administrator said the following:

-She had completed the investigation into the allegations of verbal abuse and staff being rough with a resident;
-CNA E called the administrator the morning of 12/17/24, upset with what occurred on the over night shift on 12/15/24 and 12/16/24;
-CNA E said that CNA F had forcefully pushed Resident #2 in his/her wheelchair causing the resident to scream in pain as the resident's leg was being bent;
-CNA E said that he/she heard Resident #1 yelling out and then heard CNA F tell Resident #1 to "shut up";
-The Administrator said that telling a resident to "shut up" is abuse and should have been reported immediately;

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