STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265266	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Neosho	400 Lyon Drive Neosho, MO 64850

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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; -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; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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 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 milligram (mg) was administered to the resident. Within 30 minutes of Tylenol administration, the resident reported his pain being 3/10; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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 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; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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; -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 [DATE] at 7:20 A.M.; -The facility notified the physician on 03/10/24 and the physician agreed with the resident being 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE]. Review of the resident's quarterly MDS, dated [DATE], 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; -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: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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; -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; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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 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 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 (continued on next page)

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