STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265555	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eldon Nursing & Rehab	1001 East North Street Eldon, MO 65026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, facility staff failed to meet professional standards of care when staff failed to document an assessment of new wounds and obtain treatment orders from the physician for one resident (Resident #7) out of two sampled residents with pre-existing wounds. The facility census was 62.1. Review of the facility's Pressure Ulcer Care and Prevention policy, undated, showed the purpose is to prevent and treat further breakdown of pressure ulcers, and the nurse is responsible to provide the treatment as ordered by the attending physician and to implement measures for pressure ulcer prevention. Review of the facility's Wound Care and Treatment policy, undated, showed the purpose is to prevent and treat all wounds, and there must be a specific order for the treatment. 2. Review of Resident #7's Significant Change Minimum Data Set (MDS), a federally mandated assessment, dated 10/16/25, showed staff assessed the resident as follows: -Severe cognitive impairment;-At risk for developing pressure ulcers;-Had one or more unhealed pressure ulcers;-Received hospice care. Review of the resident's care plan, revised 10/14/25, showed staff assessed the resident with wounds to his/her sacrum, left buttock, right hip, and left back. Review of the resident's weekly skin assessment note, dated 10/07/25, showed staff documented the resident was evaluated by the mobile wound physician. Orders to continue treatments to coccyx, left mid back, bilateral hips., and recommendation to add antimicrobial dressing (provides wound protection, absorbs moisture, and treats bacteria in wounds) to right hip. Notified administration of recommendation for antimicrobial dressing and resident's family notified of new orders. Review of the resident's weekly skin assessment note, dated 10/15/25, showed staff documented the resident reported pain in both knees, crying out, administered pain medication, dressings changed to both hips, left flank (between the ribs and hip), coccyx and right buttock per order. Observed new deep tissue injury to left medial knee measuring five-centimeter (cm) x three cm, applied skin prep (a dressing to protect skin from moisture, adhesive, and friction). Observed a scabbed area to right lower leg measuring 2.2 cm x 1.2 cm, applied skin prep. Per DON, hospice will be in to see resident the next day. Review of the resident's Physician's Order Sheet (POS), dated 10/15/25 through 10/19/25, showed the POS did not contain documentation of a physician's ordered wound treatment for the resident's right inner knee and left heel. Review of the resident's Treatment Administration Record (TAR), dated 10/15/25 through 10/19/25, showed the TAR did not contain documentation staff provided wound treatments to the resident's right inner knee and left heel. Review of the resident's progress notes, dated 10/17/25 through 10/19/25, showed the record did not contain documentation staff assessed, or initiated interventions to treat new wounds to the resident's right inner knee and left heel. Observation on 10/20/25 at 11:15 A.M., showed resident in bed on his/her left side with knees contracted together, heels directly on the air mattress, a dressing to the right outer leg and left inner knee dated 10/19/25, and an undated dressing to his/her right hip. Observation on 10/20/25 during wound care from 12:14 P.M. to 1:30 P.M., showed hospice Registered Nurse (RN) G completed treatments to wounds on the resident's right hip, right (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	buttock, coccyx, right outer leg, left inner knee, right inner knee, left lower back, left hip, and reinforced an undated foam dressing to the resident's left heel which was soft and spongy. During an interview on 10/20/25 at 12:48 P.M., hospice RN G said RN A reported to him/her the wound to the resident's right inner knee must have appeared over the weekend, and there wasn't a treatment order for the left heel. Hospice RN G said he/she received orders from RN A to treat the resident's right and left inner knees. During an interview on 10/20/25 at 1:18 P.M., the Director of Nursing (DON) said he/she assessed the resident's wounds on 10/17/25, and there was redness to the resident's right inner knee. The DON said he/she applied skin prep, placed a blanket between the resident's knees and directed the aides to float the resident's heels. He/She said he/she passed on the information in report to the oncoming nurse, but did not document an assessment of the resident's skin other than on the TAR. During an interview on 10/20/25 at 4:21 P.M., RN A said a facility nurse in collaboration with the hospice nurse completes the treatments to the resident's wounds daily and documents on the TAR. RN A said if the nurse identifies a new wound/skin concern, the nurse is expected to document an assessment (measurement, color, drainage, odor), notify the DON, and obtain orders from the physician. RN A said he/she did not personally assess the resident's wounds earlier in the day, but he/she took the recommendations from hospice RN G and contacted the physician for orders. During an interview on 10/20/25 at 3:55 P.M., the DON said he/she would expect the nurses to complete a skin assessment on the resident daily with scheduled wound care and document any new skin concerns. The DON said he/she would expect to see a progress note dated 10/18 or 10/19 regarding any new skin concerns and what staff did about it. During an interview on 10/22/25 at 12:32 P.M., the resident's physician said he/she considered the resident's wounds highly unavoidable but would expect if staff identified new skin concerns/wounds, staff would assess the resident and obtain a treatment. The physician said he/she had deferred the resident's wound management to a mobile wound care provider, but if the wound care provider was not available to give an order for treatment, staff could have contacted him/her for an order.Complaint# 2634421

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to provide care to meet the basic hygiene needs for six residents (Resident #1, #2, #3, #4, #5, and #6) out of six sampled residents who required assistance with showers. The facility census was 62. 1. Review of policies provided by facility staff showed the policies did not contain a shower policy. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/14/25, showed staff assessed the resident as follows: -Moderate cognitive impairment; -Required substantial to maximal assistance from staff for personal hygiene;-Dependent on staff for showers. Review of the resident's care plan, dated 10/08/25, showed staff documented the resident prefers one shower per week and as needed, and required assistance from two staff with a gait belt or mechanical lift if ordered to assist with transfer to shower chair. Review of the resident's electronic shower record, dated 08/01/25 through 08/31/25, showed staff documented the resident received a shower on 08/05/25 and 08/08/25.Review of the resident's electronic shower record, dated 09/01/25 through 09/30/25, showed staff documented the resident received a shower on 09/27/25, and refused a shower on 09/06/25.Review of the resident's electronic shower record, dated 10/01/25 through 10/19/25, showed staff documented the resident received a shower on 10/04/25, 10/11/25, and 10/18/25.Observation on 10/20/25 at 10:30 A.M., showed the resident in bed with greasy unkempt hair.During an interview on 10/20/25 at 10:30 A.M., the resident said staff are supposed to assist him/her with a shower two times per week, but he/she had not had a shower in two and a half weeks, and he/she feels yucky when he/she does not get a shower because he/she is often incontinent of bowel and bladder. He/She said he/she uses a washcloth to try and rub his/her hair, but it only does so much. He/She said it takes two people to transfer him/her for a shower, and he/she feels like staff don't want to be bothered to assist him/her.3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact;-Required partial to moderate assistance from staff for personal hygiene;-Required substantial to maximal assistance from staff for shower/bathe. Review of the resident's care plan, dated 11/19/24, showed the resident required assistance from one staff with bathing. Review of the resident's electronic shower record, dated 08/01/25 through 08/31/25, showed staff documented the resident received a shower on 08/06/25.Review of the resident's electronic shower record, dated 09/01/25 through 09/30/25, showed the record did not contain documentation the resident received a shower, or the resident refused any baths/showers. Review of the resident's electronic shower record, dated 10/01/25 through 10/19/25, showed staff did not document the resident received a shower, and did not document the resident refused any baths/showers. Observation on 10/20/25 at 9:04 A.M., showed the resident sat at the side of his/her bed with short greasy unkempt hair.During an interview on 10/20/25 at 9:04 A.M., the resident said staff are supposed to assist him/her with a shower two times per week, but he/she had not had a shower in two weeks. He/She said it makes him/her feel dirty and stinky when he/she must wait that long for a shower, so sometimes he/she uses a washcloth at the sink to freshen up, but he/she would feel better with an actual shower.4. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact;-Required substantial to maximal assistance from staff for personal hygiene;-Required substantial to maximal assistance from staff for shower/bathe. Review of the resident's care plan, dated 02/13/25, showed staff documented the resident prefers one shower per week and as needed, and requires assistance from two staff for bathing (includes transfer, not include wash back and hair). Review of the resident's electronic shower record, dated 08/01/25 through 08/31/25, showed staff documented the resident received a shower on 08/06/25.Review (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Eldon Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 East North Street Eldon, MO 65026	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the resident's electronic shower record, dated 09/01/25 through 09/30/25, showed the record did not contain documentation the resident received a shower, or the resident refused any baths/showers. Review of the resident's electronic shower record, dated 10/01/25 through 10/19/25, showed the record did not contain documentation the resident received a shower, or the resident refused any baths/showers. During an interview on 10/20/25 at 9:09 A.M., the resident said staff are supposed to assist him/her with a shower two times per week, which has not been happening because they skip us all the time. He/She said the last time staff assisted him/her with a shower was two weeks ago, and before that, he/she went about four to five weeks without a shower. He/She said he/she does not refuse a shower because he/she wants to receive showers but needs help, and his/her hair feels rough when dirty, and is looking lousy now. 5. Review of Resident #4's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Moderate cognitive impairment;-Required substantial to maximal assistance from staff for personal hygiene;-Required substantial to maximal assistance from staff for shower/bathe. Review of the resident's care plan, dated 11/27/24, showed staff documented the resident would like one shower per week and as needed, and required assistance from one to two staff for bathing. Review of the resident's electronic shower record, dated 08/01/25 through 08/31/25, showed the record did not contain documentation the resident received a shower, or the resident refused any baths/showers. Review of the resident's electronic shower record, dated 09/01/25 through 09/30/25, showed staff documented the resident received a shower on 09/22/25 and 09/29/25. Review of the resident's electronic shower record, dated 10/01/25 through 10/19/25, showed staff documented the resident received a shower on 10/03/25. Observation on 10/20/25 at 9:16 A.M., showed the resident laid in bed with greasy unkempt hair and unkempt facial hair. During an interview on 10/20/25 at 9:16 A.M., the resident said he/she liked his/her facial hair, but he/she needed a shower to make him/her feel clean and fresh. He/She said staff are supposed to assist him/her with a shower two times per week, but he/she had not had a shower for about three weeks. 6. Review of Resident #5's Quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, and dependent on staff for personal hygiene and shower/bathe.Review of the resident's care plan, dated 08/21/25, showed staff documented the resident would like one shower per week and as needed, requires total assist from one staff for bathing (includes transfer, not include wash back and hair), and staff to assist the resident with going into the shower room, gathering items and adjusting water.Review of the resident's electronic shower record, dated 08/01/25 through 08/31/25, showed staff documented the resident received a shower on 08/21/25. Review of the resident's electronic shower record, dated 09/01/25 through 09/30/25, showed the record did not contain documentation the resident received a shower, or the resident refused any baths/showers. Review of the resident's electronic shower record, dated 10/01/25 through 10/19/25, showed the record did not contain documentation the resident received a shower, or the resident refused any baths/showers. Observation on 10/20/25 at 9:28 A.M., showed the resident with greasy unkempt hair in a reclined wheelchair in front of the hallway television. 7. Review of Resident 6's Significant Change MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment;-Required partial to moderate assistance from staff for personal hygiene;-Required substantial to maximal assistance from staff for shower/bathe. Review of the resident's care plan, revised 07/02/25, showed staff documented the resident prefers one shower per week and as needed, required assistance from one staff with gait belt to transfer to shower chair and to assist the resident with bathing (includes transfer, not include wash back and hair). Review of the resident's electronic shower record, dated 08/01/25 through 08/31/25, showed staff documented the resident received a shower on 08/20/25.Review of the resident's electronic shower record, dated 09/01/25 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through 09/30/25, showed staff documented the resident received a shower on 09/04/25, 09/22/25, and 09/29/25.Review of the resident's electronic shower record, dated 10/01/25 through 10/19/25, showed staff documented the resident received a shower on 10/03/25.Observation on 10/20/25 at 8:46 A.M., showed the resident went up and down the hallways in his/her wheelchair with greasy, unkempt hair, food debris on his/her shirt, and dark brown stains on his/her pants. Observation on 10/20/25 at 9:38 A.M., showed the resident went up and down the hallways in his/her wheelchair with greasy, unkempt hair, food debris on his/her shirt, and dark brown stains on his/her pants. 8. During an interview on 10/20/25 at 4:04 P.M., Certified Nurse Aide (CNA) C said he/she is the shower aide and works 12-hour shifts. CNA C said he/she assists residents with showers from 7:00 A.M. to 3:00 P.M., and works the floor from 3:00 P.M. to 7:00 P.M. CNA C said he/she tries to do as many showers as he/she can during the day but sometimes he/she can't get all the showers completed. CNA C said staff should document showers in the Electronic Medical Record (EMR) but if it gets too busy, he/she doesn't do it. He/She said if a resident refuses a shower, he/she should tell the charge nurse or Director of Nursing (DON) and that should also be documented in the EMR. He/She said the residents who require two staff to assist are hard to get done, because they take more time and there aren't always two staff available to assist. During an interview 10/20/25 on at 4:28 P.M., Registered Nurse (RN) A said staff are expected to offer residents two showers per week, the CNAs are expected to tell the nurse if a resident refuses a shower, and the nurse would try to get the resident to shower. During an interview on 10/20/25 at 1:50 P.M., the DON said staff are expected to offer residents a shower two times per week, and he/she expects each resident to be assisted with at least one shower per week. The DON said if a resident refuses his/her shower, staff should first try to re-approach, have the resident sign refusal on paper, tell the nurse, document the refusal in the computer, and the nurse should complete a progress note. He/She said if staff did not document the resident refused his/her shower, it is likely staff did not offer or assist the resident with a shower/bath. During an interview on 10/20/25 at 4:45 P.M., the Administrator said the residents get showers at least once a week, but the expectation is two times a week, and staff are expected to document showers in the residents' medical record. The administrator said he/she has not reviewed the shower documentation in the EMR recently, but he/she visually monitors residents and directs staff to assist residents with hygiene needs. Complaint # 2620436, 2645723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview and record review, facility staff failed to ensure one resident (Resident #1) out of three sampled residents received timely assistance to schedule an appointment with a dentist, after the resident reported he/she had broken teeth and an intermittent toothache. The facility's census was 62.1. Review of the facilities policies showed facility staff did not provide a policy for dental care and services.2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 10/14/25, showed staff assessed the resident as moderate cognitive impairment, with mouth or facial pain, and discomfort or difficulty with chewing.Review of the resident's care plan, revised 10/08/25, showed staff assessed the resident has his/her own teeth, with missing or broken teeth, and required staff assistance for oral care as needed.Review of the resident's Physician's Order Sheet (POS), dated 09/01/25 through 10/20/25, showed may see dentist (to treat issues with the mouth/teeth) as needed.Review of the resident's progress note, dated 09/03/25, showed staff documented the resident requested PRN (as needed) pain medication for tooth pain this evening. PRN acetaminophen (pain medication) was brought into his/her room.Review of the resident's progress note, dated 09/05/25, showed staff documented resident upset and yelling related to his/her tooth, stating he/she needed something for the pain, the nurse offered the resident Tylenol.Review of the resident's progress note, dated 09/18/25, showed staff documented resident upset at beginning of shift, stating he/she has tooth pain which was not relieved by the acetaminophen that was given earlier in day, he/she had over-the-counter pain gel that was confiscated two weeks, and his/her pain is a chronic issue. Slight swelling observed to right side of face, physician notified and gave order for Hydrocodone (a narcotic pain medication), resident reports he/she has multiple dental complaints and needs his/her teeth extracted.Review of the resident's progress notes, dated 09/03/25 through 10/19/25, showed the notes did not contain documentation staff attempted to schedule a dental appointment for the resident.Observation on 10/20/25 at 10:30 A.M., showed the resident's mouth with three to four broken upper front teeth. During an interview on 10/20/25 at 10:30 A.M., the resident said he/she had issues with tooth decay, broke a tooth a few months ago, and reported to staff several weeks ago he/she was having frequent toothaches. He/She said staff took his/her over the counter pain gel and have been giving him/her acetaminophen for the pain. He/She said he/she did not know if staff had tried to schedule an appointment for him/her to see a dentist yet.During an interview on 10/20/25 at 2:33 P.M., the Social Worker (SW) said he/she is responsible to schedule dental appointments for residents either at the facility or outside the facility based on the resident's specific oral concerns and insurance. The SW said he/she was notified about a month ago during a morning meeting that the resident had complained of dental issues, but he/she had not met with the resident yet to see what his/her specific dental concerns are and have not attempted to schedule a dental appointment for the resident. The SW said he/she did not have a specific reason for not attempting to schedule an appointment before but knew he/she would have to find a dentist that could accommodate the resident. During an interview on 10/20/25 at 3:55 P.M., the DON said the SW is responsible to schedule dental appointments for residents either at the facility or outside the facility based on specific oral concerns and insurance. The DON said he/she would have expected the SW to attempt to make a dental appointment for the resident by now.During an interview on 10/20/25 at 4:45 P.M., the administrator said the SW is responsible to schedule dental appointments for the residents. The administrator said he/she and other staff have addressed multiple concerns for the resident and was not aware of any specific dental concern for the resident that had not been addressed by staff, but he/she would expect staff to attempt to schedule a dental appointment for the resident if needed.During an interview on 10/22/25 at 12:32 P.M., the resident's (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician said he/she was notified a few weeks ago the resident complained of a toothache, and he/she ordered pain medication to relieve the resident's pain. The physician said he/she would expect staff to attempt to schedule the resident to see a dentist to address his/her dental concerns.Complaint #2620436