STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 0563 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 116. The sample included five residents, with one resident reviewed for visitation rights. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1 was able to exercise her right to receive visitors of their choosing at the time of R1's choice. This deficient practice affected R1's psychosocial well-being and placed R1 at risk for impaired resident rights and social isolation. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and dementia (a progressive mental disorder characterized by failing memory and confusion). R1's Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated [DATE], documented R1 was alert and oriented to person and had a BIMS of three. R1's Care Plan dated, [DATE], documented R1 had impaired cognitive function/dementia or impaired through processes related to cerebral infarction. The plan directed staff to allow R1 to make daily decisions about clothing, daily care, meal alternatives, et cetera (etc.); staff kept R1's routine consistent and tried to provide consistent caregivers as much as possible in order to decrease confusion. The facility's Investigation, dated [DATE], documented on [DATE] at approximately 06:11 PM, Licensed Nurse (LN) G immediately reported to Administrative Staff A that R1's family was confrontational with staff and when R1 was upset and wanted it to stop, R1's family told R1 to shut up or she would slap her face. LN G asked R1's family to leave and when she refused, police were called and R1's family left the facility. LN G assessed R1 with no injuries noted. R1 was visibly upset and calmed down with staff support. The facility notified R1's representative, primary care provider, and police. R1's family returned to the facility and met with Social Services and Administrative Staff A. R1's family denied threatening R1 but admitted to stepping towards and cussing at staff. R1's family was unable to take responsibility for her behavior or work to create a safe plan for future visits and the facility issued a trespassing order and police escorted R1's family from the property. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 0563 Level of Harm - Actual harm Residents Affected - Few	Upon request, the facility provided the Trespass Order for R1's family. The order, dated [DATE], stated R1's family was ordered to vacate the facility and not return, if she returned then she would be prosecuted for criminal trespass. The order expired in one year. On [DATE] at 01:38 PM, R1 sat in her wheelchair in the television room and conversed with the surveyor. She stated her family got kicked out and had not threatened to smack her. She stated she never felt unsafe around her family, and it made her feel terrible as her family was the only people who visited her. R1 stated all of a sudden now her family could not come in to see her and she wanted her family to be able to come in. R1 became visibly upset and started crying while stating her family was the only person she had. On [DATE] at 12:03 PM, R1's representative stated he had nothing to do with the decision to give R1's family a trespassing order. He stated sometimes the family member lost control of herself, but she never became violent. R1's representative stated he thought it was fine that R1's family went to visit R1 and that R1 was upset that she could not see her family. He stated R1 was very upset that her family got into trouble and the facility said there was nothing they could do about it right now. R1's representative stated that R1's family had issues controlling her anger, but she had never struck R1 but got verbally abusive to staff. In a witness statement on [DATE], Certified Nurse Aide (CNA) M stated she went in to change R1's roommate and pulled the curtain. R1's family told CNA M not to touch the curtain and CNA M told her it was for privacy. CNA M stated R1 told R1's family to stop and R1's family told R1 to shut up, or she would slap her. CNA M stated she immediately stopped care and got LN G who went to R1's room. She stated that R1's family started to yell and got in CNA M and LN G's faces. CNA M stated LN G asked R1 if she felt safe and R1 stated no. CNA M stated LN G asked R1's family to leave then called the police when she refused but R1's family left before the police arrived. On [DATE] at 11:39 AM, Administrative Staff A stated R1's family threatened to slap R1. She stated that R1's family admitted to getting up in the nurse ' s face but denied saying she would slap R1 in the face. Administrative Staff A stated R1's representative understood the situation and the facility notified him he could be present during the visit, but he did not want to be at the facility. She stated R1's family had threatened R1 but never put her hands on R1 and had gotten into staff's faces. Administrative Staff A stated that R1 wanted to see her family and the facility told R1's family her significant other could pick R1 up from the facility and take R1 for a visit outside the facility. On [DATE] at 01:43 PM, LN H stated she was in the facility sometimes when R1's family visited and had never seen her threaten or hit R1. She stated sometimes R1 called her family and seemed upset about R1's family not coming in to visit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 0563 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 05:23 PM, Administrative Staff A stated prior to the incident, R1's family had issues with staff and the facility talked to her significant other about the inappropriate behavior. She stated that R1's family upset R1 and threatened to slap her and confronted staff. The facility called the police and R1's family left before they arrived. Administrative Staff A stated when staff notified her of the threat, the facility filed a police report and reported it to the State Agency (SA). She stated the next time R1's family and her significant other came to the facility; she told them they needed to talk. She stated R1's family admitted to profanity and going up to staff. Administrative Staff A stated she notified R1's family that for the safety of residents and staff, she received a no-trespassing order which upset R1's family. She stated R1's family asked what they could do to drop the trespassing order but R1's family could not come up to the facility for visitation. Administrative Staff A stated she did not reach out to the Long-Term Care Ombudsman regarding the visitation restriction. She stated R1's family received the trespassing order for being combative towards staff after being warned. The facility's Resident Rights policy, last revised [DATE], directed the facility to inform the residents orally and in writing, in a language they understood, of their rights and all rules and regulations governing resident conduct and responsibilities during their stay in the facility. The policy included Resident Rights which documented the resident had a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that did not impose on the rights of another resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 - 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** The facility identified a census of 116 residents. The sample included five residents. Based on record review and interviews, the facility failed to obtain a physician-ordered urinalysis (UA- lab analysis of urine) and other laboratory tests ordered on 06/03/25. The facility further failed to notify the physician related to the delay in obtaining the ordered UA and laboratory tests for Resident (R) 2. R2 had fallen on 06/05/25 and 06/06/25, and R2 had a change in condition on 06/07/25. R2 went to the hospital where he was admitted to the Intensive Care Unit (ICU) for septic syndrome (a life-threatening condition that arises when the body ' s response to an infection injures its own tissues and organs), urinary infection (UTI) with urosepsis (a severe, life-threatening condition where a systemic infection originating in the urinary tract, spreads throughout the body), high fever, and unresponsiveness. Findings included: - R2's Electronic Medical Record (EMR) documented diagnoses of hypertensive chronic kidney disease (kidney damage caused by long-term high blood pressure), personal history of UTI, atrial fibrillation (rapid, irregular heartbeat), repeated falls, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). R2's Annual Minimum Data Set (MDS) dated 04/19/25, documented R2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R2 had impairment on both sides of his lower extremities. R2 required setup or clean-up assistance with toileting hygiene, personal hygiene, and transfers. R2 was occasionally incontinent of urine and bowel movements. The Functional Abilities / Rehabilitation Potential Care Area Assessment (CAA) dated 04/28/25, documented R2 needed assistance with activities of daily living (ADL) related to chronic kidney disease, cardiac disease, hearing loss, unsteady gait and balance, dysphagia (difficulty swallowing), depression, and poor vision. R2's Care Plan, dated 04/10/23, documented R2 was occasionally incontinent of bowel and bladder and was at risk for complications. The plan directed staff to monitor and document signs and symptoms of UTI which included pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, chills, altered mental status, changes in behavior, and changes in eating patterns. R2's EMR revealed the following: An order on 06/03/25 for a UA, complete blood count (CBC- laboratory blood test), comprehensive metabolic panel (CMP- laboratory blood test), and magnesium (laboratory blood test) level. R2's EMR lacked documentation on signs and symptoms or the reason behind the diagnostic test orders. An eInteract SBAR [situation, background, assessment, and recommendation] Summary for Providers note on 06/05/25 at 03:51 PM documented R2 had a change in condition related to a fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 - Actual harm Residents Affected - Few	An eInteract Change in Condition Evaluation on 06/05/25 at 03:51 PM documented R2's signs and symptoms improved since the change in condition and the nurse selected No when asked if the facility notified the primary care clinician of the change in condition and notifications. An Orders- Administration Note on 06/06/25 at 02:31 PM documented R2 sat in his chair and did not feel well. R2 was uncooperative with wound care. The note lacked evidence staff notified the physician. A Nurse's Note on 06/06/25 at 04:13 PM documented staff called the nurse into R2's room after staff found him on the floor in his room. R2 stated he attempted to go from his wheelchair to his recliner and slipped. R2 denied hitting his head and was confused. The nurse did not note any trauma and staff assisted R2 into his recliner. The nurse took R2's vital signs and initiated neurological checks. R2's call light was within reach and staff educated the resident to call when he needed to transfer. An eInteract Change in Condition Follow-Up on 06/06/25 at 04:20 PM documented R2 had improved after the initial change in condition. A Nurse's Note on 06/07/25 at 07:45 PM documented R2 was confused and disoriented throughout the shift. R2 made several attempts to use the restroom but did not remove his pants. R2 became combative when the staff offered him assistance. The note documented Licensed Nurse (LN) I attempted to obtain a urine sample multiple times, but R2 refused and remained uncooperative. After lunch, R2 had a near fall on his way to the bathroom but did not sustain any injuries. Around 06:00 PM, R2 had a noticeable change in condition, staff could arouse him, but he was very drowsy and breathing loudly and heavily. LN I placed R2 on supplemental oxygen via a face mask when his oxygen saturation dropped to 85% (normal saturations are 95-100%). R2 removed the face mask, and staff switched him to a nasal cannula which he also removed several times. Due to R2's continued respiratory distress and altered mental status, LN I called for an ambulance to take R2 to the hospital. R2's medical record lacked evidence staff attempted to collect the UA as ordered by the resident's physician prior to 06/07/25. R2's medical record lacked evidence that he refused the UA or laboratory tests prior to 06/07/25. R2's medical record further lacked evidence staff notified R2's physician of any alleged refusals for the UA or the staff's inability to collect the samples for the UA and laboratory (labs) tests. R2's medical record lacked evidence the facility completed the UA or laboratory tests, ordered on 06/03/25. Upon request, the facility was unable to provide the UA results or laboratory results. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 - Actual harm Residents Affected - Few	A History and Physical Note from the hospital on [DATE] at 10:03 PM, documented R2 arrived at the emergency department from the nursing facility due to a high fever and unresponsiveness. R2 was unresponsive and had a temperature of 104.2 degrees Fahrenheit (F) (normal body temperature is 98.7 F). R2 was tachycardic (high heart rate), and tachypneic (rapid breathing), and was placed on bilevel positive airway pressure (BiPAP- treatment that uses mild air pressure to keep your airways open). The note documented R2 received intravenous (IV-administered directly into the bloodstream via a vein) fluids and antibiotics (medications used to treat infections) and was admitted to the ICU for septic syndrome, urinary infection with urosepsis, high fever, healthcare-associated pneumonia (facility-acquired lung infection), atrial fibrillation, acute hypoxic (inadequate oxygen supply) respiratory failure, and unresponsiveness. On 06/11/25 at 03:21 PM, Certified Medication Aide (CMA) R stated R2 was very confused and fell a couple of times. She stated he got combative because he was used to being independent. CMA R stated staff tried to get a UA on R2 and he refused. On 06/11/25 at 03:43 PM, Administrative Nurse D stated R2 refused cares, the UA, and ordered labs. She stated the provider rounded and put the resident's orders in. On 06/11/25 at 03:59 PM, Administrative Nurse D stated Consultant GG entered R2's UA and lab orders herself. She stated she was not sure why there was no note on the orders. On 06/11/25 at 04:37 PM, LN J stated if a resident had a change in condition, she notified the doctor, family, her supervisor, and hospice if applicable. She stated if a provider ordered labs, the facility notified the lab and put the labs into the portal to be drawn Monday through Friday. She stated a UA should have been completed within 24 hours after the order was received. If the resident refused, she notified the provider the resident refused and would see what else they could do. LN J stated she documented behaviors, notifications to family and doctors, refusals for UAs, and attempts at obtaining a UA in a nurse's note. LN J stated if a resident had confusion, staff did change in condition charting for 72 hours. She confirmed R2 had a delay in care if staff did not attempt to get a UA until 06/07/25 when it was ordered on 06/03/25. On 06/11/25 at 04:58 PM, Administrative Nurse D stated she did not see any documentation for R2's UA and lab refusals, staff attempts at obtaining R2's UA, or notification to the provider of R2's refusals of the UA and other labs. She stated Consultant GG ordered labs that R2 kept refusing and everybody told her R2 refused the UA and labs. Administrative Nurse D stated she expected the nurse to follow through with the UA order, document attempts at obtaining the UA, notification to physicians, and resident refusals. She stated she expected if staff noticed a significant change in a resident's condition, staff should immediately call the provider. She stated if they received an order and did not see an improvement within a couple of hours, she expected staff to call the physician again. Administrative Nurse D stated she noticed the nurse's note regarding R2 being confused all shift on 06/07/25 and she called the facility to ask the nurse what they did about it. She stated the nurse said they were watching R2 because everyone said it was his normal baseline. She stated she directed the nurse to call the physician. Administrative Nurse D stated if only viewing R2's medical record, it did appear he had a delay in care but if viewing in the building, it was not an intentional delay in care while they attempted to put steps into place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 - Actual harm Residents Affected - Few	On 06/11/25 at 05:16 PM, Administrative Nurse E stated on 06/05/25, she was notified a resident was on the floor when R2 fell in the bathroom. She stated if the facility received an order for a UA, the facility obtained the UA and put it in the specimen refrigerator. She stated the lab order went into the EMR then the staff put the order into the lab portal. Administrative Nurse E stated staff tried to get the UA and R2 refused. She stated she expected staff to document when a resident refused a UA, when they notified the family and/or physician and attempted to get the UA. She stated if a resident refused to do the UA, she expected staff to continue to attempt to obtain the UA and notify the physician of the refusals. Administrative Nurse E stated she expected labs to be drawn the next day, and she did not believe there was a delay in inputting orders in the lab portal. She stated she expected the UA to be completed in the first two days and the physician should be notified about refusals or the inability to get the UA timely. On 06/12/25 at 02:42 PM, Administrative Staff A emailed additional documentation from the laboratory company, which included on 06/06/25 at 04:34 PM, R2's urinalysis with culture attempt was unsuccessful because the specimen was not collected. On 06/18/25 at 01:47 PM, LN I stated on 06/05/25, she went to lunch and received a text reporting a resident fell. She stated Administrative Nurse E took over until she returned and continued neurological checks on R2. LN I stated she notified Consultant HH and was instructed to continue with assessments and neurological checks with no change to his plan of care. She stated she did not know R2 very well or much about his baseline. LN I stated she saw R2 had an order for a UA and labs but nobody could obtain them. She stated she did not document the refusals for the UA and noted the facility used a book to communicate with the provider during rounds. Staff would write it in the book if they were unable to obtain the UA. LN I stated whoever notified the physician would document the notification. On 06/18/25 at 01:56 PM, Consultant GG stated on 06/03/25, she had a brief interaction with staff who mentioned R2 reported he had brain fog but otherwise seemed at baseline. She stated as she left the facility that day, she put in an order for a UA and labs to figure out why R2 did not feel great. Consultant GG stated she did not know if the facility completed the UA and labs as she went on vacation the next day and Consultant HH took over for her while she was gone. She stated the facility had a book to communicate to the provider during rounds for anything not emergent like medication refills or rashes. Consultant GG stated she expected staff to call with anything that needed immediate intervention and typically received calls when a resident refused a UA or labs. On 06/18/25 at 02:01 PM, Consultant HH was unavailable for an interview. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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 - Actual harm Residents Affected - Few	On 06/18/25 at 02:03 PM, LN K stated on 06/07/25, R2 had a change in condition and was confused and not able to do things for himself like he normally did. She stated the facility was supposed to do a UA that day but was not able to obtain it. She stated sometimes R2 got up to the toilet, would sit there, and then go back to his chair. LN K stated when she did rounds in the afternoon, she and the CMA went into R2's room and found him having a hard time breathing. She stated she took his vital signs and placed an oxygen mask on him, but he removed the mask, so she placed a nasal cannula for supplemental oxygen. LN K stated R2 could hear but he would not open his eyes, so she called for an ambulance. She stated she was told that staff were unable to get the UA because he was confused and aggressive with refusing care. She stated she was not told whether the facility notified the physician about the refusals and behaviors. LN K stated normally, she notified the provider for refusals and documented the refusals and physician notification. She stated that R2's representative sounded very frustrated and told her he had been asking for prophylactic (preventative in nature) antibiotics for a UTI. On 06/18/25 at 02:12 PM, LN L stated on 06/06/25, she learned R2 had two previous falls prior to her taking care of him. She stated it was the first day she met him and did not know his baseline. She stated she did not remember his full report. LN L stated if a resident had an order for a UA, she tried to get the UA done but residents had the right to refuse, and she had to make sure medications were given correctly and timely before getting a UA. She stated she assessed R2 throughout the day, his vitals were okay, and he was oriented to himself. LN L stated nursing was a 24-hour job so if one shift did not obtain the UA then the next shift should have obtained it. She stated she usually notified the physician of refusals of UA and lab tests and documented the physician's notification and refusal in the resident's record. LN L stated the CNA reported to her that R2 needed help to the bathroom, and he became combative, but he did not appear combative when she went to help, just confused. The facility's Notification of Changes policy, last revised on 10/21/24, directed the facility to consult with the resident's physician when there was a change requiring such notification. Circumstances that required notification included a significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status; and circumstances that required a need to alter treatment such as a new treatment or discontinuation of current treatment due to adverse consequences, acute condition, or exacerbation of a chronic condition. The facility's Provision of Physician Ordered Services policy, dated 2025, directed the facility to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality.