STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265123	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lebanon North Nursing & Rehab	596 Morton Road Lebanon, MO 65536

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43193 Based on interview and record review, the facility failed to report an allegation of abuse to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required time two hour frame when one resident (Resident #1), out of six sampled residents, made an allegation of sexual abuse to facility staff. The facility census was 55. Review of the facility's policy titled Reporting, dated 11/28/16, showed the following: -It is the policy of this facility that each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion; -The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements; -All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown sources, and misappropriation of resident will be reported immediately but no later than the following timeframes. If abuse is alleged or the allegation results in serious bodily injury, the allegation must be reported within two hours after the allegation was made. If the allegation does not allege abuse or result in serious bodily injury, the report must be made within 24 hours after the allegation was made; -The facility will adhere to reporting timeframes as outlined for reporting to the State Survey agency for reporting to law enforcement. When there is reasonable suspicion that a crime has occurred, to include but not limited to: abuse or the crime results in serious bodily injury, the crime must be reported within two hours. If the crime is not abuse or result in serious bodily injury, the report must be made within 24 hours; -The facility must 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 two 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) in accordance with State law through established procedures. (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: 265123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER: Lebanon North Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 596 Morton Road Lebanon, MO 65536	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Employees must always report any abuse or suspicion of abuse immediately to the Administrator. If Administrator is not there, report to the Director of Nursing (DON) or immediate supervisor and they will report to the Administrator. 1. Review of the resident's face sheet (a document that gives a patient's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included urinary tract infection (UTI - an infection in any part of the urinary system), anxiety, chronic pain, and depression. Review of the resident's significant change Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 07/31/24, showed the following: -Cognitively intact; -No behaviors; -Required maximum assistance from staff for toilet hygiene, upper body dressing, lower body dressing and putting on/taking off footwear, required supervision of staff for personal hygiene and oral hygiene and was dependent on staff for bathing; -Used a wheelchair for locomotion. Review of the resident's care plan, revised 08/07/24, showed the following: -The resident had a potential for behavior issues during showers. Staff to provide a calm and quiet environment, keep the environment at the temperature that he/she found comfortable, and provide music of his/her choice if he/she desired. The resident needed help washing parts of his/her body and he/she can not lift his/her arms past his/her shoulders. The resident had a catheter (a flexible tube inserted through a narrow opening into a body cavity). Staff to position it carefully; -He/she was at risk for infections related to having a suprapubic urinary catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow). The nurse would assess him/her for pain and discomfort due to catheter use. The staff would check his/her catheter tubing for kinks throughout the shift. Secure the dignity bag on the bed in a manner to prevent it from being stepped on during cares. Staff would provide catheter care every shift and as needed; -The resident was able to complete most his/her own activities of activities of daily living (ADL - dressing, eating, bathing, etc.). The resident ambulated independently and fed self and showered with staff assistance to include his/her hair care. Staff to observe, document, and report any functional decline and provide increased assistance as needed. Staff to notify the charge nurse, physician, and therapy of increased need. Review of the resident's nurses' progress notes showed the following: (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/08/24, at 4:10 P.M., the resident came up to the desk and stated that he/she wanted to go to the hospital because he/she had something up inside him/her. The nurse asked if the resident had a bowel movement and the resident stated no, he/she had one yesterday. The resident kept saying that he/she wanted to go to the hospital to be checked out. He/she complained of pain 8 out of 10 and oxycodone (a medication to treat pain) 5 milligrams (mg) given. At 5:00 P.M., the nurse attempted to contact the resident's guardian and left a message. The physician was notified and received an order to send to the ER for evaluation. Staff notified EMS at 5:05 P.M. that the nurse needed to transfer the resident to the ER. EMS arrived at 5:20 P.M. and left at 5:30 P.M.; -On 08/08/24, at 7:54 P.M., received a call from the resident's guardian at 7:53 P.M. The guardian stated he/she was okay with the resident being sent to the local ER since the issue was not with the resident's heart. He/she also stated he/she spoke with the ER and was told the resident had a UTI and they were not sure at this time if they would admit or not. The guardian stated that the ER reported to him/her that the resident was not at baseline as far as orientation and he/she told them to check for sepsis (a serious condition in which the body responds improperly to an infection). ER staff reported to the guardian that blood work had already been drawn and they were waiting on results; -On 08/08/24, at 11:31 P.M., as per phone conversation with ER staff, the resident had been transferred to another ER due to having the possibility of a gasrtrointestinal (GI) bleed (a sign of a disorder in the digestive tract) from an unknown source. The ER staff said the resident's guardian was aware. Review of the resident's Emergency Department (ED) Provider Notes dated 08/08/24, at 5:35 P.M., showed the following: -The resident reported that maybe somebody stuck something in his/her vagina last night while he/she slept. He/she did not remember anybody coming into his/her room. He/she did not remember seeing anybody around his/her room. He/she slept in a room by him/herself at the nursing facility; -On arrival, the resident reported vaginal pressure and he/she thought that somebody may have stuck something inside of him/her. He/she also reported that he/she may have been drugged because he/she did not wake up in the middle night from this. Police report was filed by charge nurse. Review of the resident's ED Notes showed the following: -On 08/08/24, at 5:45 P.M., resident presented to the (ED) by EMS from facility. Resident reported vaginal pain and stated I think someone came In my room in the middle of the night and stuck something up there. I think it's still there. Resident said I may have been drugged with my nighttime medication. Resident denied waking up during that time and stated he/she woke today with vaginal pain; -On 08/08/24, at 6:27 P.M., hospital staff notified police department of reported sexual assault. The dispatcher reported an officer would be sent to take a report; -On 08/08/24, at 7:10 P.M., police department present at hospital to take report. Hospital staff notified senior services at this time; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/08/24, at 7:51 P.M., hospital staff spoke with the resident's guardian by phone at this time and updated on resident's condition as well as sexual assault allegations. Advised that the police department and Department of Health and Senior Services (DHSS) were notified. The guardian requested update regarding the resident's disposition. Review of the facility's investigation, dated 08/12/24, showed the following: -The MDS Coordinator notified the resident's guardian, Administrator, QA Nurse, DON, and physician and obtained witness statements from employees; -The MDS Coordinator interviewed the resident; -The resident was sent to the hospital for evaluation; -As evidenced from the emergency room (ER) visit documentation, the resident did not have anything inside of him/her and the allegation was not verified; -The hospital staff reported the allegation to law enforcement. Review of statement dated 08/08/24, at 4:30 P.M., completed by Certified Nursing Assistant (CNA) E, showed he/she was at the desk when the resident came and said that someone put something inside him/her last night. The CNA reported to the MDS Coordinator and then left to answer call lights. During an interview on 08/09/24, at 1:06 P.M., the Administrator said the following: -The resident made the allegation of abuse to the MDS Coordinator on 08/08/24, between 5:00 P.M. and 5:30 P.M.; -The MDS Coordinator reported the allegation to the corporate Quality Assurance (QA) Nurse on 08/08/24 and to the Administrator around 7:00 P.M.; -The resident reported someone put something in his/her behind; -The resident's story kept changing and the resident was sent to the hospital; -He/she considered the allegation the resident made to be an allegation of sexual abuse; -He/she did not report the allegation to DHSS because the corporate QA nurse told him/her to wait to hear from the hospital; -The MDS Coordinator obtained statements from staff and started an investigation; -He/she should have reported the allegation to DHSS within two hours. During an interview on 08/09/24, at 1:28 P.M., the MDS Coordinator said the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/08/24, at 4:10 P.M., the resident reported to Certified Nursing Assistant (CNA) D that someone stuck something up inside the resident and the CNA brought the resident to him/her to report the allegation; -He/she did a head to toe assessment on the resident and the resident had no injuries; -He/she reported to the Administrator on 08/08/24 at approximately 4:30 P.M., attempted to contact the resident's guardian, notified the resident's physician, and reported the allegation to the corporate QA Nurse; -The allegation the resident made was an allegation of physical or sexual abuse and should have been reported to DHSS within two hours; -The Administrator and corporate QA nurse told him/her to wait and find out what the hospital said before he/she reported to DHSS; -He/she continued to ask the Administrator and QA Nurse for guidance because he/she knew the clock was ticking; -He/she did not report to DHSS because he/she followed the direction of the QA Nurse and Administrator; -He/she should have reported the allegation. Review of DHSS records showed DHSS did not receive a self-report regarding the resident's abuse allegations. During an interview on 08/09/24, at 1:43 P.M., the Director of Nursing (DON) said the following: -On 08/08/24, at 4:30 P.M., the MDS Coordinator reported to him/her that the resident reported somebody put something down there; -He/she spoke with the resident and the resident stated someone put something in his/her vagina; -The resident was not able to tell who the alleged perpetrator was, but was sure something was put inside him/her; -The allegation made by the resident was an allegation of abuse and should have been reported to DHSS immediately; -The MDS Coordinator reported allegations of abuse to DHSS; -The MDS Coordinator and the Administrator started an investigation and gathered statements from staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the a statement dated 08/08/24, at 4:30 P.M., completed by CNA D, showed the resident had stopped the CNA in the hall and told the CNA he/she needed to talk to the CNA, but could not say it out loud. The CNA went over to the resident and the resident explained that someone the night before or the night prior to that put something inside of him/her and it was stuck and hurting him/her. The CNA immediately went and reported to the MDS Coordinator; During an interview on 08/09/24, at 1:55 P.M., CNA D said the following: -On 08/08/24, at approximately 4:00 P.M., the resident came down the hall and said they needed to talk, but said they could not say it out loud; -The resident reported he/she had something stuck inside him/her and the CNA pointed out the resident's catheter. The resident said that was not what he/she was talking about; -The resident then reported that either last night or the night before, someone stuck something inside of him/her and it was still there; -The resident did not name an alleged perpetrator; -The CNA told the resident they needed to report to the MDS Coordinator; -The CNA took the resident to the MDS Coordinator and reported the allegation the resident made; -He/she considered the allegation the resident made to be sexual abuse and the allegation should have been reported to DHSS within two hours; -The resident was crying and distressed and told him/her not to tell anyone. The CNA told the resident the CNA had to report to the nurse. During an interview on 08/09/24, at 12:51 P.M., CNA A said the following: -If a resident reported abuse to him/her, he/she reported to the charge nurse immediately; -The Administrator reported to DHSS within two hours. During an interview on 08/09/24, at 12:55 P.M., CNA B said the following: -If a resident reported abuse to him/her, he/she reported to the charge nurse immediately; -The Assistant DON or charge nurse reported to DHSS within two hours. During an interview on 08/09/24, at 1:55 P.M., CNA D said the following: -If a resident reported abuse to him/her, he/she reported to the charge nurse or Administrator immediately; -The Administrator reported to DHSS within two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/09/24, at 1:00 P.M., Certified Medication Technician (CMT) C said the following: -If a resident reported abuse to him/her, he/she reported to the charge nurse immediately; -The charge nurse reported to the DON and Administrator immediately; -The DON or Administrator reported to DHSS within two hours. During an interview on 08/09/24, at 1:28 P.M., the MDS Coordinator said the following: -If a resident reported abuse to a CNA, the CNA reported to the charge nurse immediately; -The charge nurse started an investigation, assessed the resident, and notified the resident's physician, responsible party and the Administrator; -The charge nurse, MDS Coordinator, DON, or Administrator reported to DHSS within two hours; -Any allegation of abuse should be reported to DHSS within two hours. During an interview on 08/09/24, at 1:43 P.M., the DON said the following: -If a resident reported to a CNA or CMT, the CNA or CMT reported to the charge nurse immediately; -The charge nurse reported to the DON immediately; -He/she reported to DHSS within two hours; -All allegations of abuse had to be reported to DHSS within two hours. During an interview on 08/09/24, at 1:06 P.M., the Administrator said any allegation of abuse should be reported to DHSS within two hours. MO00240273 MO00240289