

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  04/15/2025
NAME OF PROVIDER OR SUPPLIER  Lebanon North Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide care per professional standards when the facility staff failed to transcribe physician orders for wound care treatment and interventions, failed to notify the physician of changes noncompliance by the resident and changes in the wounds in a timely manner, failed to document wound care, and failed to update the care plan regarding wound care interventions for one resident (Resident #1). The facility census was 76.</p> <p>Review of the facility's policy titled, Charting and Documentation, undated, showed the treatment documentation should include the date and time each treatment was administered, name of person administering the treatment, specific duties performed, reason(s) for a resident's refusal of the treatment, and the signature and title of the person recording the data.</p> <p>The facility did not provide a wound treatment/management policy or a skin assessment policy.</p> <p>1. Review of the Resident #1's face sheet (brief look at resident information) showed the following information:</p> <p>-admission date of 03/06/25;</p> <p>-Diagnoses included infection of surgical wound, atherosclerosis of native arteries of extremities (a condition where plaque builds up inside the arteries, restricting blood flow to the legs and feet), and breakdown of femoral arterial graft (a procedure where a new route for blood flow is created to bypass a blocked or narrowed artery in the thigh).</p> <p>Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff), dated 03/12/25, showed the following:</p> <p>-Resident had moderate cognitive impairment;</p> <p>-Resident required partial to moderate assistance with walking, bathing, toileting, transferring from chair to bed, and from sit to stand;</p> <p>-Resident required required supervision or touching assistance with verbal cues or touching with rolling left to right, going from sit to lying, and lying to sitting on the side of the bed.</p> <p>Review of the resident's admission orders from the discharging hospital, dated 03/06/25, showed the following information:</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Clean bilateral groin sites daily with soap and water;</p> <p>-Remove Silveron dressings (a type of dressing used for wound healing) in five days.</p> <p>Review of the resident's admission wound assessment, dated 03/06/25, showed the following:</p> <p>-Surgical wound to right groin measuring 11.5 centimeters (cm) with 11 staples, epithelial tissue (a layer of cells that cover the body's surface) present, no exudate (fluid that leaks out of the blood vessels into surrounding tissue), no odor, surrounding tissue intact and healthy, no edema (swelling) and no pain. Facility physician notified by fax, continue treatment, no change, and initiate plan of care;</p> <p>-Surgical wound to left groin measuring 15 cm with 15 staples, no exudate, no odor, surrounding tissue intact and healthy, no edema, and no pain. Facility physician notified by fax, continue treatment, no change, and initiate plan of care.</p> <p>(Staff did not document regarding the wound care instruction on the resident's admission orders from the discharging hospital.)</p> <p>Review of the resident's progress note dated 03/06/25, at 7:14 P.M., showed the following:</p> <p>-The resident was transferred from hospital to the facility and admitted under the care of the facility physician;</p> <p>-The facility physician was notified of arrival, and the resident's medication list was sent to the facility physician's office, reviewed, and approved. The approved medication list was sent to the pharmacy.</p> <p>(Staff did not document regarding the wound care instruction on the resident's admission orders from the discharging hospital.)</p> <p>Review of the resident's progress notes dated 03/06/25, at 11:57 P.M., showed the following:</p> <p>-Bilateral groin surgical incisions with staples intact;</p> <p>-The resident refused to leave the dressings on and picked at the incisions;</p> <p>-Dressings replaced numerous times. No signs and symptoms of infection, redness, or drainage.</p> <p>(Staff did not document physician notification regarding the dressings being removed earlier than five days post-surgery.)</p> <p>Review of the resident's March 2025 Physician Order Sheet (POS) showed no wound care orders from admission on [DATE] through 03/15/25.</p> <p>Review of the resident's care plan, revised on 03/07/25, showed staff did not care plan related to the resident's wounds or wound care.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(Staff did not document physician notification regarding the resident removing the dressings.)</p> <p>Review of the resident's progress note, dated 03/16/25, showed the following:</p> <ul style="list-style-type: none"> <li>-The surgical incisions noted to bilateral groin areas were dry with no signs and symptoms of infection noted;</li> <li>-All staples were intact;</li> <li>-The resident refused to keep his/her dressing on this shift;</li> <li>-His/her sibling was present for short time and made aware of the resident's elevated temperature earlier this shift.</li> </ul> <p>(Staff did not document physician notification regarding the resident removing the dressings.)</p> <p>Review of the resident's progress note dated 03/16/25, at 4:12 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had a temperature of 102 Fahrenheit (a unit of temperature measurement) and Tylenol was given;</li> <li>-He/she voiced concerns of fatigue and was sleeping most of the day;</li> <li>-Incisions to bilateral groin appear to be healing well with no noted signs and symptoms of infection;</li> <li>-The resident denied suprapubic (anything situated, occurring, or performed above the pubic bone) tenderness;</li> <li>-Staff notified the facility physician.</li> </ul> <p>Review of the resident's medical record and treatment records, dated March 2025, showed staff did not document completion of wound care from admission [DATE] to 03/15/25.</p> <p>Review of the resident's March 2025 POS showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 03/16/25, to check dressings to bilateral groin areas every day and night shift;</li> <li>-An order, dated 03/16/25, to monitor incisions to bilateral groin area as needed. Cleanse daily and as needed with wound cleanser and pat dry. Cover with clean dry border gauze. Discontinue this order when healed.</li> <li>-An order, dated 03/16/25, to monitor incisions to bilateral groin area once a day. Cleanse daily with wound cleaner and pat dry. Cover with clean dry border gauze. Discontinue this order when healed. Special instructions: Report signs and symptoms of infection.</li> </ul> <p>Review of the DON's wound documentation, dated 03/17/25, showed a right groin wound with staples intact and a left groin wound that was warm with minimal swelling.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's progress note dated 03/17/25, at 1:05 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Bilateral groin surgical incisions with staples;</li> <li>-The resident removed his/her dressings numerous times and will pick at the incisions;</li> <li>-Dressings are replaced;</li> <li>-No signs and symptoms of infection, redness, drainage or edema noted.</li> </ul> <p>Review of the resident's progress note dated 03/18/25, at 4:08 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident's right groin dressing was not in place and the resident stated the incision itched;</li> <li>-No drainage noted;</li> <li>-Area cleansed with wound cleanser and new dressings applied to both groin surgical incisions.</li> </ul> <p>Review of the resident's progress note dated 03/18/25, at 10:30 P.M., showed the left and right groin dressings were clean, dry, and intact with no drainage.</p> <p>Review of the resident's progress notes, dated 03/19/25 at 11:36 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-When staff changed the groin dressings, the right groin dressing was partially in place and saturated with drainage;</li> <li>-The resident had been messing with the dressing and it was almost completely off;</li> <li>-The resident had been pulling dressings off at times;</li> <li>-The area was cleansed, and a new dressing applied;</li> <li>-The resident appeared to have a knot coming up at the bottom of the incision on the left groin;</li> <li>-Staff spoke with the resident's siblings that were taking the resident to see his/her vascular surgeon for his/her follow-up and asked them to let them know the resident had been messing with the groin incisions and will not leave the dressings on;</li> <li>-Staff let the siblings know that the right groin was draining, and the resident has been messing with the staples;</li> <li>-Staff asked the siblings to make sure the vascular clinic staff looked at the left incision where a knot was coming up at the bottom of the incision;</li> <li>-The facility's physician's office was called and informed of the issue with the resident's surgical incision.</li> </ul> <p>Review of the resident's progress note dated 03/19/25, at 4:35 P.M., showed the following:</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If he/she noticed a new area of concern on a resident's skin, he/she would report it to a nurse.</p> <p>During an interview on 04/15/25, at 11:24 A.M., CNA E said the following:</p> <p>-He/she knew the resident continued to remove the wound bandages;</p> <p>-He/she would notify the nurse of any drainage or concerns regarding any wound.</p> <p>During an interview on 04/15/25, at 11:42 A.M., Certified Medication Tech (CMT) D said if he/she noticed a change in condition or new area of concern on a resident's skin, he/she would report it to a nurse.</p> <p>During an interview on 04/15/25, at 12:02 P.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-The resident came to the facility with wounds due to bilateral groin surgery;</p> <p>- Upon admission, there was an order to monitor for drainage and to change the dressings daily;</p> <p>-He/she was off for two days prior to the resident having the appointment with the vascular surgeon;</p> <p>-He/she noticed drainage to the right groin wound the morning of the vascular surgeon visit, but had not noticed any drainage prior to that;</p> <p>-The resident left for the vascular surgeon appointment and was admitted to the hospital the same day;</p> <p>-Prior to the resident leaving for the appointment, LPN A informed the family about the right groin are drainage;</p> <p>-He/she has a wound vac and is having some drainage now;</p> <p>-The resident still picks at his/her wounds, staples, and tape;</p> <p>-Current wound orders are found in the resident's Medication Administration Record (MAR);</p> <p>-The resident currently had an order to change the wound vac dressing Monday, Wednesday, and Friday, but he/she goes to the vascular surgeon's office for those dressing changes;</p> <p>-The resident had a current order for the left groin hematoma (a pool of mostly clotted blood that forms in an organ, tissue, or body space). The order was to change the ABD pad (a sterile dressing used for wound management) and tape daily but leave the packing alone;</p> <p>-Physician orders are located in the MAR under orders;</p> <p>-On admission from the hospital the orders come from the hospital;</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-She took measurements of the wound the first night the resident was at the facility because the resident removed the dressing;</p> <p>-The resident did not have any drainage of the wounds upon admission to the facility. The incisions looked good on bilateral groin areas;</p> <p>-The nursing staff should document in the progress notes all communication with the vascular wound clinic, including notification that the resident was removing his/her dressings;</p> <p>-The DON confirmed that she did not locate any wound care orders in the resident's MAR that were dated prior to the resident being hospitalized ;</p> <p>-The hospital discharge orders were not put into the resident's MAR;</p> <p>-She cleaned the resident's wounds with wound cleanser even though there was not an order for it prior to the resident's hospitalization;</p> <p>-She did not recall if she documented in the resident's chart when she cleaning the wounds and changing the dressings;</p> <p>-A nurse at the facility spoke to the resident's siblings and the wound clinic about the drainage. She believed the nurse made a progress note in the resident's medical record with that information;</p> <p>-The facility was tracking and monitoring the wound measurements and keeping the information on a handwritten sheet of paper;</p> <p>-The nursing staff was responsible for wound treatments;</p> <p>-The MAR should be used to document treatments, dressing changes, and orders for as needed care;</p> <p>-Staff would document in the progress notes if there is a problem or concern with a resident;</p> <p>-The facility does not have standing orders for wound care. The facility must have either an order from the hospital at discharge that is approved by the facility's physician or an order initiated by the facility physician or nurse practitioner;</p> <p>-The facility admission's nurse receives the hospital orders and faxes them to the facility physician for approval. Once approved the orders are place on the residents MAR. The facility has a new process for obtaining physician orders. There is an on-call basket for after hours, weekends, and holidays. Requests are placed in the on-call basket and faxed to the physician for approval or denial by the physician or one of the physician's three nurse practitioners. If the order is approved, then staff puts the order on the resident's MAR.</p> <p>During a phone interview on 04/21/25, at 3:50 P.M., the facility physician said the following:</p> <p>-He/she did not recall the facility staff notifying him about the wound condition change of drainage being present;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she felt that the resident picking at the wounds and removing the dressings would have affected the healing of the wounds;</p> <p>-By the facility staff not cleaning the wounds daily as ordered per the hospital discharge orders, it would increase the resident's chance of infection;</p> <p>-Hospital discharge orders are sent to him/her from the facility for approval and his/her signature;</p> <p>-If additional orders are needed, his/her office staff writes the order and faxes them to the facility for the facility staff to follow;</p> <p>-If a resident had an order to leave a dressing in place for five days after admission to the facility and the resident removed the dressing earlier, he/she would expect the facility staff to notify him/her because removing the dressing earlier might have an impact on the wound healing.</p> <p>During an interview on 04/15/25, at 4:58 P.M., the Administrator said the following:</p> <p>-When a resident was admitted from the hospital with wound care orders, he/she would expect the orders to be entered on the MAR as well as followed up on and documented appropriately;</p> <p>-He/she would expect weekly skin assessments, measurements, and tracking to be documented in the EHR.</p> <p>MO00252509, MO00252565</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review, the facility failed to maintain complete and accurate medical records when staff failed to document contacting the physician for catheter orders, failed to document a catheter insertion attempt, failed to document a hospital transfer, and failed to document notification to the family of a change in condition for one resident (Resident # 2). The facility census was 76.</p> <p>Review of the facility's policy titled, Charting and Documentation, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-Treatment documentation should include the date and time each treatment was administered, name of person administering the treatment, specific duties performed, and signature and title of person recording the data;</li> <li>-Intake and output documentation should include consistent and accurate documentation and measurement of the resident's intake and output, each shift's eight-hour total output, other pertinent observations as necessary, and signature and title of person recording the data;</li> <li>-Both intake and output documentation must be recorded when a resident has a catheter, IV, tube feeding, etc., and whenever deemed necessary by the nurse (i.e. suspected dehydration, elevated temperature, possible urinary tract infection, cloudy urine, etc.).</li> </ul> <p>Review of the facility's policy titled, Condition Change, Resident (Observing, Recording, and Reporting) (Includes Fall and Injury), undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The purpose was to observe, record, and report any change in condition to the attending physician so that proper treatment can be implemented;</li> <li>-Have someone stay with the resident while the nurse is calling the attending physician, if necessary. If unable to reach the attending physician or the physician on call, call the facility medical director for emergency situations;</li> <li>-Complete an incident, accident, or risk management report per facility guidelines;</li> <li>-Notify resident's responsible party;</li> <li>-Monitor resident's condition frequently until stable;</li> <li>-Notify physician of condition change, need for treatment orders and/or medication orders.</li> </ul> <p>1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> <li>-admission date of 03/12/25;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included chronic obstructive pulmonary disease (COPD- a lung disease causing restricted airflow and breathing problems) and benign prostatic hyperplasia (BPH - a noncancerous condition where the prostate gland grows larger than normal) without lower urinary tract symptoms.</p> <p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/18/25, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was moderately impaired;</li> <li>-The resident required substantial/maximal assist for toileting, sit to stand and chair to bed to chair transfers;</li> <li>-The resident required a manual wheelchair.</li> </ul> <p>Review of the resident's physician order report, dated 03/12/25 to 04/10/25, showed the following:</p> <ul style="list-style-type: none"> <li>-An order dated 03/12/25, for tamsulosin (Flomax - helps relax the muscles in the prostate and the opening of the bladder) 0.4 mg capsule. Give two capsules once an evening at 7:00 A.M. for benign prostatic hyperplasia without lower urinary tract symptoms.</li> <li>-No order for an in and out catheter.</li> </ul> <p>Review of the resident's care plan, dated 03/12/25, showed staff did not document any urinary tract problems or interventions.</p> <p>Review of the resident's nurses' progress note dated 04/06/25, at 1:29 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was having trouble urinating;</li> <li>-He/she reported taking Flomax (a medication used to treat enlarged prostate) in the morning at home and requested to have his/her dose moved from the evening to the morning at the facility;</li> <li>-Flomax was moved to the morning as the resident was taking it at home.</li> </ul> <p>During an interview on 04/14/25, at 12:12 P.M., the resident said the following:</p> <ul style="list-style-type: none"> <li>-He/She went to the emergency room the other day due to problems urinating;</li> <li>-He/She was supposed to be set up with a urologist;</li> <li>-While at the hospital, they did a scan that showed a small amount of urine in the bladder and took a sample of urine;</li> <li>-The hospital had him/her drink two to three glasses of water and he/she urinated at the hospital and was sent back to the facility;</li> <li>-He/She has had urination problems for the past couple of years;</li> </ul> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The staff at the facility knew about his/her problems urinating for three days prior to doing anything;</p> <p>-The facility staff informed him/her that they would call the doctor, but the doctor never came in to assess him/her. He/she had only seen the facility doctor the first week he/she was admitted to the facility;</p> <p>-The staff at the facility did a catheter before sending him/her to the hospital, but they did not get any urine out;</p> <p>-The facility was administering his/her Flomax at night when he/she was admitted to the facility, but he/she has requested to take the medication during the morning, and he/she is now receiving the medication during the morning;</p> <p>-He/she stated that if he experienced a change in condition or was sent to the hospital, the facility should notify his/her child.</p> <p>During an interview on 04/15/25, at 12:02 P.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-The resident mentioned urination problems to him/her the day before he/she went to the hospital, but acted like it was not a big deal;</p> <p>-The resident reported that he/she was able to urinate;</p> <p>-The following day, the resident informed him/her that he/she could not urinate, so he/she informed the Director of Nursing (DON), and the DON went in to assess the resident and sent him/her to the emergency room;</p> <p>-He/She did not recall if he/she made any notes in the resident's chart regarding his/her complaints of not being able to urinate, but if he/she did the information would have been documented in a progress note in the resident's electronic record;</p> <p>-He/She did not notify the physician regarding a change in condition with urination concerns because the DON was notified, and she was supposed to follow up on the situation;</p> <p>-LPN A would expect the DON to chart in the resident's electronic record in a progress note what he/she did for the resident, including the results of an in and out catheter if one was completed;</p> <p>-He/She was not aware of any facility standing orders for an in and out catheter;</p> <p>-LPN A would call the physician for an order prior to inserting an in and out catheter on a resident.</p> <p>During an interview on 04/15/25, at 2:19 P.M., the DON said the following:</p> <p>-The resident complained of not being able to urinate;</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she continued to complain of only having a small amount of urine output;</p> <p>-The resident was sent to the emergency room and the hospital reported that he/she was urinating fine;</p> <p>-The DON attempted an in and out catheter on the resident, but he/she could not get the catheter to advance into the bladder, so he/she stopped the attempt;</p> <p>-The resident requested to go to the hospital;</p> <p>- The DON left a phone message for the resident's child. The child called the DON back, and the DON informed him/her the resident was sent to the hospital per his/her request;</p> <p>-He/She contacted the physician who provided him/her with an order to perform a one time in and out catheter on the resident;</p> <p>-The DON said he/she failed to enter the order into the resident's medical record;</p> <p>-The physician also gave an order to send the resident to the hospital, but he/she failed to enter the order into the resident's medical record;</p> <p>-He/She intended to have LPN F enter the catheter and hospital transfer orders, but LPN F also failed to enter the orders;</p> <p>-The resident went to the hospital and was back at the facility within two to three hours;</p> <p>-The hospital report showed good urine output, with no concerns found;</p> <p>-The resident has not complained about urination issues since the hospitalization.</p> <p>Review of the resident's progress notes and physician orders, dated 03/16/25 to 04/15/25, showed the following:</p> <p>-Staff did not document an order for an in and out catheter;</p> <p>-Staff did not document regarding an in and out catheter attempt;</p> <p>-Staff did not document regarding the resident being transferred to the hospital;</p> <p>-Staff did not document notification of the family regarding a change in the resident's condition.</p> <p>During an interview on 04/21/25, at 3:50 P.M., the facility physician said the following:</p> <p>-He/She was aware of the resident having problems urinating and that the resident was sent to the hospital;</p> <p>-He/She did not recall giving the DON a verbal order for an in and out catheter for the resident;</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she checked and there was no evidence any other staff in the office gave a verbal order for the in and out catheter;</p> <p>-The DON contacted his/her office and requested an order to send the resident to the emergency room due to the inability to urinate and pain with urination. The Nurse Practitioner (NP) gave a verbal order to send the resident to the emergency room.</p> <p>During an interview on 04/15/25, at 4:58 P.M., the Administrator said the following:</p> <p>-He/She was aware the resident had complaints about not being able to urinate;</p> <p>-The nursing staff did an in and out catheter for the resident and sent him/her to the hospital.</p> <p>During an interview on 04/15/25, at 12:02 P.M., LPN A said the following:</p> <p>-If a resident had a change in condition, he/she would notify the DON, call the physician and ask if he/she wants any tests completed, and notify the family;</p> <p>-He/She would document in the nurses notes as soon as the resident left the facility if a resident was sent to the emergency room or hospital;</p> <p>-If a resident had a new issue, he/she would obtain physician orders and document in the progress notes;</p> <p>-If a resident needed a straight catheter the physician would be notified for an order and the order would be documented on the resident's Medication Administration Record (MAR);</p> <p>-If he/she knew a resident needed a straight catheter, he/she would document in the resident's progress notes;</p> <p>-LPN A is not aware of any facility standing orders for an in and out catheter;</p> <p>-If a resident did not have an order for an in and out catheter, he/she would call the physician for an order prior to doing an in and out catheter on a resident.</p> <p>During an interview on 04/15/25, at 2:19 P.M., the DON said the following:</p> <p>- If a resident has a change in condition, staff are expected to notify the family, physician, hospice, and the facility physician;</p> <p>-Family notification should be documented in progress notes;</p> <p>-If staff leave a message for the family, they should document who was notified and when under the notifications tab or events tab within the electronic health record;</p> <p>-Staff should document a resident's change in condition in the electronic health record under the event tab or in the progress notes.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/15/25, at 4:58 P.M., the Administrator said the following:</p> <p>-If a resident had a change in condition, he/she would expect staff to document in the resident's record immediately and send the resident to the hospital as soon as possible, if necessary;</p> <p>-He/She would expect staff to obtain a physician's order for an in and out catheter and to document the order in the resident's record;</p> <p>-If a resident was sent to the hospital, he/she would expect staff to notify the physician, family or durable power of attorney (DPOA- a person that is given authority to make decisions on behalf of another person if that person becomes unable to do so).</p> <p>MO00252565</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Deficiency Text Not Available</p>