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	08/14/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure all residents were treated in a dignified manner, when staff withheld one resident's (Resident #1's) belongings, and would not return them timely, after the resident displayed behaviors. The facility census was 75.Review of the facility policy titled Resident's Rights, undated, showed the following:-The resident has a right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility;-The resident has the right to exercise his/her rights as a resident of the facility and as a citizen or resident of the United States;-The resident has the right to be free of interference, coercion, discrimination and reprisal form the facility in exercising his/her rights, and be supported by the facility in the exercise of his/her rights;-The resident may retain personal possessions as space permits, unless to do so would infringe on the rights of others. 1. Review of Resident #1's face sheet (admission data) showed the following:-admission date of 07/14/25;-Diagnoses included bipolar disorder (mental health condition characterized by extreme shifts in mood, energy, ranging from highs to lows), anxiety disorder (excessive and persistent worry and fear), personality disorder (long lasting disruptive patterns of thinking, behavior, mood and relating to others), epilepsy (sudden surges of electrical activity in the brain that leads to convulsions or loss of consciousness and changes behavior), intellectual disabilities (limitations in learning, thinking, and problem-solving skills), and Parkinson's disease (progressive nervous system disorder that affects movement). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/04/25, showed the following information:-Memory problems, moderately impaired cognitive skills, inattention, and disorganized thinking;-Physical and verbal behaviors the last four to six days towards others;-Partial assistance with oral, personal and toileting hygiene, upper and lower body dressing;-Substantial assistance with showers and personal hygiene. Review of the resident's July 2025 Progress Notes showed the following:-On 07/14/25, at 4:41 P.M., the resident admitted to the facility. The resident was able to make needs known, had behaviors. Resident has tantrums and will throw his/her belongings if he/she doesn't get his/her way. Resident likes to color and likes puzzles and superheroes at times if you cannot redirect the resident;-On 07/17/25, at 3:27 P. M., resident alert to self and staff anticipates all needs and cares. Resident can be aggressive with staff and combative. He/she does throw his/her belongings and will have tantrums if not getting his/her way. If he/she is having behaviors, he/she enjoys coloring and puzzles;-On 07/19/25, at 9:02 A.M., the resident screaming and crying in dining hall. When asked to go to his/her room he/she started screaming louder and threw his/her coloring pages and toys in the hall, slamming the door. Review of the resident's August 2025 Progress Notes showed the following:-On 08/01/25, at 4:57 P.M., the resident was up in the hallway pacing a lot during this shift and wanting his/her coloring pages and certain coloring pages. Resident was redirected multiple times. Resident did not get aggressive or angry;-On 08/02/25, at 9:45 P.M., resident had been screaming all of this shift, throwing items into the hall and in room, cussing, hitting, and refusing to take medication. Staff unable to redirect;-On 08/09/25, at 10:32 A.M., resident behaviors continue including screaming, throwing items into the hall and at the staff, and other resident, and slamming door to room. Difficult to administer medications. Resident not easy to redirect. Review of the resident's care plan, revised on 08/05/25, showed the following:-Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by rejecting cares at times. Staff will assess whether the behavior endangers the resident and or others and intervene as necessary. Avoid over-stimulation. Convey attitude of acceptance toward the resident. Maintain a calm environment and approach to the resident. When resident becomes socially inappropriate/disruptive, provide comfort measures for basic needs;-Resident at risk for loneliness related to behaviors towards others. Staff will allow resident to have control over situations, if possible. Identify relationships that resident could draw on. Involve resident with those who have shared interests. Provide activity calendar. Place resident in position of almost certain success in an activity;-Resident has difficulty understanding others related to mental health issues and intellectual disabilities. Staff will ask resident to repeat what he/she what has been said to confirm the message was understood. Staff will face the resident when speaking. Staff will obtain resident's attention before speaking. Staff will speak clearly and adjust tone as needed;-Resident has impaired decision making related to behaviors towards others and reject cares. Encourage resident to verbalize feelings, concerns and fears. Give objective feedback when appropriate decisions are made. Discuss future options to improved decision making. Respect resident's rights to make

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to management and within two hours to the state licensing agency (Department of Health and Senior Services - DHSS) when staff failed to report allegations of verbal abuse and involuntary seclusion involving one resident (Resident #1) to management and DHSS in a timely fashion. The facility census was 75.Review of the facility policy titled Abuse Prohibition Protocol Manual, revised January 2017, showed the following:-Educate all staff to report to the Administrator and/or designees any alleged violations involving abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property;-The Administrator or designee must report to the State Survey agency no later than two hours after the allegation is made if the event involved abuse or resulted in injury;-All residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation;-Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents regardless of their age, ability to comprehend, or disability;-Physical abuse is defined as hitting, slapping, pinching, kicking, biting, etc. It also includes controlling a resident's actions through personal punishment;-Report immediately, within two hours, if the events that cause the allegation involve abuse or result in serious bodily injury. Review of the facility's policy titled, Resident's Rights, undated, showed resident shall not be subjected to physical, sexual, or emotional injury or harm. 1. Review of Resident #1's face sheet (admission data) showed the following:-admission date of 07/14/25;-Diagnoses included bipolar disorder (mental health condition characterized by extreme shifts in mood, energy, ranging from highs to lows), anxiety disorder (excessive and persistent worry and fear), personality disorder (long lasting disruptive patterns of thinking, behavior, mood and relating to others), epilepsy (sudden surges of electrical activity in the brain that leads to convulsions or loss of consciousness and changes behavior), intellectual disabilities (limitations in learning, thinking, and problem-solving skills), and Parkinson's disease (progressive nervous system disorder that affects movement). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/04/25, showed the following information:-Memory problems, moderately impaired cognitive skills, inattention, and disorganized thinking;-Behaviors the last four to six days of physical and verbal towards others. Review of the resident's care plan, revised on 08/05/25, showed the following:-Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by rejecting cares at times. Staff will assess whether the behavior endangers the resident and or others and intervene as necessary. Avoid over-stimulation. Convey attitude of acceptance toward the resident. Maintain a calm environment and approach to the resident. When resident becomes socially inappropriate/disruptive, provide comfort measures for basic needs;-Resident at risk for loneliness related to behaviors towards others. Staff will allow resident to have control over situations, if possible. Identify relationships that resident could draw on. Involve resident with those who have shared interests. Provide activity calendar. Place resident in position of almost certain success in an activity;-Resident has difficulty understand ding others related to mental health issues and intellectual disabilities. Staff will ask resident to repeat what he/she what has been said to confirm the message was understood. Staff will face the resident when speaking. Staff will obtain resident's attention before speaking. Staff will speak clearly and adjust tone as needed;-Resident has impaired decision making related to behaviors towards others and reject cares. Encourage resident to verbalize feelings, concerns and fears. Give objective feedback when appropriate decisions are made. Discuss future options to improved decision making. Respect resident's rights to make decisions. Review of Certified Nurse Aide (CNA) D's written statement dated 08/11/25, at 11:31 A.M., showed CNA said he/she had personally witnessed a towel put into the resident's door to keep him/her locked in his/her room. The CNA said he/she had reported this to his/her nurse on duty for C wing and he/she stated he/she didn't want to get int the middle of things. CNA D went to B wing to see if the resident received the coloring books he/she had gotten for the resident and was told no because the resident hit CNA I. CNA I made the statement if the resident keeps fucking around with me, CNA I will take the resident's bed out and the resident can sit on the fucking floor. CNA D was told by a Housekeeper E that he/she had heard CNA I say that CNA I would put the resident in a head lock if the resident touches CNA I again. Review of CNA B's written statement dated 08/11/25, no time, said CNA B had heard CNA I say to the resident that CNA I would take everything out of the resident's room and the resident would be left with nothing but his/her bed if he/she didn't stop acting up Review of DHSS records