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	10/07/2025

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide care that reflected the resident's wishes as expressed by the residents advance directives (written instruction, such as a living will or durable power of attorney, relating to the provision of health care when the individual is incapacitated) when the facility failed to ensure one resident's (Resident #1) Do Not Resuscitate order (DNR- refers to a medical order issued by a physician or other authorized practitioner that directs healthcare providers not to administer cardiopulmonary resuscitation (CPR - a medical intervention used to restore circulatory and/or respiratory function)) was clearly and consistently documented in the resident's chart resulting in staff providing CPR when the resident wished to be a DNR. The facility census was 80. Review of the facility's policy titled Advance Directive, undated, showed the following information:-Upon admission of a resident to the facility, the social services designee (SSD) will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive;-Upon admission of a resident, the SSD will inquire of the resident, and/or his/her family members, about the existence of any written advance directives;-Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record under the advance directive tab;-DNR indicates that in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative has directed that no CPR or other life-saving methods are to be used. 1.Review of Resident #1's face sheet (brief look at resident information) showed the following information:-admission date of [DATE];-Code status (refers to the level of medical interventions a person wishes to have started if their heart or breathing stops) as a full code (wished to receive CPR);-Diagnoses include pneumonia (infection that inflames the air sacs in one or both sides of the lungs), metabolic encephalopathy (occurs when problems with your metabolism cause brain dysfunction), kidney failure, and sepsis (a life-threatening complication of an infection).Review of the resident's Advanced Directives tab in the Electronic Medical Record (EMR) showed the following:-A DNR was scanned and loaded into the system on [DATE];-The scanned in DNR was signed by the resident and physician and dated [DATE].Review of the resident's Physician's Orders, dated [DATE] to [DATE], showed an order, dated [DATE], for resident to be code status of no CPR (DNR). Review of the resident's care plan, last updated [DATE], showing the resident had a code status of DNR. Review of the resident's 5-Day Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated [DATE], showed the resident had severe cognitive impairment. Review of the resident's progress note dated [DATE], at 10:30 P.M., showed the Assistant Director of Nursing (ADON) noted the following information:-Around 9:15 P.M., he/she went into the resident's room to administer medication and found the resident struggling to breath and foaming at the mouth;-The resident was barely responsive, and his/her pulse was barely palpable (able to be touched or felt). The resident's oxygen saturation (the percentage of hemoglobin in the blood that is carrying oxygen, typically read using a pulse oximeter) would not read;-The resident was a full code;-Staff notified emergency services (EMS) and as the ADON was getting off the phone with EMS, the resident became completely unresponsive and had stopped breathing with no pulse;-Staff began CPR and completed several rounds of CPR prior to EMS arrival;-EMS arrived and took over CPR. The fire department also arrived onsite and continued CPR for 45 minutes, when EMS asked to call the resident's family;-Family was notified of the situation. CPR continued, EMS then phoned the hospital and waited for a doctor to call the time of death. While waiting for the doctor to respond, there was a pulse indicated on the monitors, so EMS loaded the resident up for transport to the emergency department at 10:20 P.M.During an interview on [DATE], at 1:27 P. M., the ADON said the following:-The resident was admitted to the facility for a couple of weeks;-He/she was working night shift on [DATE], and was going into the resident's room to administer his/her medication;-Upon entering the room, the resident was lying in bed and had foam coming out of his/her mouth;-He immediately checked the resident's code status on the resident's face sheet, which indicated the resident was a full code (CPR);-He checked the resident's Advanced Directives tab in the EMR as well, and nothing was in the system at the time, showing the resident was a DNR;-He checked the resident's sticker on his/her door, showing a green dot which indicated full code (CPR);-He called EMS and began CPR;-Medical records is responsible for scanning and loading DNR's into the residents EMR. They also should communicate with the staff when they become aware of a signed DNR;-DNR orders should be loaded into the EMR immediately