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	11/20/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to ensure residents were free from accidents when the facility failed to have a process in place to ensure staff were aware of the care planned needs of each resident resulting in the fall of one resident (Resident #1), resulting in a laceration and neck fracture, when staff provided cares alone when care planned for two staff present during cares. The facility had a census of 80.Review of a facility policy titled, Care Plan Comprehensive, not dated, showed the following information:-A comprehensive care plan for each resident is to be developed and maintained that identifies the highest level of functioning the resident may be expected to attain;-The care plan will be oriented to prevent avoidable decline in functioning and manage risk factors to the extent possible or indicating the limits of such interventions.Review of a facility's checklist form titled, Fall Prevention Intervention Care Plan, dated June 2006, showed the following checklist measures:-Ask resident every one to two hours if they need to use the bathroom;-Answer call lights promptly;-Remind the resident to ask for assistance;-Eliminate side rails and bedside commodes;-Individualize toilet schedule and/or bowel and bladder re-training;-Reorient the resident to surroundings frequently;-Visually check the resident every two hours or more often as determined by the care team;-Eliminate potential hazards;-Assess the environment to maximize safety.Review showed the facility did not provide a policy regarding falls or accidents.1. Review of Resident #1's face sheet (basic information sheet) showed the following:-admission date of 08/06/24;-Diagnoses included depression (a group of conditions associated with the elevation or lowering of a person's mood, such as depression or bipolar disorder), persistent mood disorder (persistent feelings of depression), history of urinary tract infections (UTI), and a history of falls.Review of the resident's Minimum Data Sheet (MDS- a federally mandated assessment tool completed by facility staff), dated 10/15/25, showed the following:-The resident had severe cognitive impairment;-The resident had impairment of both sides of the upper and lower extremities;-The resident was dependent on staff for personal cares, bed mobility, and transfers. Review of the resident's care plan, dated 10/23/25, showed the following:-The resident had impaired mobility requiring dependence on staff for all activities of daily living (ADLs- activities related to personal cares including bathing, showering, dressing, getting in and out of bed or a chair, walking, toileting, and eating);-The resident had increased risk for falls;-Interventions included two staff assistance with bed mobility. Staff to turn and reposition the resident every two hours as needed if resident unable to do so on his/her own;-Two staff Hoyer lift (mechanical lift used for resident who cannot bear weight) transfer assistance;-Two staff assistance for ADL's.Review of the resident's Fall Event Report, dated 11/17/25, showed the following:-A fall was noted on 11/17/25. at 4:54 A.M.;-The fall was witnessed;-Resident rolled into the floor during dressing; -Resident had a three-inch laceration on the top middle of his/her head with a knot forming;-Staff to have all supplies next to them during cares;-The location of the fall was noted as the resident's room;-Assessment showed the resident exhibited/complained of pain to the top of his/her head;-The pain scale was noted as a 1 out of 10 (mild pain);-The resident had full range of motion without pain or limitations;-The resident was noted as lethargic/drowsy.During an interview on 11/20/25, at 1:42 P.M., Nurse Aide (NA) D said the following: -He/she was providing care to the resident on 11/17/25, when the resident fell from bed;-Certified Nurse Aide (CNA) G was present in the room assisting the resident's roommate when the fall occurred;-The NA was providing peri-care and changing the resident's clothing. The resident was positioned on his/her left side away from him/her on the bed;-The NA turned his/her head from the resident to grab peri-care supplies;-The resident rolled away from him/her while looking away, falling from the bed to the floor between the bed and the wall;-The NA did not see the resident fall from the bed or how he/she landed. He/She heard the resident hit the floor with a thump;-The bed was positioned at the NA's waist height;-The NA observed the resident on the floor on his/her stomach;-The NA immediately responded to the resident and observed the resident bleeding from an approximately three inch cut on the top of his/her head. He/She did not notice any other injuries at that time;-CNA G immediately left the room and notified the Assistant Director of Nursing (ADON):-The ADON immediately responded to the room and took over care of the resident;-The resident typically required one staff assistance for care and two staff assistance for Hoyer transfers. He/She usually provided one person care to the resident;-He/She did not know how many staff were required for care according to the care plan. He/she did not know what was indicated in the resident's care plan;-If the resident's care plan indicated two staff for care, two staff should be present for the care to ensure the