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	02/10/2026

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Review of the undated facility policy Resident Rights showed the following:-Always be provided with the highest level of care and service;-Each resident shall be treated with consideration, respect a full recognition of his/her dignity and individuality, including care of his/her personal needs.1. Review of Resident #4's face sheet (gives basic profile information) showed the following information:-admission date of 04/04/25;-Diagnoses included pain in right hip, generalized anxiety disorder, pain in left shoulder, age-related osteoporosis with current pathological fracture (condition that occurs when severely weakened, low-density bone breaks due to minimal trauma, such as a minor fall, bending, or coughing), insomnia (difficulty falling or staying asleep), pain, unspecified, nicotine dependence. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff), dated 01/10/26, showed the following information:-Cognitively intact;-Setup or clean-up assistance for eating, personal hygiene, and oral hygiene;-Substantial to maximal assistance for toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer;-Walking none attempted due to medical condition or safety concerns;-Uses a wheelchair and/or scooter; Review of the resident's care plan, last updated 08/25/25, showed the following information:-Allow choices for care;-Staff to provide care according to the physician medical orders;-Handle gently and try to eliminate any environmental stimuli;-Monitor and record any non-verbal signs of pain (guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal);-Position for comfort with physical support as necessary;-At risk for pressure ulcers related to incontinence and decreased bed mobility;-Use absorbent, skin-friendly pads/briefs to maintain personal hygiene and dignity;-Allow resident to choose options (activities in the morning vs. afternoon);-Requires assistance with activities of daily living;-Encourage to do as much for self as possible;- Offer as much assistance as needed to complete tasks;-Break tasks into smaller simple steps if needed;-Has urinary incontinence;-Provide incontinence care after each incontinent episode. Review of the resident's progress notes showed the following:- On 01/05/26 at 7:37 A.M., the resident was observed yelling from his/her room, requesting assistance from the certified nurse aide (CNA) to get out of bed. Call light was activated. CNA responded and assisted the resident. After being placed in bed for 10 minutes, the resident began yelling again, requesting assistance to get out of bed. The resident was assisted safely with transfer. Will continue to monitor and ensure call light is within reach;-On 01/06/26 at 12:37 P.M., the resident was able to make needs known. Resident mostly continent of bowel and bladder with pads and briefs used. Sitting up in wheelchair in room;-On 01/07/26 at 3:36 P.M., the resident often yells and screams for help if not helped right away. Self-propels wheelchair, does not walk;-On 01/08/26 at 2:19 A.M., the resident yells/screams for help if not helped right away. Does not walk;-On 01/08/26 at 8:51 A.M., the resident is mostly continent of bowel and bladder with pads and briefs used. The resident is a one to two person assist with transfers and cares. Record review of the Resident Council meeting minutes, dated 01/29/26, showed call lights not being responded to on time. No further details (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Lebanon North Nursing & Rehab	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided. During an interview on 02/06/26, at 12:26 P.M., Resident #4 said the following:-He/She has asked Nurse Aide (NA) B several times to do something for him/her and NA B says he/she will, but never comes back;-One day recently, he/she asked NA B to help him/her get ready to smoke for the scheduled smoke break, but NA B ignored him/her, so Resident #4 asked another certified nurse aide (CNA)to assist him/her. As he/she was telling the other CNA that he/she asked NA B for assistance multiple times, NA B walked by and stopped at the end of the hall and yelled at him/her, saying Don't be putting things in my mouth. He/She said his/her response back to NA B was I'm not, but NA B continued to yell like crazy at him/her from the linen closet in the hall;-NA B has a chip on his/her shoulder;-NA B does not have any compassion in him/her and you have to have compassion to work here;-He/She is not afraid of NA B, but he/she thinks NA B might lash out or hit or strike him/her because he/she has the potential to do that because of the way he/she comes across;-NA B is the rude master, the master of rudeness;-Resident #4 has not talked to staff about NA B;-When he/she asks for help, CNA E tells him/her to be quiet because he/she is waking up the other residents;-The only way to get the staff's attention is to yell;-Resident #4 and CNA C weighed one of Resident #4's depends (an incontinence brief) about a month ago because staff had not assisted him/her with changing it all day;-They weighed the wet depends on a scale in the dining room, and it weighed one pound; -He/She told LPN J, LPN S, and the DON how much it weighed and they all pretty much said oh well;-He/She did not have any depends yesterday and no one comes in to check on him/her. He/she would like to be taken care of;-Staff get him/her up and leave him/her in the chair all day;-When needing something, he/she will ask staff, and they tell him/her to wait and then no one comes back to help; -He/She is always out of depends each month, so staff will use depends which are too big or too small;-They are always running out of his/her depends and residents are not allowed to have a full package of depends in their rooms. During an interview on 02/09/26, at 2:53 P.M., Resident #4 said the following:-When his/her pants get soaked from the depend getting too full he/she can smell it and it makes him/her aggravated;-He/She does not like to smell like urine;-When he/she starts smelling like urine he/she asks to be changed. Staff say they will be back and then they never come back;-CNA D comes in around 2:00 P.M., and changes him/her;-Other staff have to know that he/she has to pee during the day. During interview on 02/06/26 at 9:50 A.M., Certified Nurse Assistant (CNA) D said the following:-He/She witnessed Nurse Aide (NA) B backtalk Resident #4 when asked to help him/her get ready for his/her smoke break;-CNA E heard Resident #4 ask NA B twice to assist him/her with getting ready for the smoke break and NA B told the resident both times he/she was busy;-Resident #4 told CNA D that NA B would not get him/her ready for the smoke break and asked CNA E to assist and he/she did;-NA B was standing in the hall and yelled back at Resident #4 I never said I would not help you, so stop putting words in my mouth. During an interview on 02/06/26, at 1:10 P.M., the DON said the following:-It is not appropriate for staff to tell him/her to be quiet when he/she yells out at night because of back pain due to his/her mattress;-Staff encourage the resident to use his/her call light;-If the resident pushes his/her call light and it is not answered as soon as he/she thinks it should have been, he/she should not be yelling out because it would disturb other residents;-If his/her call light goes off, staff would send an aide to check on him/her;-Resident #4 has not complained to him/her about his/her call light not being answered;-Staff is using what is available to them for Resident # 4 because he/she did not want to go without a depend/brief. During an interview on 02/06/26, at 1:56 P.M., CNA E said the following:-The resident yells out about his/her cigarette breaks and does not want to be late;-Staff tell Resident #4 he/she is not the only resident they have to care for;-The resident does not use the call light, he/she screams for staff to help instead;-When the resident is in bed he/she screams because he/she wants to get up and go smoke;-If he/she does not get Resident #4 up for the 9:00 A.M. cigarette break, the resident will yell out. During an interview on 02/06/26, at 2:00 P.M., CNA C said the following:-He/She did assist Resident #4 with weighing his/her depend as he/she came on for his/her shift;-Resident #4 said he/she had not been changed all day;-The resident's wet depend had soaked through his/her (continued on next page)

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Lebanon North Nursing & Rehab	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pants;-The depend was weighed on the scale in the dining room and it weighed 1.3 pounds;-The resident laughed about it, but CNA C felt that it was a defense mechanism to help him/her emotionally;-He/She informed LPN S about the weight of the depend;-The facility was also out of wipes that day, so he/she used wet paper towels and wet washcloths to clean Resident # 4 up;-Several residents do not have enough depends, including Resident #4. It did not use to be that way, but now the facility is frequently out of depends and wipes;-Last Thursday, Resident #4 did not have the right size of depends. The resident uses an extra-large to 2X size, but the only size of depends he/she had to use was large, and it was snug on him/her;-CNA C feels like dayshift staff ignores Resident #4 because he/she is vocal. During an interview on 02/06/26, at 10:08 A.M., LPN F said residents may be left soiled at night because some mornings when he/she comes in the residents are soaking wet. During an interview on 02/06/26, at 1:10 P.M., the DON said the following:-The facility does have a shortage of depends and when it is close to delivery day the supply get shorter;-The DON has been combating with the aides because there has not been enough depends;-The DON orders the depends and supplies every two weeks unless there are five weeks in the month then he/she orders every three weeks;-He/She is over budget on depends;-Staff place the depends in resident rooms, so they have been instructed to only take in a few at a time and not a full package;-The facility received a shipment yesterday, but not everything came in;-The only depends/briefs that came in yesterday were the bariatric ones;-He/She is not aware of resident's being left soiled;-Staff should check and change residents every two hours;-If he/she goes over budget he/she has to get approval from the administrator;-The administrator has never denied him/her to order supplies even if he/she is over budget;-If the staff get low on something he/she puts it on the list for the next order. During an interview on 02/06/26, at 1:56 P.M., CNA E said he/she is concerned with the depends supply and not having enough depends/briefs. The supply issue impacts the residents that get up out of bed. During an interview on 02/06/26, at 2:00 P.M., CNA C said the following:-Last week the facility did not have any large gloves, so he/she had to use a different size;-On Thursday he/she was told the delivery truck came but they only received size 5 x depends;-The staff had to use pull ups on one resident because they did not have any depends for him/her;.-LPN S went to Walmart and bought a couple of bags of depends;-The facility has had supply issues for a couple of months now;-He/She has had to put the 5X size of depends on some residents that did not need that size because that was all that was available;-The night shift is pretty short staffed. 2. Review of Resident #5's face sheet (admission information at a glance), showed the following:-admission 7/28/25;-Diagnoses that included osteoporosis, anxiety disorder, depression, hypothyroidism (low thyroid) neuralgia(intense, sharp, burning, or electric shock-like pain caused by damaged or irritated nerves and neuritis (inflammation of a nerve or general inflammation of the peripheral nervous system ,chronic obstructive pulmonary disease (progressive , long-term lung disease making it difficult to breathe), pneumonia, mild cognition impairment. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 12/18/25 showed the following:-intact cognition;-requires substantial/maximal assistance. Helper lifts or holds trunk or limbs and provides more than half the effort;-frequently incontinent of urine and bowel;-On antipsychotic (used to manage psychosis (set of symptoms indicating loss of contact with reality, characterized primarily by hallucinations and delusions), schizophrenia (chronic, severe brain disorder that distorts how a person thinks, feels, acts, and perceives reality), bipolar mania (abnormally elevated extreme mood, energy, or activity lasting at least 7 days or requiring hospitalization), and severe depression. Review of the resident's care plan revised 11/11/25, showed the following:-Impaired mobility;-Approaches included: Staff assist with turning and repositioning every 2 hours as needed if unable to do so on own, two staff to assist with transfers, able to propel own wheelchair; usually refuses a shower;-At risk for bowel and bladder incontinence:-Approaches included: staff to assist res to the bathroom every two hours and PRN;-Have Anxiety:-If have a panic attack or anxiety episode, attempt to redirect the resident to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	something that will change their focus, Use a calm voice and approach during anxiety attack;-Prefer to stay in room and have little socialization/activity interest with others;-Approaches included: Allow time to reminiscing of past life experiences, offer emotional support as needed, remind of activities in the facility;-Psychosocial well-being; wishes his/her children would come and see him/her;-Approaches included: allow time to vent feelings about limited family contact, monitor for signs of depression, sadness, and isolation; Staff to provide conversations while in room providing care, preferred to stay in his/her own room. Review of the resident's progress notes, showed the following:-On 12/13/25, resident is alert and able to make needs know, puts on call light if has slight urine incontinence and after a few minutes starts yelling out help. Resident prefers to stay in his/her room and away from other residents. Room door stays closed at all times and stays closed at all times;-On 12/14/25, resident was incontinent of bowel and bladder and will put on call light for changes and wears briefs. Eats meals in room per choice.-On 12/15/25, the resident eats all meals in his/her room. If he/she goes just the least little bit, can be demanding after a few minutes and starts yelling out Help. Resident prefers to stay in his/her room and can be demanding after a few minutes and starts yelling out. Prefers to stay in his/her room and away from other residents. Door stays closed at all time and must knock before entering this door;-On 1/9/26, the resident refused care this shift by staff. Staff do rounds every two hours and the resident refuses at times saying he/she is dry and refuses to let staff check him/her. During interview on 2/6/26 at 11:00 A.M., Resident #5 said the following:-He/she felt like NA B was rude when he/she was having a conversation about his/her personal life with CNA O while they were changing him/her; -NA B was talking over him/her;-CNA O was helping with changing him/her;-He/she did report this to LPN J who said he/she would not allow NA B in his/her room anymore;-NA B talking about his/her personal life made the resident feel uncomfortable; -NA B had not been in his/her room since it happened over a week ago;-He/she was not afraid of NA B but did not want him/her touching him/her since it would make him/her feel uncomfortable. During interview on 2/10/26 at 4:37 P.M., CNA L said the following:-They were to respect the residents as they wanted to be respected by them and how they wanted to be treated;-Staff were not to talk about their personal life around residents;-They were not to talk over the residents during personal cares;-NA B was not really rude to residents but may come off wrong to some of them. During interview on 2/10/26 at 2:40 P.M., CMT (Certified Medication Technician) N said the following:-Residents should be treated with respect and not yelled at;-Care partners should not talk about personal lives and talk over residents to another care partner while providing care. During interview on 2/6/26 at 9:55 A.M., Licensed Practical Nurse (LPN) J said the following:-Resident #5 had complained about Nurse Aide (NA) B being rude to him/her;-Resident #5 said he/she did not want NA B to change him/her;-Certified Nurse Aide (CNA) O had assisted NA B with Resident #5's care and they had an inappropriate conversation with each other while assisting with the care;-NA B was high strung, impatient with residents and other staff;-NA B was talking about all his/her dates and dating life with CNA O while providing incontinence care;-Staff should not talk about their intimate personal lives in front of the residents;-LPN J did not write the incident up yet since he/she wanted NA B to sign the form;-Residents had complained about NA B being rude to them;-He/she had observed him/her say in front of the nurse's desk, My God, (resident's name), what do you want now? and seemed impatient;-LPN J told NA B it was not acceptable to talk that way;-Other residents did not want NA B in their room too;-He/she told the DON, wound care nurse, and administrator about NA B and they said they would take care of it. During interview on 2/10/26 at 5:10 P.M., LPN F said the following:-Dignity and respect is treating everyone as he/she wanted to be treated;-Approach residents as they wanted to be;-staff should not yell in anger or frustration, and may need to walk away and remove themselves for a few minutes;-staff should not talk about personal lives around the residents or talk over them doing personal cares. During interview on 2/6/26 at 12:30 P.M. and 2/10/26 at 5:39 P.M., the Director of Nursing said the following:-Other staff say NA B can be rather loud;-Other residents have not complained to him about NA B but one resident (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Resident #5) complained to CNA L who reported to him that the resident said NA B and another aide were talking over him/her about their dating life;-He had not talked to NA B about this but will plan to talk to NA B the next time he worked with NA B;-Staff should not talk over a resident during care. Staff should talk with them and engage them in conversation during cares;-For dignity and respect, staff were not to belittle anyone and treat residents as you want to be treated;-Staff were not to yell at anyone but can raise voice for them to hear you;-Staff should not talk over residents during personal cares such as to another coworker but rather talk to the resident;-Staff were not to talk about their personal lives. During interview on 2/6/26 at 11:35 A.M., the administrator said the following:-LPN J reported to her that NA B and another aide were talking about his/her intimate personal life to another nurse aide while providing personal care to a resident, which was wrong;-She thought LPN J had addressed this with both NA B and CNA O;-Both were discussing something about personal dating life;-The resident did not care about hearing their personal dating life;-She was unaware of any other residents who don't want NA B in their room to do personal cares;-There were no write ups or counseling in their personnel files, and they do put write ups in a file.-She would expect staff to treat residents with dignity and respect.3. Review of the Resident #6's face sheet (a document that gives a resident's information at a quick glance) showed the following:-An admission date of 06/07/25; -Diagnoses included paraplegia (partial or complete loss of motor and sensory function in the lower half of the body); depression, and chronic pain.Review of the resident's care plan, revised on 12/16/25, showed the following:-Staff should encourage resident to do as much as possible for self;-Staff should offer assistance as needed;-Resident had a mood disorder;-Staff should not argue, confront, or argue against his/her thoughts;-Staff should main a calm environment and approach with the resident.Review of the resident's quarterly MDS dated [DATE] showed the following:-Cognitively intact;-Dependent on staff for showering, toileting, transfers, and bed mobility;-Independent with mobility using a wheelchair.During an interview on 02/05/26, at 10:50 A.M., Resident #6 said the following: -He/she recently asked Nurse Aide (NA) B to remake his/her bed because it was not made correctly;-NA B got irritated at him/her, walked off, and started using his/her phone;-NA B was rude and his/her tone and gestures were not good;-NA B did not come back and remake his/her bed;-NA B just walked past him/her and would ignore him/her.During interview on 02/06/26 at 9:50 A.M., Certified Nurse Assistant (CNA) D who worked on the dementia unit, said the following:-Nurse Aide (NA) B recently inappropriately restrained Resident #2 by holding his/her arms and hands behind his/her back like he/she was being arrested;-The NA had his/her arms intertwined with Resident #2's arms to keep Resident #2's arms and hands from moving;-Resident #2 was upset and crying;-He/She heard resident #2 tell the NA No I'm not going and the NA responded to Resident #2 by saying Yes you are;-One of the kitchen staff members and CNA E witnessed the altercation;-The situation happened in the dining room area at the front entrance to the facility;-Resident # 2 and the NA were in the business office manager's (BOM's) office, and he/she probably seen it happen, he/she for sure would have heard it;-NA B held Resident #2's arms and hands behind his/her back the entire way while walking him/her from the BOM's office until he/she got to the special care unit; -He/She is not sure why NA B had Resident #2 out of the special care unit because Resident #2 has a hard time going back into the unit;-Resident #2 is not normally taken out of the special care unit, so he/she is not sure why he/she was in the BOM's office;-CNA E told LPN F and the DON about the situation and the DON informed him/her that he/she would handle it;-NA B was moved out of the special care unit and CNA D was put in the unit in his/her place.4. During an interview on 02/10/26, at 6:25 P.M., the Administrator said the following:-Staff should not tell residents to be quiet;-He/She would expect staff to respect the resident's wishes;-Staff should not yell at residents or talk over them, they should talk to the residents and not talk about their personal life;-He/She would expect staff to remake a resident's bed and accommodate a resident if they were asked by the resident to remake the bed;-Staff should not ignore residents.Complaint 2735227

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure all residents had a comfortable environment when staff failed to address the mattress of one resident (Resident #4) that had a dip in which caused difficulty with position and sleeping, and contributed to the resident's pain. A sample of three residents was selected for review. The facility census was 77.Review of a facility policy titled Pain Management Policy and Procedure, with no date, showed the following information:-The purpose is to establish procedures for identifying, assessing, treating, and monitoring pain in long-term care residents, supporting individualized and effective pain management strategies while promoting safety and regulatory compliance;-Include both pharmacologic and non-pharmacologic strategies in the care plan;-Review and update the care plan regularly or as needed;-Document assessment findings, interventions, and resident response. 1. Review of Resident #4's face sheet (gives basic profile information) showed the following information:-admission date of 04/04/25;-Diagnoses included pain in right hip, generalized anxiety disorder, pain in left shoulder, age-related osteoporosis with current pathological fracture (condition that occurs when severely weakened, low-density bone breaks due to minimal trauma, such as a minor fall, bending, or coughing), insomnia (difficulty falling or staying asleep), and pain, unspecified. Review of the resident's care plan, updated 08/25/25, showed the following information:-Complains of chronic pain related to right hip;-Acknowledge to the resident that his/her pain is unique and believable;-Assess effects of pain on the resident (disturbances in sleep, activity, self-care, appetite, and psychosocial);-Monitor and record any non-verbal signs of pain (guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal);-Position for comfort with physical support as necessary.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff), dated 01/10/26, showed the following information:-Cognitively intact;-Substantial to maximal assistance for rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer;-Received scheduled pain medication;-Received as needed pain medications;-History of pain;-Pain frequency almost constantly;-Occasional sleep disturbance due to pain;-Pain interferes with day-to-day activities almost constantly;-Rates pain as 8 on a pain scale of 0 to 10;-Pain described as severe.Review of the resident's progress notes showed on 01/05/26, at 7:37 A.M., the resident was observed yelling from her room, requesting assistance from the certified nurse aide (CNA) to get in bed. During an interview on 02/06/26, at 12:26 P.M., the resident said the following:-He/She gets in the hole in his/her bed and cannot get out of it once he/she is in the hole;-He/She cannot sleep decent at night because of the hole in his/her bed;-The hole in his/her bed hurts his/her back;-They do not fix his/her bed, and they know what is going on with it because she has told several staff about it;-He/She yells because her bed feels like it is going to snap her in two, but staff keep telling him/her to be quiet;-He/She was not trying to be rude by yelling, but his/her back hurts and he/she cannot lay in the bed any longer;-The bed is not good. It has a dip in it, and it hurts his/her back.During an interview on 02/09/26, at 2:53 P.M., the resident said the following:-There is a dip in the bed itself;-The bed hurts his/her lower back bad, and he/she yells at staff to get him/her up;-The bed/mattress has hurt his/her back for several months.During an interview on 02/06/26, at 2:00 P.M., CNA C said the following:-The resident complains about his/her back hurting;-The resident does complain about his/her hips and back hurting and he/she complains of his/her mattress hurting her because of a dip in it that he/she falls into;-The resident's mattress is not a mattress that you can flip over or turning around;-There is not a physical hole in the mattress, it is a dip or crease area in the mattress;-The resident was sleeping in his/her recliner for a few nights a while back to see if it would help, but the recliner is gone now. During an interview on 02/06/26, at 1:10 P.M., the Director of Nursing (DON) said the following:-The resident slides down in his/her bed and staff keep repositioning him/her;-He/She yells out at night because he/she slips down into the (continued on next page)

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	02/10/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hole in his/her bed, but the DON thinks it is the way the resident lays in his/her bed;-The DON has not observed or inspected the resident's mattress, but other staff have;-It should be in the maintenance book if anything is wrong with his/her bed;-The mattresses are all the same, so it is probably just his/hers with the hole that dips down;-The resident should have a mattress that he/she is comfortable in and that does not hurt his/her back.During an interview on 02/10/26, at 6:25 P.M., the Administrator said the following:-He/She is not aware of the resident's bed hurting his/her back;-Staff could have changed the mattresses out if it was causing the resident pain;-He/She was not aware that the resident yelled out at night due to his/her bed hurting his/her back;-He/She would expect staff to let the nurse, DON, and/or housekeeping know if a resident has a concern with their bed.

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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 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical restraint when staff physically restrained one resident (Resident #2) while assisting him/her back to the special care unit by holding the resident's arms behind his/her back resulting in the resident being upset and crying. The facility census was 77.Review of a facility policy titled Resident Rights, undated, showed the following:-It is the intent of the facility to promote and ensure the highest standards of conduct and reliability by its employees and consultants to in turn produce environments in the facility that promote the highest standards of care and security for our residents and families we serve;-The exercise of resident rights shall be free from restraint, interference, coercion, discrimination or reprisal;-Each resident shall be free from mental and physical abuse;-Residents have the right to be free from any physical or chemical restraint except when used to treat a specified medical symptom as a part of a total program of care to assist the resident in attaining and maintaining highest practicable level of physical, mental, or psychosocial well-being;-The use of restraints must be authorized in writing by physician for a specified period of time or when necessary, in an emergency to protect the resident from injury to self or others, in which case restraints may be authorized by professional personnel so designated by the facility. The action shall be reported immediately to the resident's physician and an order obtained which shall increase reason for restraint, when restraint may be removed, type of restraint and any other action required;-When restraints are indicated, only devices that are the least restrictive for the resident and consistent with the resident's total treatment program shall be used;-Each resident shall be treated with consideration, respect a full recognition of his/her dignity and individuality. Review of the facility's Abuse Prevention Policy and Procedure Checklist,revised11/28/16, showed the following:-The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restrain not required to treat the resident's medical symptoms;-The intent of this requirement is for each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical restraints for discipline or convenience and prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity. 1.Review of Resident #2's face sheet (admission information at a glance) showed the following:-admission date of 07/14/25;-Diagnoses that included bipolar II disorder (mental health condition characterized by depressive episodes and hypomania (elevated, irritable, or energetic moods)), anxiety disorder, personality disorder, epilepsy (seizure disorder), and parkinsonism (movement symptoms such as slow movements, stiffness, walking and balance problems, and tremor). Review of the resident's care plan, revised 10/28/25, showed the following:-Socially inappropriate/disruptive behavioral symptoms as evidenced by rejecting cares at times;-Assess whether behavior endangers the resident and/or others and intervene if necessary;-Avoid over-stimulation (noise, crowding, other physically aggressive residents);-Convey an attitude of acceptance toward the resident;-Maintain a calm environment and approach to the resident;-When resident begins to become socially inappropriate/disruptive, provide comfort measures for basic needs (such as pain, hunger, toileting, too hot/cold, etc.)-Resident has difficulty understanding others related to mental health issues and intellectual disabilities;-Ask resident to repeat what has been said to confirm the message was understood;-Face the resident when speaking;-Obtain (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 0604 Level of Harm - Actual harm Residents Affected - Few	resident's attention before speaking;-Repeat phrases as needed and rephrase if necessary;-Speak clearly and adjust tone as needed;-Resident has disorganized thinking or is incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject) related to mental health problems;-Assess factors that may be associated with signs and symptoms of delirium such as time of symptom onset, change in mood, change in social situations, use of restraint;-Be calm and reassuring in approaching resident;-Orient to person, place, and time. Speak quietly, slowly, and repetitively;-Provide a quiet, well-lit, calm environment, Surround resident with familiar objects.(Staff did not care plan use related to specific physical restraint use on the resident for behaviors.) Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/20/26, showed the following:-Cognition was severely impaired;-Independent with functional abilities to move from sitting to lying down, standing, and walking. Review of the resident's progress note, dated 01/20/26, showed the following:-Resident was alert to self and knew his/her name;-Autistic and can have episodes with behaviors where he/she wants medications now, covered up now, or his/her meal tray picked up now, or he/she will throw personal belongings at times such as throwing his/her coloring papers at staff and then throwing them on the floor. The resident will come back and apologize for his/her behavior;-Able to make needs know and knows when he/she has an accident and needs staff to come;-Enjoys comic books and superheroes coloring pages and likes to watch game shows;-Up ad lib (on own) around the unit and does not make attempts to seek exiting unit. Review of the resident's physician's orders, dated 01/06/26 to 02/06/26, showed there was no physician's order for a physical restraint for behaviors. Review of the resident's progress notes showed staff did not document regarding use of a restraint when the resident returning from the business office and to the special care unit. During an interview on 02/06/26, at 2:20 P.M., Nurse Aide (NA) B said the following:-He/she was in the business office with the resident while on a call with Social Security;-When the call ended, he/she and the Business Office Manager (BOM) tried to get the resident to go back to the unit but the resident refused;-The BOM had been printing out pictures of [NAME] and the more you give the resident, the more he/she wants;-The resident had a temper tantrum and he/she escalated in the business office;-The resident got more upset and angry but this was not at the point, he/she restrained him/her;-Outside the business office, the resident began swinging his/her arms hitting him/her several time on his/her head and at that point, my training in behavioral health kicked in and took my arms, wrapped them around the resident from his/her back underneath the arms, like tucked them behind his/her mid-back and restrained him/her so he/she could not hit him/her. It upset the resident and he/she began crying;-The BOM did not tell him/her to let the resident go and was beside him/her all the way to the unit;-The resident cried the whole time;-He/she did not hurt the resident and in the unit, he/she released the resident;-He/she didn't have training here about what to do when a resident was having behaviors but had training in previous jobs;-The Director of Nursing (DON) called him/her to his/her office and was told not to do that. During interview on 02/06/26, at 1:57 P.M., Certified Nurse Aide (CNA) E said the following:-He/she witnessed the incident with the resident and NA B last week when he/she was in the dining room;-He/she observed NA B yell, Yes, you are! and NA B got behind the resident, put his/her arms (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	behind his/her back like being arrested and it raised up the resident's shoulders;-The resident cried as he/she walked with his/her hands held up behind him/her behind his/her back like being arrested;-The BOM walked beside them and he/she saw the way NA B did this to the resident;-The BOM did try to calm the resident down but it was not appropriate for staff to touch and or restrain him/her;-Back on the unit when the resident threw fits and threw stuff like his/her coloring pages at staff. They were to scoot to the side of the nurses' desk when the resident does this;-They were to let the resident settle down, take a break and then try again;-He/she talked to the DON about NA B. During an interview on 02/06/26, at 9:50 A.M., CNA D, who worked on the dementia unit, said the following:-NA B recently inappropriately restrained the resident by holding his/her arms and hands behind his/her back like he/she was being arrested;-The NA had his/her arms intertwined with the resident's arms to keep the resident's arms and hands from moving;-The resident was upset and crying;-He/She heard the resident tell the NA No I'm not going, and the NA responded to the resident by saying Yes you are;-The situation happened in the dining room area at the front entrance to the facility;-NA B held the resident's arms and hands behind his/her back the entire way while walking him/her from the BOM's office until he/she got to the special care unit;-CNA E told LPN F and the DON about the situation and the DON informed him/her that he/she would handle it. During interview on 2/9/26 at 12:00 P.M., the DON said the following:-Holding a resident's hands behind their back may or may not be considered abuse;-It depended on the intent;-Holding a resident's arms and hands behind their back would not necessarily be considered abuse if there are no marks left on the resident;-Staff saw what happened between the resident and NA B and thought it was resident abuse, so he/she spoke with LPN F, and the two of them determined that it was not abuse or restraining a resident;-The DON and LPN F ruled out abuse and neglect on their own;-He/She completed verbal counseling with NA B;-The DON did not complete an investigation of the allegation;-NA B was not written up, but he/she was informed that he/she cannot physically restrain a resident's arms and hands behind their back. During an interview on 02/18/26, at 3:43 P.M., the Facility Physician said the following:-Facility staff should not physically restrain any resident unless they are aggressive against staff, and they are exhibiting behaviors that could bring danger to their self or others;-The resident does not have a physician's order for physical restraints, but he/she does have a chemical restrain ordered for agitated behavior;-He/She felt the situation with the resident and NA B was excessive and not acceptable;-He/She considers NA B holding the resident's arm and hands behind his/her back and walking him/her from the BOM's office to the special care unit a physical restraint. During an interview on 02/06/26, at 11:35 A.M., the Administrator said the following:-An employee, NA B, had inappropriate behavior and the DON talked to him/her;-They were not to restrain the resident or put anyone's hands behind their back. They would consider it a restraint;-She would not expect NA B to use technique that Department of Corrections used. #2735227

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all allegation of possible abuse were reported to the State Survey Agency (Department of Health and Senior Services - DHSS) when staff did not report an allegation of staff to resident abuse/restraint involving one resident (Resident #2) to DHSS. The facility census was 77. Review of the facility's Abuse Prevention Policy and Procedure Checklist, revised11/28/16, showed the following:-The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms;-The intent of this requirement is for each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical restraints for discipline or convenience and prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity.1.Review of Resident #2's face sheet (admission information at a glance) showed the following:-admission date of 07/14/25;-Diagnoses that included bipolar II disorder (mental health condition characterized by depressive episodes and hypomania (elevated, irritable, or energetic moods)), anxiety disorder, personality disorder, epilepsy (seizure disorder), and parkinsonism (movement symptoms such as slow movements, stiffness, walking and balance problems, and tremor).Review of the resident's care plan, revised 10/28/25, showed the following:-Socially inappropriate/disruptive behavioral symptoms as evidenced by rejecting cares at times;-Assess whether behavior endangers the resident and/or others and intervene if necessary;-Avoid over-stimulation (noise, crowding, other physically aggressive residents);-Convey an attitude of acceptance toward the resident;-Maintain a calm environment and approach to the resident;-When resident begins to become socially inappropriate/disruptive, provide comfort measures for basic needs (such as pain, hunger, toileting, too hot/cold, etc.)-Resident has difficulty understanding others related to mental health issues and intellectual disabilities;-Ask resident to repeat what has been said to confirm the message was understood;-Face the resident when speaking;-Obtain resident's attention before speaking;-Repeat phrases as needed and rephrase if necessary;-Speak clearly and adjust tone as needed;-Resident has disorganized thinking or is incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject) related to mental health problems;-Assess factors that may be associated with signs and symptoms of delirium such as time of symptom onset, change in mood, change in social situations, use of restraint;-Be calm and reassuring in approaching resident;-Orient to person, place, and time. Speak quietly, slowly, and repetitively;-Provide a quiet, well-lit, calm environment, Surround resident with familiar objects; Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/20/26, showed the following:-Cognition was severely impaired;-Independent with functional abilities to move from sitting to lying down, standing, and walking.Review of the resident's progress note, dated 01/20/26, showed the following:-Resident was alert to self and knew his/her name;-Autistic and can have episodes with behaviors where he/she wants medications now, covered up now, or his/her meal tray picked up now, or he/she will throw personal belongings at times such as throwing his/her coloring papers at staff and then throwing them on the floor. The resident will come back and apologize for his/her behavior;-Able to make needs know and knows when he/she has an accident and needs staff to come;-Enjoys comic books and superheroes coloring pages and likes to watch game shows;-Up ad lib (on own) around the unit and does not make attempts to seek exiting unit.During an interview on 02/06/26, at 2:20 P.M., Nurse Aide (NA) B said the following:-He/she was in the business office with the resident while on a call with Social Security;-When the call ended, he/she and the Business Office Manager (BOM) tried to get the resident to go back to the unit but the (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	resident refused;-The BOM had been printing out pictures of [NAME] and the more you give the resident, the more he/she wants;-The resident had a temper tantrum and he/she escalated in the business office;-The resident got more upset and angry but this was not at the point, he/she restrained him/her;-Outside the business office, the resident began swinging his/her arms hitting him/her several time on his/her head and at that point. NA B said my training in behavioral health kicked in and took my arms, wrapped them around the resident from his/her back underneath the arms, like tucked them behind his/her mid-back and restrained him/her so he/she could not hit him/her. It upset the resident, and he/she began crying;-NA B said he/she wanted to keep him/her and everyone else safe;-The BOM did not tell him/her to let the resident go and was beside him/her all the way to the unit;-He/she was not aggressive and did not hurt the resident and in the unit, he/she released the resident;-He/she didn't have training here about what to do when a resident was having behaviors but had training in previous jobs;-The Director of Nursing (DON) called him/her to his/her office and was told not to do that and was not written up for it. During an interview on 02/06/26, at 1:57 P.M., Certified Nurse Aide (CNA) E said the following:-He/she witnessed the incident with the resident and NA B last week when he/she was in the dining room;-They should have never taken the resident out of the locked unit;-He/she observed NA B yell, Yes, you are! and NA B got behind the resident, put his/her arms behind his/her back like being arrested and it raised up the resident's shoulders;-The resident cried as he/she walked with his/her hands held up behind him/her behind his/her back like being arrested;-The BOM walked beside them and he/she saw the way NA B did this to the resident;-The BOM did try to calm the resident down but it was not appropriate for staff to touch and or restrain him/her;-He/she reported this incident to the DON about NA B and the resident. Review of the facility records showed staff did not document notification of DHSS regarding the allegation of abuse in the form of restraint use with not order, no care plan, and for staff benefit. Review of DHSS records showed the facility did not self-report the allegation of abuse in the form of restraint use with not order, no care plan, and for staff benefit.During an interview on 02/10/26, at 4:37 P.M., CNA L said the following:-Staff were to report directly to the DON of any abuse and neglect and this was to be reported to Department of Health and Senior Services (DHSS) within two hours;-This included reporting staff restraining a resident such as holding arms down or behind them or swing arms like on dementia unit. Staff should leave the resident alone a bit to calm down and then re-approach them or have another staff come to help calm the resident.During an interview on 02/10/26, at 2:40 P.M., Certified Medication Technician (CMT) N said the following:-A restraint was to hold a residents' hands, tie them down with something, put them in a wheelchair and put on the wheelchair brakes, shut their door and keep them in their room for examples;-For any allegation of abuse and neglect, even if staff physically restrain a resident, they were to report to the charge nurse and DON immediately and then report this within two hours to the state.During an interview on 02/06/26, at 10:26 A.M., Licensed Practical Nurse (LPN) F who worked on the dementia unit, said the following:-The administrator and the business office manager witnessed NA B had an incident with the resident;-The resident was upset about not getting his/her coloring pages. NA B put the resident's hands behind his/her back like handcuffs with his/her arms on each side and walked the resident to the unit;-If staff witness any abuse and/or neglect, they were to report this to the DON whether they were here in the building or not. If after hours, they were to notify the Administrator. They were to notify them within one hour and to report to the state within two hours. During interviews on 02/06/26, at 12:30 P.M., and on 02/09/26, at 12:00 P.M., the DON said the following:-The incident with the resident and NA B happened sometime last week;-CNA D and CNA E reported to him they saw the resident irate and out of control;-NA B was trying to keep the resident's hands from hitting other people in the main dining room, he could not say what residents were in the dining room;-NA B tried to hold both the resident's hands and/or arms;-The aides said NA B was restraining the resident and it looked like NA B was holding his/her arms down;-The state was not contacted regarding the allegation;-He and LPN F ruled out abuse and neglect on their own;-Abuse and neglect should be (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	reported to the DON and Administrator and then reported to the state within two hours. During interviews on 02/06/26, at 11:35 A.M., and on 02/10/26, at 6:25 P.M., the administrator said the following:-An employee, NA B, had inappropriate behavior and the DON talked to him/her;-They were not to restrain the resident or put anyone's hands behind their back. They would consider it a restraint;-For abuse/neglect, staff were to report to the DON;-The DON should have looked into it and called the state with a self-report within 2 hours; -The abuse and neglect policy included information about restraints. #2735227

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all allegation of possible abuse were investigated timely with steps to protect all residents implemented during the investigation when the facility failed to complete a full and documented investigation, including steps taken protect resident during the investigation, of an allegation of staff to resident abuse/restrain involving one resident (Resident #2}). The facility census was 77.Review of the facility's policy Abuse Prevention Policy and Procedure Checklist, revised11/28/16, showed the following:-The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms;-The intent of this requirement is for each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical restraints for discipline or convenience and prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity;-The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in progress;-Take appropriate corrective action, as a result of investigation findings. 1.Review of Resident #2's face sheet (admission information at a glance) showed the following:-Admit 7/14/25;-Diagnoses that included Bipolar II disorder (mental health condition characterized by depressive episodes and hypomania (elevated, irritable, or energetic moods), anxiety disorder, personality disorder, epilepsy (seizure disorder), parkinsonism (movement symptoms such as slow movements, stiffness, walking and balance problems, and tremor).Review of the facility's policy Abuse Prevention Policy and Procedure Checklist, revised11/28/16, showed the following:-The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms;-The intent of this requirement is for each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical restraints for discipline or convenience and prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity;-The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in progress;-Take appropriate corrective action as a result of investigation findings.1.Review of Resident #2's face sheet (admission information at a glance) showed the following:-admission date of 07/14/25;-Diagnoses that included bipolar II disorder (mental health condition characterized by depressive episodes and hypomania (elevated, irritable, or energetic moods)), anxiety disorder, personality disorder, epilepsy (seizure disorder), and parkinsonism (movement symptoms such as slow movements, stiffness, walking and balance problems, and tremor).Review of the resident's care plan, revised 10/28/25, showed the following:-Socially inappropriate/disruptive behavioral symptoms as evidenced by rejecting cares at times;-Assess whether behavior endangers the resident and/or others and intervene if necessary;-Avoid over-stimulation (noise, crowding, other physically aggressive residents);-Convey an attitude of acceptance toward the resident;-Maintain a calm environment and approach to the resident;-When resident begins to become socially inappropriate/disruptive, provide comfort measures for basic needs (such as pain, hunger, toileting, too hot/cold, etc.)-Resident has difficulty understanding others related to mental health issues and intellectual disabilities;-Ask resident to repeat what has been said to confirm the message was understood;-Face the resident when speaking;-Obtain resident's attention before speaking;-Repeat phrases as needed and rephrase if necessary;-Speak clearly and adjust tone as needed;-Resident has disorganized thinking or is incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, unpredictable switching from subject to subject) related to mental health problems;-Assess (continued on next page)

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	265123	A. Building B. Wing	02/10/2026

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	factors that may be associated with signs and symptoms of delirium such as time of symptom onset, change in mood, change in social situations, use of restraint;-Be calm and reassuring in approaching resident;-Orient to person, place, and time. Speak quietly, slowly, and repetitively;-Provide a quiet, well-lit, calm environment, Surround resident with familiar objects; Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/20/26, showed the following:-Cognition was severely impaired;-Independent with functional abilities to move from sitting to lying down, standing, and walking.Review of the resident's progress note, dated 01/20/26, showed the following:-Resident was alert to self and knew his/her name;-Autistic and can have episodes with behaviors where he/she wants medications now, covered up now, or his/her meal tray picked up now, or he/she will throw personal belongings at times such as throwing his/her coloring papers at staff and then throwing them on the floor. The resident will come back and apologize for his/her behavior;-Able to make needs know and knows when he/she has an accident and needs staff to come;-Enjoys comic books and superheroes coloring pages and likes to watch game shows;-Up ad lib (on own) around the unit and does not make attempts to seek exiting unit.During an interview on 02/06/26, at 2:20 P.M., Nurse Aide (NA) B said the following:-He/she was in the business office with the resident while on a call with Social Security;-When the call ended, he/she and the Business Office Manager (BOM) tried to get the resident to go back to the unit, but the resident refused;-The BOM had been printing out pictures of [NAME] and the more you give the resident, the more he/she wants;-The resident had a temper tantrum and he/she escalated in the business office;-The resident got more upset and angry but this was not at the point, he/she restrained him/her;-Outside the business office, the resident began swinging his/her arms hitting him/her several time on his/her head and at that point, my training in behavioral health kicked in and took my arms, wrapped them around the resident from his/her back underneath the arms, like tucked them behind his/her mid-back and restrained him/her so he/she could not hit him/her. It upset the resident and he/she began crying;-NA B wanted to keep him/her and everyone else safe;-The BOM did not tell him/her to let the resident go and was beside him/her all the way to the unit;-He/she did not the resident and in the unit, he/she released the resident;-The DON called him/her to his/her office and was told not to do that and was not written up for this.During an interview on 02/06/26, at 1:57 P.M., Certified Nurse Aide (CNA) E said the following:-He/she witnessed the incident with the resident and NA B last week when he/she was in the dining room;-They should have never taken the resident out of the locked unit;-He/she observed NA B yell, Yes, you are! and NA B got behind the resident, put his/her arms behind his/her back like being arrested and it raised up the resident's shoulders;-The resident cried as he/she walked with his/her hands held up behind him/her behind his/her back like being arrested;-The BOM walked beside them and he/she saw the way NA B did this to the resident;-The BOM did try to calm the resident down but it was not appropriate for staff to touch and or restrain him/her;-He/she reported this incident to the DON about NA B and the resident.Review of the facility records showed the facility did not provide a written investigation of the allegation of abuse/restraint. During interviews on 02/06/26, at 12:30 P.M., and 02/09/26, at 12:00 P.M., the DON said the following:-The incident with Resident #2 and NA B happened sometime last week;-No investigation was completed regarding the allegation;-He and LPN F ruled out abuse and neglect on their own.During interviews on 02/06/26, at 11:35 A.M., and on 02/10/26, at 6:25 P.M., the administrator said the following:-An employee, NA B, had inappropriate behavior and the DON talked to him/her;-For abuse/neglect, staff are to report to the DON and he should have looked into it;-Abuse and neglect policy includes information about restraints;-She would have expected the DON to do a written investigation;-It is the DON's or her responsibility to determine if it is an abuse situation. MO 2735227

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to complete timely and complete skin assessments, failed to document accurate wound assessments, failed to obtain and update orders timely, failed to follow physician orders, failed to provide treatment as ordered, and failed to care plan wounds for two residents (Resident # 1 and # 9) of three sampled residents, with a pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). The facility census was 77.x Review of the facility policy titled Wound Care and Treatment, undated, showed the following:-There must be a specific order for the treatment;-Documentation of the treatment should be done immediately after the treatment;-Staff should conduct on going skin assessments with weekly documentation of status;-The care plan should reflect the current status of the wound and appropriate goals and approaches;-The quality assurance nurse should be consulted when the following exist:-Multiple stage 2 wounds (partial thickness loss of the skin with exposed dermis, appearing as a shallow, open ulcer with a red-pink wound bed or an intact or ruptured fluid filled blister);-Stage 3 wound (full thickness tissue loss where subcutaneous fat is visible, but muscle, tendon, or bone is not exposed) or greater;-No improvement in existing wounds following two to three weeks plan of care. Review of the facility policy titled Charting and Documentation, undated, showed the following:-The purpose of the guidelines is to provide a complete account of the resident's care., treatment, response to care, signs, symptoms, as well as the resident's progress; provide guidance to the physician in prescribing appropriate medications and treatments; provide the facility with a tool for measuring the quality of care provided to the resident; provide nursing services personnel with a record of the physical and mental status of each resident; assistance in the plan of care for each resident; provide the elements of quality medical nursing care; provide a legal record that protects the resident, physician, nurse, and the facility; and provide an information source for resident changes;-Chart all pertinent changes in the resident's condition, reaction to treatments, medications, as well as routine observations;-Be concise, accurate, and complete;-Document only the facts and chart as often as necessary and as the need arises;-Document daily treatments and vital signs;-Lab work documentation should include date and time the specimens were obtained;name of the person; date and time specimens were forwarded to the lab; date and time the results were obtained; and date and time the physician was notified of the lab results;-Refusal of treatment documentation should include date and time treatment was attempted; treatment attempted; resident's response and reason for the refusal; name of person attempting to administer treatment; and documentation that the resident was informed of the purpose of the treatment and the consequences of not receiving the care;-Document each time the resident refuses treatment, the resident condition, and any adverse effects due to the refusal; date and time the physician was notified as well as the physician response;-Skin lesion documentation should include specific location of the skin problem and number, size, degree, and measurement of pressure sores; any changes in the resident's condition or response to treatment; date of occurrence of a skin problem and date the problem was solved; progress, deterioration, or the development of new problems; use of special creams, lotions, medications, or devices; and the cause of any wound; -Miscellaneous documentation should include any time the physician or family is called as well as their response and each time a physician visits a resident. 1. Review of Resident #1's face sheet (document that gives resident's information at a quick glance) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed the following:-admission date of 10/16/25;-Diagnoses included high blood pressure, depression, and generalized edema (widespread fluid accumulation in the body's tissues). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/22/26, showed the following:-Cognitively intact;-Resident had impairment to one side of the upper and lower extremities;-Required substantial assistance with dressing, showers, and toileting;-Resident at risk for pressure ulcer development;-Resident did not have any unhealed pressure ulcers;-Resident dependent on staff for bed mobility, and transfers. Review of the resident's care plan, revised 01/27/26, showed the following:-Resident had fragile skin related to age and medications;-Staff will monitor skin during cares and anytime skin is exposed;-Skin assessments to be done weekly by the nurse;-Nurse will monitor for signs and symptoms of infection and report to the physician as needed;-Resident required one to two staff assistance with activities of daily living (ADL – fundamental self-care tasks such as hygiene, dressing, eating, toileting, and mobility) and cares.(Staff did not care plan related to wounds or wound care.) Review of the resident's admission assessment, dated 10/16/25, showed the resident had areas of dark hard eschar (thick, dry, black or brown layer of dead tissue that forms over severe pressure ulcers) to the left heel. Review of the resident's initial wound assessment, dated 10/16/25, showed the following:-Resident had black, hard eschar on the left heel and a reddened buttock that was present on admission;-No drainage or odor noted;-Interventions to include pressure reducing device for bed, turning and repositioning, and heel protectors; -No change in treatment;-Physician notified. Review of the resident's nursing progress note, dated 10/17/25, showed the resident admitted on [DATE] with dark hard eschar on the left heel measuring 2 centimeters (cm) x 2 cm. Review of the resident's October 2025 Physician Order Sheet (POS) showed an order, dated 10/16/25, for Desitin (barrier cream) paste, apply twice daily and as needed to buttock and coccyx (tail bone) for a diagnosis of pain. (Staff did not document orders for treatment of identified area on the resident's heel.) Review of the resident's weekly skin assessment, dated 10/23/25, showed skin was intact with no issues. The right and left foot had no issues and treatment marked as not applicable. Review of the resident's nurse practitioner visit note, dated 10/23/25, showed the following:-Resident had a left heel wound with dry eschar without redness around site;-Right posterior thigh had a superficial linear open area with no drainage and possibly from the resident's brief;-See nursing wound documentation for measurements;-Diagnosis for this visit was pressure injury of the left heel, unstageable (full thickness skin loss where the base is completely covered by eschar);-Plan is to apply barrier paste to open area on the right posterior thigh three times daily and as needed, outside facility wound care consult, and heel protectors on always in bed. Review of the resident's medical record showed staff did not document a weekly skin assessment documented for 10/30/25. Review of resident's medical record showed staff did not document additional wound assessments (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for October 2025. Review of the resident's October 2025 nursing progress notes showed staff did not complete additional documentation related to the resident's left heel. Review of the resident's nursing progress note, dated 11/04/25, showed the resident said staff were not turning him/her and getting him/her off his/her bottom due to the sores on the bottom. He/she said that the staff are not changing his/her bandages on the wound like they are supposed to be doing. Review of the resident's medical record showed staff did not document a weekly skin assessment for 11/06/25. Review of the resident's nurse practitioner visit note, dated 11/06/25, showed the following:-Resident had a left heel wound with dry eschar without redness around site;-Coccyx did not have an open area;-Left buttock had an open superficial wound with a pink, moist wound bed and no sign of infection;-See nursing wound documentation for measurements;-Plan for wound care company to see resident for buttock wounds, low air loss mattress, and clean left buttock and coccyx wound with wound cleanser and cover with foam dressing daily. Review of the resident's nursing progress note, dated 11/07/25, showed the nurse practitioner visited resident on 11/06/25 and emailed orders for a low air loss bed, outside facility wound care consult, and treatment order for left buttock and coccyx wound. Review of the resident November 2025 POS showed the following:-An order, dated 10/16/25, for Desitin paste, apply twice daily and as needed to buttock and coccyx for a diagnosis of pain;-An order, dated 11/07/25, for the left buttock and coccyx wound to be cleansed with wound cleanser and covered with foam dressing daily;-An order, dated 11/07/25, for a low air loss bed;-An order, dated 11/07/25, for wound care consult to evaluate and treat buttock wounds. Review of the resident's November 2025 TAR showed the following:-An order, dated 11/07/25, for the left buttock & coccyx wound to be cleansed with wound cleanser daily and cover with foam dressing completed as ordered except on the following dates:-On 11/09/25, staff noted administered due to no time;-On 11/23/25, staff noted not administered due to not done on this shift. Review of a nursing progress note dated 11/10/25, showed the resident's low air low mattress came arrived. Review of the resident's weekly skin assessment, dated 11/13/25, showed skin was intact with no issues. The right and left foot had no issues and treatment marked as not applicable. Review of the resident's monthly resident summary, dated 11/15/25, showed general skin condition was good. (The summary did not mention wound to coccyx/left buttocks or left heel.) Review of the resident's weekly skin assessment, dated 11/20/25, showed skin was intact with no issues. The right and left foot had no issues and treatment marked as not applicable. Review of the resident's weekly skin assessment, dated 11/27/25, showed resident had an existing non-foot skin issue. The right and left foot had no issues. Treatment in place and effective. (Staff did (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not document related to the location or details of an existing skin issues.) Review of resident's medical record showed staff did not document wound assessments for November 2025. Review the resident's November 2025 nursing progress notes showed staff did not document further progress notes related to the left heel or coccyx/left buttock wound. Review of the resident's wound care company note, dated 12/02/25, showed the following:-Wound to the coccyx had improved and was measuring smaller with less drainage. Will continue same treatment of calcium alginate (highly absorbent dressing), border foam, and change every other day. (The facility did not have an order for wound care to the coccyx indicating calcium alginate was being used.); -The coccyx wound measured 8.9 cm by 8.3 cm. Wound indicated to be a stage 2 pressure ulcer. Wound care orders indicated as cleanse with hypochlorous acid (a cleanser that is used in wound care to fight infections), irrigate and scrub the wound bed, protect peri wound area with skin protectant, apply calcium alginate to wound base, and cover with a bordered foam dressing every other day and as needed.(The wound care company did not address the resident's left heel wound.) Review of the resident's December 2025 showed staff did not document additional nursing progress related to the left heel or coccyx/left buttock wound. Review of the resident's wound care company note, dated 12/09/25, showed the following:-Wound to coccyx improved and skin was now intact;-Staff should continue using foam dressing as a protectant;-Wound resolved. Review of the resident's nursing readmission note, dated 12/20/25, showed the resident had a left heel pressure area covered by eschar. Review of the resident's POS showed the following orders for December 2025:-An order, dated 12/30/25, to cleanse the left heel with wound cleanser and pat dry, and apply Thera honey (wound dressing), and dressing every other day;-An order, dated 12/30/25, to cleanse the right heel with wound cleanser and pat dry. Apply skin prep to heel and cover with dressing every 3 days. Review of the resident's December 2025 TAR showed on 12/30/25 and 12/31/25, staff did not complete the ordered treatment to left and right heel on 12/30/25 or 12/31/25. Review of the resident's January 2026 POS showed the following;-An order dated, 11/07/25, for the left buttock and coccyx wound, cleanse with wound cleanser, and cover with foam dressing daily. The order was discontinued on 01/23/26;-An order, dated 12/30/25, to cleanse the left heel with wound cleanser and pat dry. Apply Thera honey and dressing every other day;-An order, dated 12/30/25, to cleanse the right heel with wound cleanser and pat dry. Apply skin prep to heel and cover with dressing every 3 days. The order was discontinued on 01/26/26. Review of a dietician note, dated 01/12/26, showed staff reported the resident had a pressure ulcer on the left heel. Review of the resident's progress notes, dated January 2026, showed staff did not document regarding left heel wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nursing progress note, dated 02/03/26, showed the wound care company saw resident and completed wound treatments. Wound care company nurse reported left heel debrided (remove damaged tissue) and to continue current treatment. He/she also drained the large blood blister from foot. Treatment to right ball of foot was to cleanse with wound cleanser, pat dry, and apply Thera honey and dressing every other day. Review of the resident's wound care company progress note, dated 02/03/26, showed the following:-Initial visit for wounds on both feet;-Nurse said wound to left heel had been there for several weeks and was stable eschar;-Left foot pressure wound unstageable and measured 3 cm by 3.4 cm by 0.1 cm;-Treatment orders indicated to cleanse the left foot with hypochlorous acid and protect the peri wound area with skin prep. Place calcium alginate in the wound bed and fill wound with Medi honey. Cover with a bordered foam dressing every other day and apply a Tubi grip (compression stocking) to left extremity;-Wound to right sole appeared over the weekend;-Right foot wound appeared to be a blood blister that had opened and measured 4.1 cm by 4.2 cm by 0.2 cm;-Right foot wound was a stage 3 pressure ulcer;-Treatment orders indicated as cleanse with hypochlorous acid and protect the peri wound area with skin prep. Place calcium alginate in the wound bed and cover with a bordered foam dressing every other day and apply Tubi grip to right extremity. Review of a February 2026 POS showed the following: -An order dated 12/30/25, to cleanse the left heel with wound cleanser and pat dry. Apply Thera honey and dressing every other day (order not updated to current order 02/03/26 to include calcium alginate and Tubi grip);-An order dated 02/03/26, to cleanse the right ball of the foot with wound cleanser and pat dry. Apply Thera honey and dressing every other day. (Order did not include skin protectant or Tubi grips and Medi honey not indicated in new order) Review of the resident's nursing progress note, dated 02/04/26, showed the wound care company at facility and debrided the left heel. Right foot at ball had a large blood blister which was drained. Nurse completed wound care today and the measurements for the left heel were 3 cm by 3 cm by 0.5 cm with no signs of infection or drainage. Right ball of foot measured 5 cm by 3 cm with no depth, drainage, or sign of infection noted. During an interview on 02/05/26, at 10:36 A.M. Licensed Practical Nurse (LPN) J said the following:-The resident had a wound on the resident's right foot that measured 5 cm by 3 cm wide which had been a blood blister;-On the resident's left heel, wound care plus debrided and this measured 3 cm by 3cm by 0.5 cm;-They did a treatment every other day on the left heel;-The resident was on a bariatric bed (for larger, heavier residents) with air loss mattress;-They try to to keep an eye on these wounds;-They do weekly skin assessments. During interview on 02/09/26, at 11:10 A.M., Nurse Aide (NA) B said the following:-He/she went to assist LPN J to do wound dressing changes on the resident;-On the ball of the resident's left heel, the date on the bandage was 01/13/26, 13 days before that day;-The wound care company came in soon after to see the resident. During interview on 02/06/26, at 1:25 P.M., the Director of Nursing (DON) said the following:-The physician sees the resident and his/her notes were sent to them and they scan them into the electronic medical record. The wound care company came weekly and dressing changes were done as ordered and prescribed by the charge nurses;-They do keep soft boots on the resident's feet and sometimes the resident kicks them off;-He was not aware of a problem with wound care supplies. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/10/26, at 12:38 P.M., the wound care company nurse practitioner said the following:-He/she started seeing the resident last week for a left heel wound and a right sole of the foot blister;-The staff told her the left heel blister had been there for several months;-The staff were applying skin protectant to the left heel which was covered in dry eschar;-The blister to the right sole of the foot was approximately 4 cm by 4 cm;-Both wounds were debrided on the initial visit. 2. Review of Resident #9's face sheet showed the following:-admission date of 09/11/25;-Diagnoses included pressure induced deep tissue damage of sacral region (localized injury to skin and underlying soft tissue caused by prolonged pressure over tailbone), diabetes mellitus (metabolic disorder characterized by high blood sugar due to the body's inability to produce insulin), and high blood pressure. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Resident had one stage 2 pressure ulcers, 3 stage 3 pressure ulcers, and one unstageable pressure ulcer;-Resident dependent with showers, toileting, and transfers Review of the resident's care plan, revised 09/25/25, showed the following:-Resident had thin and fragile kin due to age and medications;-Resident had pain related to wounds;-Resident dependent on staff for activities of daily living (ADL). Review of the resident's current POS showed the following orders:-An order, dated 09/11/25, to cleanse buttock wound with wound cleanser and apply Santyl to wound bed, apply wet dry dressing, and secure with tape twice daily;-An order, dated 09/22/25, for wound care company to evaluate and treat buttocks wound, left great toe, and right heel ulcer;-An order, dated 09/22/25, to clean left heel ulcer with wound wash and skin prep daily;-An order, dated 09/23/25, for magnetic resonance imaging (MRI) of sacrum/coccyx to rule out osteomyelitis (infection of the bone);-An order, dated 11/07/25, for a low air loss mattress;-An order, dated 12/06/25, to cleanse the left lower extremity with wound cleanser and apply Santyl to wound bed, apply wet to dry dressing, and secure with tape, change twice daily. Review of the resident's wound care company progress note, dated 12/02/25, showed the following:-Wound to sacrum improved this week measuring smaller with less drainage;-Sacrum wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Sacrum was a stage 3 pressure ulcer that measured 7.6 cm by 4.1 cm with a large amount of serosanguineous (thin, watery pink to light red fluid) drainage;-Left heel wound deteriorated and measured larger with nonviable tissue present;-Incorrect dressing on left heel upon arrival, resident had calcium alginate and Tegaderm on;-Left heel was an unstageable deep tissue injury and measured 1.9 cm by 1.5 cm with moderate serosanguinous drainage;-Left heel wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Left calf was a stage 3 pressure wound and measured 5 cm by 2.1 cm by 0.2 cm with large amount of serosanguinous drainage;-Left calf wound had improved from previous week;-Left calf wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Right foot had incorrect dressing of calcium alginate upon arrival;-Right foot was a stage 3 pressure ulcer and measured 2.1 cm by 2.7 cm by 0.9 cm and had moderate serosanguineous drainage;-Right foot wound had deteriorated since last week visit;-Right foot wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue and cover with a bordered gauze dressing and change daily. (continued on next page)

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	265123	A. Building B. Wing	02/10/2026

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's December POS showed staff did not update the physician orders to reflect the wound care orders from wound care company. Review of the resident's weekly skin assessment, dated 12/04/25, showed the resident had a left foot/ankle issue with treatment in place. Resident had treatment to the buttocks and had an area to lower extremity. Staff noted treatment effective Review of a wound care company progress note dated 12/09/25 showed the following:-All wounds had incorrect treatment;-Facility was using a wet to dry dressing instead of calcium alginate or hydrofera blue;-Wound to sacrum had deteriorated this week measuring larger;-Sacrum wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Sacrum was a stage 3 pressure ulcer that measured 8 cm by 4.6 cm by 0.8 cm with a large amount of serosanguineous drainage;-Left heel wound improved from previous visit-Left heel was an unstageable deep tissue injury and measured 1.2 cm by 1.3 cm with moderate serosanguinous drainage;-Left heel wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Left calf wound improved from previous visit;-Left calf wound is stage 3 pressure ulcer that measured 5.4 cm by 1.7 cm by 0.7 cm with large amount of serosanguinous drainage;-Left calf wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Right foot was a stage 3 pressure ulcer and measured 1.8 cm by 1.6 cm by 0.6 cm and had moderate serosanguineous drainage;-Right foot wound had improved since last week visit;-Right foot wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a bordered gauze dressing and change daily. Review of the resident's December POS showed staff did not update the physician orders to reflect the wound care orders from wound care company. Review showed the facility did not a skin assessment for 12/11/25. Review the resident's December 2025 TAR showed the following:-On 12/14/25, staff did not document completion of the ordered treatment to the buttock, the left heel, and lower left extremity; -On 12/12/25, staff document treatment to lower left extremity not completed due to running out of time. Review of the resident's nursing progress note, dated 12/14/25, showed the resident had a couple pressure areas on the left outer side of his/her foot that were not open with boot in place. Wound care company in this day and did wound care. Review of the resident's nursing progress note, dated 12/15/25, showed the resident had a couple pressure areas on the left outer side of his/her foot that were not open with boot in place. Wound care company in this day and did wound care. Review of the resident's wound care company progress note, dated 12/16/25, showed the following:-Wound to sacrum had improved this week;-Sacrum wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Sacrum was a stage 3 pressure ulcer that measured 7.6 cm by 3.7 cm by 0.9 cm with a large amount of serosanguineous drainage;-Left heel wound improved from previous visit-Left heel was an unstageable deep tissue injury and measured 1.7 cm by 1.1 cm with (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moderate serosanguinous drainage;-Left heel wound care will change to cleanse wound with hypochlorous acid, apply hydrogel and then apply hydrofera blue,and cover with a super absorbent pad, wrap with kerlix and change daily;-Left calf wound improved from previous visit;-Left calf wound is stage 3 pressure ulcer that measured 6.1 cm by 2 cm by 0.3 cm with large amount of serosanguinous drainage;-Left calf wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Right foot was a stage 3 pressure ulcer and measured 1.6 cm by 1.8 cm and had moderate serosanguineous drainage;-Right foot wound had deteriorated since last week visit;-Right foot wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a bordered gauze dressing and change daily; Review of the resident's December 2025 POS showed staff did not update the orders to reflect the orders from the wound care company orders. Review of the resident's nursing progress note, dated 12/17/25, showed the resident had a couple pressure areas on the left outer side of his/her foot that were not open with boot in place. Review of the resident's weekly skin assessment, dated 12/18/25, showed resident had a right foot/ankle issue with treatment in place and an existing non-foot skin issue. Review of the resident's wound care company progress note, dated 12/23/25, showed the following:-Wound to sacrum had improved this week;-Sacrum wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Sacrum was a stage 3 pressure ulcer that measured 7.2 cm by 3.7 cm by 1.2 cm with a large amount of serosanguineous drainage;-Left heel wound improved from previous visit-Left heel was an unstageable deep tissue injury and measured 1.1 cm by 0.9 cm with moderate serosanguinous drainage;-Left heel wound care will continue to cleanse wound with hypochlorous acid, apply hydrogel and then apply hydrofera blue, and cover with a super absorbent pad, wrap with kerlix and change daily;-Left calf wound improved from previous visit;-Left calf wound is stage 3 pressure ulcer that measured 3.1 cm by 2.2 cm with large amount of serosanguinous drainage;-Left calf wound care will change treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad, wrap with kerlix, and change daily;-Right foot was a stage 3 pressure ulcer and measured 1.8 cm by 1.9 cm and had moderate serosanguineous drainage;-Right foot wound had deteriorated since last week visit;-Right foot wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a bordered gauze dressing and change daily. Review of the resident's weekly skin assessment, dated 12/25/25, showed resident had an existing non foot skin issue and no issues with right and left feet or ankles. Treatment in place and effective. Review of the resident's wound care company progress note, dated 12/30/25, showed the following:-Wound to sacrum had improved this week;-Sacrum wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Sacrum was a stage 3 pressure ulcer that measured 5.6 cm by 4.5 cm by 0.8 cm with a large amount of serosanguineous drainage;-Left heel wound improved from previous visit-Left heel was an unstageable deep tissue injury and measured 0.9 cm by 0.8 cm with moderate serosanguinous drainage;-Left heel wound care will continue to cleanse wound with hypochlorous acid, apply hydrogel and then apply hydrofera blue, and cover with a super absorbent pad, wrap with kerlix and change daily;-Left calf wound improved from previous visit;-Left calf wound (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is stage 3 pressure ulcer that measured 1.6 cm by 1.0 cm with large amount of serosanguinous drainage;-Left calf wound care will change treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad, wrap with kerlix, and change daily;-Right foot was a stage 3 pressure ulcer and measured 2.0 cm by 1.3 cm and had moderate serosanguineous drainage;-Right foot wound had deteriorated since last week visit;-Right foot wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a bordered gauze dressing and change daily. Review of the resident's December 2025 notes showed staff did not document additional information regarding the resident's wounds. Review of the resident's January 2026 POS showed the following:-An order, dated 09/11/25, to cleanse buttock wound with wound cleanser and apply Santyl to wound bed, apply wet dry dressing, and secure with tape twice daily;-An order, dated 01/31/26, to cleanse the buttock wound with wound cleanser and apply moistened hydrofera blue (foam dressing infused with medication) to wound bed, apply wet to dry dressing, and secure with tape, change twice daily;-An order, dated 12/06/25, to cleanse the left lower extremity with wound cleanser and apply Santyl to wound bed, apply wet to dry dressing and secure with tape, change twice daily;-An order, dated 01/31/26, to cleanse the left lower extremity wound with wound cleanser and apply moistened hydrofera blue to wound bed, apply wet to dry dressing and secure with tape, change twice daily;-An order, dated 02/06/26, to cleanse the right lateral foot with wound cleanser and apply moistened hydrofera blue to wound bed, apply wet to dry dressing and secure with tape, change twice daily. (The POS did not reflect the most recent wound company treatment orders.) Review of the resident's wound care company progress note, dated 01/06/26,showed the following:-Wound to sacrum had improved this week;-Sacrum wound care will continue same treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad and change daily;-Sacrum was a stage 3 pressure ulcer that measured 2.0 cm by 6.2 cm by 1.0 cm with a large amount of serosanguineous drainage;-Left heel wound improved from previous visit-Left heel was an unstageable deep tissue injury and measured 0.4 cm by 0.4 cm with moderate serosanguinous drainage;-Left heel wound care will continue to cleanse wound with hypochlorous acid, apply hydrogel and then apply hydrofera blue, and cover with a super absorbent pad, wrap with kerlix and change daily;-Left calf wound improved from previous visit;-Left calf wound is stage 3 pressure ulcer that measured 6.1 cm by 1.9 cm with large amount of serosanguinous drainage;-Left calf wound care will continue treatment to cleanse wound with hypochlorous acid, apply hydrofera blue, and cover with a super absorbent pad, wrap with kerlix, and change daily;-Right foot was a stage 3 pressure ulcer and measured 1.3 cm by 1.6 cm and had moderate serosanguineous drainage;-Right foot wound had deteriorated since last week visit;-Right foot wound care will continue same treat