

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Lebanon North Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 596 Morton Road Lebanon, MO 65536	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on observation, record review, and interview, the facility failed to ensure a Notice of Medicare Non-Coverage (NOMNOC) notification was provided timely for two residents (Residents #49 and #270) of three residents reviewed for beneficiary notification out of a total sample of 24 residents.</p> <p>1. Review of Resident #49's Admission Record, located in the Profile tab of the electronic medical record (EMR), showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included foot drop right foot.</p> <p>Review of the resident's SNF Beneficiary Notification Review, form showed Medicare Part A skilled services start date was 03/01/24 and the last day covered was 03/16/24.</p> <p>Review of the resident's medical record showed staff did not have documentation of a NOMNOC or ABN (Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage - Form if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. It is the facility ' s responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services) notification provided prior to the last date of services.</p> <p>During an interview on 05/23/24, at 3:35 P.M., the resident said he/she was receiving some therapy services in March, but it was only for a very a very short period. The facility did not discuss when his/her skilled therapy services would end or that he/she had any option to appeal when his/her services ended. He/she said he/she had a torn rotator cuff in his/her left arm and due to this transferring with a Hoyer lift causes significant pain and discomfort. If he/she could have continued therapy services his/her bed mobility may have improved, which may have enabled him/her to transfer in and out of bed with less assistance and he/she could get up and out of bed more often. He/she would have appealed the decision had he/she been provided with the opportunity to do so.</p> <p>2. Review of Resident #270's Admission Record, located in the Profile tab of the EMR, showed the following:</p> <p>-admitted [DATE];</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included muscle weakness.</p> <p>Review of the resident's SNF Beneficiary Notification Review, form showed Medicare Part A skilled services start date was 12/08/23 and the last day covered was 12/13/23.</p> <p>Review of the resident's medical record showed staff did not have documentation of a NOMNOC or ABN notification provided prior to the last date of services.</p> <p>3. During an interview on 05/23/24, at 2:22 P.M., the Business Office Manager (BOM) said their corporate office's clinical intake issued an email with a resident's NOMNOC to her along with the Administrator, Social Services Director, and Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) Coordinator. No staff were aware they had to also provide an ABN form. The BOM said she was not aware when an ABN needed to be completed and provided to the residents.</p> <p>4. During an interview on 05/23/24, at 2:22 P.M., the Administrator said she was not aware of the ABN process and that all NOMNOC forms came from their corporate office.</p> <p>5. During an interview on 05/23/24, at 2:30 P.M. the Social Services Director said she received an email from their corporate office with a resident's NOMNOC form. She said there was a meeting every Thursday and they discussed which residents were coming off skilled services, but there was not an internal system to track residents being discharged from Part A to ensure a NOMNOC was provided timely. She did not know why she did not issue one for either resident that it was an oversight since she did not get an email.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on observation, record review, and interview, the facility failed to ensure a significant change assessment was completed within 14 days for one resident (Resident #33) out of two residents reviewed for hospice out of a total sample of 24 residents.</p> <p>Review of the Resident Assessment Instrument (RAI) Manual, dated October 2023, showed the following:</p> <ul style="list-style-type: none"> -A Significant Change in Status Assessments (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program or changes hospice providers and remains a resident at the nursing home; -The ARD must be within 14 days from the effective date of the hospice election. <p>1. Review of Resident #33's Admission Record, located in the Profile tab of the electronic medical record (EMR), showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included unspecified dementia. <p>Review of the resident's Physician Orders, located under the Orders tab in the EMR, dated 08/29/23, showed the resident was admitted to hospice services.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 02/22/24, showed the resident had moderate cognitive impairment. The MDS did not reflect hospice services received.</p> <p>Review of the resident's Care Plan, located under the Care Plan tab of the EMR, dated 05/20/24, showed the resident had chosen to be hospice.</p> <p>During an interview on 05/23/24, at 9:22 A.M., the MDS Coordinator said when a resident went on or off hospice services a significant change assessment would need to be completed. The resident was discharged on [DATE] and then readmitted . She completed a significant change on 08/24/23 in relation to that episode, but she missed completing one for hospice. The MDS Coordinator verified that a significant change assessment should have been completed for hospice.</p> <p>During an interview 05/23/24, at 1:14 P.M., the Director of Nursing (DON) said she expected that when there was a significant change in a resident's condition that a significant change assessment should be completed within the appropriate time frame.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>07246</p> <p>Based on record review and interviews, the facility failed to refer a Pre-Admission Screening and Resident Review (PASSAR) resident who had a negative Level I Preadmission Screen, who was later identified with a new mental disorder diagnosis to the appropriate state designated authority for a Level II PASARR evaluation and determination for one resident (Resident #61) of five residents reviewed for PASARR of 24 sample residents. This failure had the potential to negatively affect the resident's mental and psychosocial well-being.</p> <p>Review showed the facility did not provide a policy related to PASARR screening/process.</p> <p>1. Review of Resident #61's Face Sheet, undated, located in the electronic medical record (EMR) under the profile tab showed the resident was diagnosed with anxiety disorder on 11/22/23, major depressive disorder on 07/11/24, and with bipolar disorder on 07/23/24.</p> <p>Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), with an Assessment Reference Date (ARD) of 02/16/24, showed the resident had moderately impaired cognition.</p> <p>Review of the resident's EMR showed a PASARR with a referral completed date of 02/13/23 which indicated under Section D Level 1 Screening Criteria for Serious Mental Illness, under items 1, 2, and 3, the resident did not have any signs, symptoms, current, suspected, or history of a major mental illness.</p> <p>During an interview on 05/22/24, at 3:40 P.M., the Social Worker confirmed that the resident's PASARR Level 1 screen had been completed on 02/13/24, at which time the resident was not triggered for a current, suspected, or history of a major mental illness. The Social Worker said she was unaware of the resident's change in diagnosis and verified that the resident had not been screened for a PASARR level II. The Social Worker said the regulating authority Missouri Health and Senior Services had not been notified to ensure a PASARR re-screening was to be completed.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917</p> <p>Based on observation, record review, and interviews, the facility failed to provide an ongoing group or individual activity program to support the physical, mental, and psychosocial well-being of three residents (Resident #15, #32, and #44) of five sampled residents residing on the secure unit.</p> <p>Review of the Facility Activity/Recreational Therapy Manual, dated March 2012, provided by the Administrator, showed the following:</p> <ul style="list-style-type: none"> -The policy and procedures for the activity program was to plan, organize, and carry out a program of activities to meet individual psychological, social and spiritual needs of each resident; -Individualized program of activity would be implemented for residents unable to participate in or attend activities; -Progress notes should include a resident's response to an activity as active or passive, and the extent of the activity involvement for each resident; -Resident participation should be documented on a daily basis to monitor a resident's attendance, participation, refusal and level of participation that would be utilized to determine changes that may or may not need to be made to the resident's individual activity program through the care plan process. <p>1. Review of Resident #15's electronic medical record (EMR) titled Admission Record, located under the Profile tab, showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), anxiety disorder, persistent mood, major depressive disorder, and Alzheimer's disease. <p>Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) annual assessment, located in the Resident Assessment Instrument (RAI) tab of the EMR, with an assessment reference date (ARD) of 08/01/23, showed the following:</p> <ul style="list-style-type: none"> -The resident was the primary respondent for his/her daily and activity preferences; -Daily activity preferences for reading books and magazines, listening to music, interacting with animals and pets, group activities with other residents, and going outside were all somewhat important, but indicated it was not important to her to attend religious services. <p>Review of the resident's admission MDS, located in the RAI tab of the EMR, with an ARD of 05/20/24, showed resident was severely cognitively impaired.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Care Plan, located under the Care Plan tab in the EMR, dated 05/20/24, showed the following:</p> <ul style="list-style-type: none"> -It was important to draw on the resident's previous experiences and knowledge. (Staff did not document any previous experiences or knowledge.); -The resident liked to attend cooking classes, crafts, and pretty nails; -The Activity Director (AD) would discuss the strengths and positive aspects of the resident. (The AD did not document the resident's strengths and positive aspects that were discussed or identified.) <p>Review of the resident's monthly activity progress notes, located in the EMR progress notes tab, dated 03/12/24, 04/05/24, and 05/08/24, by the AD, showed the resident would occasionally participate in facility activities and enjoyed watching movies, church services, holiday parties, pretty nails, and bingo.</p> <p>Review of the resident's attendance logs, provided by the AD, showed the resident refused all activities scheduled on the activity calendar for March 2024, April 2024, and May 2024. Staff did not document alternate approaches or interventions, or one-to-one activities were offered to meet the cognitive and psychosocial needs of the resident.</p> <p>Observations on 05/21/24, at 12:55 P.M., showed the resident appeared alert and personable when asked how he/she was doing. The resident appeared happy to engage in conversation with staff, but consistently asked, where do I go, what do I do. Staff members were observed redirecting the resident to his/her room and to the television (TV) room. Certified Nursing Assistant (CNA)1 was observed offering the resident a cup of coffee. The resident appeared happy and said he/she loved to drink coffee.</p> <p>2. Review of Resident #32's EMR titled, Admission Record, located under the Profile tab, showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included restlessness and agitation, major depressive disorder, moderate dementia, mood disturbance, and anxiety. <p>Review of the resident's admission MDS, located in the RAI tab of the EMR, with an ARD of 04/29/24, showed the following:</p> <ul style="list-style-type: none"> -Severely cognitively impaired; -Resident's daily activity preferences for reading books and magazines, listening to music, interacting with animals and pets, group activities with other residents, and going outside were all somewhat important, but indicated it was not important to her to attend religious services. <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Care Plan, located under the Care Plan tab in the EMR, dated 05/20/24, showed the resident had a history of depression and would benefit from engaging in activities with staff and residents with an approach to assist him/her to out-of-room activities and one-to-one social interactions.</p> <p>Review of the the resident's monthly activity progress notes, located in the EMR's progress notes tab, dated 03/14/24, 04/30/24, and 05/07/24, documented by the AD, showed the resident likes to visit with family and friends, participate in pretty nails, church services, and facility holiday parties and will mostly do one-on-one activities.</p> <p>Review of the resident's Attendance Logs, provided by the AD, showed the resident refused all activities scheduled on the activity calendar for March 2024, April 2024, and May 2024. Staff did not document alternate approaches or interventions, or one-to-one activities offered to meet the cognitive and psychosocial needs of the resident.</p> <p>Observation on 05/20/24, at 11:17 A.M., showed the resident sat in his/her wheelchair in the TV room. He/she appeared clean and comfortable, but could not be interviewed.</p> <p>Observation on 05/21/24, at 1:24 P.M., showed the resident sat in his/her room alone. He/She appeared to be clean and comfortable.</p> <p>3. Review of Resident #44's EMR titled, Admission Record located under the Profile tab, showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included senile degeneration of the brain, anxiety disorder, altered mental status, major depressive disorder, bipolar disorder, and dementia.</p> <p>Review of the resident's admission MDS, located in the RAI tab of the EMR, with an ARD of 05/24/23, showed the following:</p> <p>-Severely cognitively impaired;</p> <p>-Daily activity preferences for singing and doing things with groups of people.</p> <p>Review of the resident's Care Plan, located under the Care Plan tab in the EMR, dated 02/21/24, showed the resident had a history of depression and would benefit from engaging in singing activities with staff and residents with an approach to assist him/her to out of room activities and one-to-one social interactions with those that have shared interests.</p> <p>Review of the resident's monthly activity progress notes located in the EMR, progress notes tab, dated 03/06/24 and 04/05/24, by the AD, showed the resident enjoyed singing, listening to music, watching tv, coloring, and participating in facility parties.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Attendance Logs, provided by the AD, showed the resident refused all activities scheduled on the activity calendar for March 2024, April 2024, and May 2024. Staff did not document alternate approaches or interventions, or one-to-one activities were offered to meet the cognitive and psychosocial needs of the resident.</p> <p>Observation on 05/21/24, at 1:03 P.M., showed the resident sat in a recliner in the day room on the secure unit. He/She made comments that could not be understood, but spoke with an angry tone of voice</p> <p>4. During an interview on 05/23/24, at 10:39 A.M., Activity Assistant (AA) said for activities with the residents, he/she helps pass food trays for breakfast every morning and talks to the residents while helping with their meals. He/She stated that the R on the attendance sheets was to indicate the resident refused all activities for the day. Sometimes, he/she will bring a resident from the unit to the activity room for nail polishing. He/She does not document or write notes to indicate which activity a resident refused. When asked what other interventions were done to try to engage a resident for psychosocial stimulation, the AA said he/she does not know any other things to do. Sometimes he/she documented 1-1 on a resident's attendance sheet, but does not document the content of the one-to-one interaction. He/she stated that usually his/her one-to-one activity is visiting and talking to the resident at breakfast.</p> <p>5. During an interview on 05/23/24, at 10:44 A.M., CNA1 said the secure unit does not offer any group or individual activities and a resident must leave the secure unit if they want to attend a scheduled activity. Some of the ladies residing on the secure unit will sit in front of the TV, but usually doze off.</p> <p>6. During an interview on 05/23/24, at 10:54 A.M., Certified Nursing Assistant/Restorative Nurse Aide (CNA/RNA) 1 said the secure unit does not offer group or individual activities to the residents. Some of the residents like to leave the unit to play bingo or go to church. A resident with confusion or Alzheimer/dementia like characteristics, will almost always say no if he/she is asked a direct question. If he/she approaches a resident with excitement about an activity or shower, and says to the resident come on, it is time to go shower or go to activity, the resident will get excited and will usually go along with little resistance.</p> <p>7. During an interview on 05/23/24, at 11:15 A.M., the AD said she does not have a separate activity calendar for the secure unit. Some of the residents attend group activities outside of the secure unit. The AA documents participation logs for the residents on the secure unit. The CNA's on the secure unit provide some activities.</p> <p>8. During an interview on 05/22/24, at 12:38 P.M., CNA/RNA2 said the CNA's on the secure unit are expected to provide some activities, but they do not have the time or knowledge to provide resident specific activities. They have no specific job description regarding activities for the residents on the secure unit and they do not document when a resident attends an activity outside the secure unit. Many of the residents wander around the secure unit with no focus or interaction/engagement with anyone, but some would participate in some sort of focused group activity or one-to-one interaction.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. During an interview on 05/22/24, at 1:10 P.M., Licensed Practical Nurse (LPN) 1 said there are no scheduled activities or specific resident interactions on the secure unit. The CNA's work their scheduled assignments for resident care and they did not provide activities for the residents residing on the secure unit.</p> <p>10. During an interview on 05/23/24, at 2:10 P.M., the Administrator said her expectations for the activity program were to provide physical, mental, and psychosocial interventions to meet the needs of the residents on the secure unit. The secure unit was in the process of expanding and that it was a work in progress. She was not aware that the AD did not provide individual or group activities on the secure unit.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48187</p> <p>Based on record review and interviews, the facility failed to ensure all residents were kept free from possible accident hazards when the facility staff failed to fully secure one resident (Resident #1) in a wheelchair during transport in the facility's van. The facility census was 54.</p> <p>Review showed the facility did not have a policy and procedure or a job description specific to transporting residents in the facility van.</p> <p>1. Review of Resident #1's face sheet (brief resident profile sheet) showed the following information:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included hypertension (high blood pressure), congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and left leg amputation at the hip. <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/06/24, showed the following information:</p> <ul style="list-style-type: none"> -Cognitively intact; -Left leg amputation; -Dependent on staff for transfers from bed to wheelchair. <p>Review of the resident's care plan, revised 07/23/24, showed the following information:</p> <ul style="list-style-type: none"> -Resident is at risk for falls due to weakness, decreased functional ability, chronic pain, and left leg amputation; -Extensive assistance needed for dressing, bathing, toilet hygiene; -Total assistance needed for transfers and mobility. <p>Review of the facility's Transport Incident Report for the resident dated 07/17/24, showed the following:</p> <ul style="list-style-type: none"> -Resident was being transported back to the facility from Senior Days at the Fair; -Transportation A and Transportation B loaded Resident #1 into the back of the van in his/her electric wheelchair; -Transportation A strapped down all four wheels on resident #1's wheelchair, but did not strap resident's shoulder/lap seat belt in place; <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Transportation A reported that three other residents were loaded in the front of the van, and three wheelchairs were placed in the back of the van, in front of Resident #1's wheelchair;</p> <p>-Transportation A was not able to strap Resident #1's shoulder/lap belt due to the three wheelchair's being stacked over the seatbelt strap that was located on the floor of the van;</p> <p>-During transport, Resident #1 slid out of his/her wheelchair when the van stopped at a stop sign, hitting his/her knee on his/her leg rest of the wheelchair;</p> <p>- Transportation A stopped the van and Transportation A and Transportation B lifted Resident #1 back into his/her wheelchair;</p> <p>- Transportation A remained next to the resident during the remainder of the transport.</p> <p>Review of the facility's internal event investigation file showed the following:</p> <p>-A signed statement by Transportation A, dated 07/16/24, showed Transportation B loaded Resident #1 into the back of the van. Transportation A strapped down all four wheels but did not strap the shoulder/lap belt on the resident.</p> <p>-Transportation A proceeded to assist in loading three other residents into the front bench seat of the van. Transportation A then placed all three wheelchairs in the back of the van next to Resident #1.</p> <p>-Transportation A began driving the van back to the facility, when he/she stopped at a stop sign, heard Resident #1 yelling. Transportation A stopped the van and went to the back of the van and seen that Resident #1 had slid out of his/her wheelchair seat, leaning forward with his/her knee up against the leg rest of his/her wheelchair.</p> <p>-Transportation A and Transportation B lifted the resident back into his/her wheelchair, still not securing his/her shoulder/lap belt.</p> <p>-Transportation A remained in the back of the van, next to the resident during the remainder of the trip.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Lebanon North Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 596 Morton Road Lebanon, MO 65536	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/19/24, at 1:00 P.M., Transportation A said he/she was transporting residents back and forth to the Fairgrounds for Senior Days. Transportation B loaded Resident #1 in the back of the van. Transportation A strapped down all four wheels. Transportation A then assisted Transportation B in loading three additional residents in the front bench seat and then placing three wheelchairs in the back of the van next to the resident. After placing the additional wheelchairs in the van, Transportation A was not able to secure the shoulder/lap belt on Resident #1 due to the wheelchairs being in the way of the belt. Transportation A said they were driving back to the facility, stopped at a stop sign, when he/she heard Resident #1 yell. Transportation A stopped the van and went to the back of the van and seen that the resident had slid out of his/her chair, leaning forward up against the other wheelchairs with his/her knee resting on the leg rest of his/her wheelchair. Transportation A and Transportation B pulled the resident back into his/her wheelchair and Transportation A remained next to the Resident the remainder of the trip allowing Transportation B to drive back to the facility. Transportation A said that he/she received van transportation training on hire a few months ago by another transportation driver which included locking the wheels on the wheelchair, anchoring the wheelchair with four corner straps, and securing the resident with the shoulder/lap safety belt.</p> <p>Review of the facility's internal event investigation file showed the following:</p> <ul style="list-style-type: none"> -A signed statement by Transportation B, dated 07/16/24, showed that he/she loaded Resident #1 into the van, stated that Transportation A strapped down the wheelchair but did not buckle the shoulder/lap safety belt. -While Transportation A was driving, Resident #1 slid down off his/her wheelchair onto his/her footrest. -Transportation A and Transportation B lifted the resident back into his/her wheelchair and Transportation A stayed in the back of the van with the resident. -Transportation B drove back to the facility. <p>During an interview on 07/19/24, at 1:22 P.M., Transportation B said that he/she loaded Resident #1 into the back of the van and Transportation A strapped down the wheelchair but did not buckle the lap/shoulder safety belt. Transportation B and Transportation A then loaded three other residents into the front bench seat of the van placing three wheelchairs in the back of the van next to Resident #1. Transportation A was driving when they heard Resident #1 yell. Transportation A stopped the van, got out and checked on the resident. Transportation B then got out and seen that the resident had slid out of his/her seat onto his/her footrest. Transportation A and Transportation B lifted the resident back into his/her wheelchair. Transportation A stayed in the back of the van and Transportation B drove back to the facility. Transportation B said that he/she was hired to be a transportation driver. He/she received van transportation training a few years ago by another transportation driver which included locking the wheels on the wheelchair, anchoring the wheelchair with four corner straps, and securing the resident with the shoulder/lap safety belt.</p> <p>Review of the facility's Employee Counseling Notice showed the following:</p> <ul style="list-style-type: none"> -Transportation A received a verbal warning on 07/10/24 regarding the importance of safety restraints during transport. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Transportation A received a written warning dated 07/16/24, for failure to complete job duties including failure to fasten seatbelt/negligence/carelessness.</p> <p>-Transportation B received a verbal warning on 07/10/24 regarding the importance of safety restraints during transport.</p> <p>-Transportation B received a written warning dated 07/16/24, for failure to complete job duties including failure to fasten seatbelt/negligence/carelessness.</p> <p>Observation made of the facility van on 07/19/24, at 2:10 P.M., showed the van would accommodate one wheelchair. There were four-point straps and shoulder/lap belt on the floor in the back of the van.</p> <p>During an interview on 07/19/24, at 11:40 A.M., Resident #1 said that on 07/09/24, her and some of the other residents got to attend Senior Days at the fair. The resident said he/she remembers being loaded in the back of the van and remembers Transportation A put both straps across his/her waist but does not remember if both straps were placed coming back. The resident said that Transportation A drove over two large potholes in the road, and it bounced him/her out of his/her seat in the wheelchair. The resident said that he/she hit his/her right knee on the folded wheelchairs that were piled up in front of him/her. The resident said that Transportation A stopped the van and immediately came to the back of the van to check on him/her. Transportation B then came to the back, and they were both able to lift the resident back up into his/her wheelchair seat. Transportation A rode in the back of the van the rest of the way to the facility to make sure the resident did not fall again.</p> <p>During an interview on 07/19/24, at 12:40 P.M., with Physician Bohdan Lebedowicz, the Physician said that on 07/09/24, Resident #1 was transported to and from the fair for Senior Days. During coming back, the resident fell out of his/her wheelchair while in the transportation van, hitting his/her right knee on the folded wheelchair in front of his/her. The Physician did not know if the resident was properly secured during transportation. The physician said that he ordered a portable x-ray the same day, which did not show a fracture. The Physician said that he/she repeated the x-ray 5 days later, which then showed a fracture to the resident's leg.</p> <p>During an interview on 07/19/24, at 1:25 P.M., the Social Services Assistant (SSA) said that he/she is the supervisor for Transportation A and Transportation B. He/she said that they both received training prior to SSA taking over the supervisor position. The facility had initiated a new competency checklist that should be utilized for all van drivers. The driver should secure all wheelchairs with the four straps provided in the van, and they should put the shoulder/lap safety belt on the resident. Everyone in the van should wear a seatbelt.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/17/24, at 01:40 P.M., with the Administrator and the Director of Nursing, the Administrator said that he/she was notified of the incident the following day (07/10/24). The Administrator said he/she was told that the resident had been strapped in except the top buckle had not been placed. The Administrator instructed the SSA to give verbal warning to Transportation A and B. The Administrator states that a portable x-ray was obtained that reported no fracture initially. A repeat x-ray that was obtained 07/16/24, showed a fracture to the resident's leg. The Administrator notified Corporate Office and was instructed to give Transportation A and B written warnings and review the importance of properly strapping in the chair and the resident with all safety belts during transport. The Administrator said they have a checklist that ensures all four safety straps and shoulder/lap safety belt are in place prior to transport in the van. The Administrator expects all transportation staff to fill out the checklist every time prior to leaving the facility with a resident. The Administrator said the facility did not have a specific policy regarding van transportation.</p> <p>34871</p> <p>XX. During an interview on 07/25/24 at 10:10 A.M. Licensed Practical Nurse (LPN) A said the transportation staff should buckle up residents when transported on the facility van.</p> <p>XX. During an interview on 07/25/24 at 01:40 P.M. the MDS coordinator said the following:</p> <ul style="list-style-type: none"> -The transportation staff are both CNAs; -The transportation staff should ensure the front and back wheels on a resident's wheelchair are strapped correctly; -Staff should place the seat belt across a resident's wheelchair and buckle it; -It is not safe if staff did not buckle the seat belt. <p>XX. During an interview on 07/25/24 at 02:55 P.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> -Staff load up a resident in the facility van and secure them; -Staff use the facility van's seat belts and floor straps to secure a resident in the van; -She did not know how to secure a resident in the van and would have to go look at the van. <p>XX. During an interview on 07/25/24 at 02:55 P.M., the administrator said she expects the staff to place the seat belt on residents for safety when transported in the van.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on observation, record review, and interview, the facility failed to ensure there was ongoing pre and post dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly)communication for a resident receiving dialysis three times a week for one resident (Resident #8) out of one resident reviewed for dialysis out of a total sample of 24 residents.</p> <p>Review of the facility's policy titled, Dialysis, Care of a Resident Receiving Dialysis, undated, showed the following:</p> <ul style="list-style-type: none"> -All care concerns within the last 24 hours will be addressed, including the last medications given and facility contact person; -The dialysis unit will complete the lower portion of the report to include weight prior to and after dialysis, any labs completed, medication given, follow up information, and any new physician's orders; -The lower portion will be signed by the dialysis nurse and returned to the facility. <p>1. Review of Resident #8's Admission Record, located in the Profile tab of the electronic medical record (EMR), showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included end stage renal disease. <p>Review of the resident's Physician Orders, located under the Orders tab in the EMR, dated 12/18/23, showed hemodialysis three times weekly.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 02/19/24, showed the resident's cognition was moderately impaired and received dialysis services.</p> <p>Review of the resident's Care Plan, located under the Care Plan tab of the EMR, dated 02/20/24, showed the resident received dialysis three times a week.</p> <p>Review of resident's Dialysis Transfer Form, for the months of March 2024, April 2023, and May of 2024, showed the forms were only completed for the dates of 04/17/24, 05/15/24, 05/17/24, and 05/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/23/24, at 11:24 A.M., Licensed Practical Nurse (LPN) 2 said night shift got the resident ready and sent him/her off to dialysis in the morning and sent the pre dialysis form with the resident to dialysis. The resident went out to dialysis yesterday with a pre dialysis form, but he/she did not come back with it. It has been an ongoing issue that the dialysis center never sends the form back. Staff contacted the resident's guardian and let them fight it out with the dialysis center because there was nothing else the facility could do. Management is aware. Staff do not reach out to the dialysis center to ensure there has not been an issue with dialysis. He/she assumed if there was any concern the dialysis center would reach out to the facility.</p> <p>During an interview on 05/23/24, at 1:10 P.M., the Director of Nursing (DON) said she just became aware that the pre and post and dialysis forms were not being returned from the dialysis center. She said that she did expect those forms to be completed both pre and post dialysis because it was important to have ongoing communication before and after a resident goes out for dialysis services.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>20243</p> <p>Based on record review and interview, the facility failed to ensure a registered nurse (RN) was on duty for eight consecutive hours on 05/05/24 and 05/18/24.</p> <p>Review showed the facility did provide a policy regarding RN coverage.</p> <p>1. Review of the facility's Nurse Monthly Staff Schedule, dated May 2024, showed the following:</p> <p>-There was not an RN scheduled on 05/05/24 and 05/18/24.</p> <p>Review of the Administrator's (who is also an RN) and the Directory of Nursing's (DON) Timecard, dated 01/01/24 to 05/22/24, and review of RN1's Time Card, dated 01/01/24 to 05/21/24, confirmed that no RN worked on 05/05/24 and 05/18/24.</p> <p>During an interview on 05/21/24, at 4:01 P.M., the DON said the facility knew they were out of compliance with this requirement. The DON said the facility employs one RN.</p> <p>During an interview on 05/23/24, at 5:53 P.M., the Minimum Data Assessment Coordinator (MDSC) said she assists with staff scheduling and when the facility advertises, they do not receive applications.</p> <p>During an interview on 05/23/24, at 5:53 P.M., the Administrator confirmed there was no RN coverage for 05/05/24 and 05/18/24. The facility has had difficulty hiring RNs.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07246</p> <p>Based on observation, record review, and interview, the facility failed to ensure there was documented clinical rationale for as needed (PRN) psychotropic medication orders longer than 14 days for two residents (Resident #6 and #32) of the five residents reviewed for unnecessary medications.</p> <p>1. Review of Resident #6's Admission Record, located in the Profile tab of the electronic medical record (EMR), showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included mood disorder and anxiety disorder.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 03/14/24, showed the following:</p> <p>-No cognitive impairment;</p> <p>-Prescribed psychotropic medication.</p> <p>Review of of the resident's Care Plan, located under the Care Plan tab of the EMR, dated 03/14/24, showed psychotropic drug use with intervention in place to complete medication evaluations as ordered.</p> <p>Review of of the resident's Physician Orders, located under the Orders tab in the EMR, dated 12/19/23, showed an order for Xanax (an antianxiety medication) .25 milligram (mg) by mouth (PO), PRN for anxiety.</p> <p>Review of the resident's record showed documented indication for continued clinical use past 14 days.</p> <p>Review of the resident's Pharmacist Recommendation to Prescriber, for the months of March 2024, April 2023, and May of 2024, showed no review of Xanax or recommendation for scheduled order or to discontinue PRN order after initial 14-day order.</p> <p>Review of the resident's Medication Administration Record, located under the Records tab in the EMR, dated May 2024, showed one dose of Xanax 0.25 mg was given on 05/09/24 at 8:48 P.M. that was effective.</p> <p>During an interview on 05/22/24, at 4:23 P.M., the Pharmacist Consultant (RX) said he completed all the resident's monthly medication reviews. He said he was unable to state why there has not been any documentation asking for a rationale or justification for the continued use of the PRN Xanax. He was aware of the regulation, but he simply missed it.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/23/24, at 1:15 P.M., the Director of Nursing (DON) said they just noticed there wasn't a stop date for the resident's PRN Xanax order. The DON said staff notified the physician and he put in a stop date for June. The DON said because of the June stop date it did not trigger for the pharmacist to review the medications therefore he missed that it was still a PRN. The DON said she expected that PRN orders for psychotropic medications to have documented rationale for use past 14 days.</p> <p>2. Review of Resident #32's EMR titled Admission Record, located under the Profile tab, showed the following:</p> <p>-admitted [DATE];</p> <p>-Hospice admitted [DATE];</p> <p>-Diagnoses included restlessness and agitation, major depressive disorder, moderate dementia, mood disturbance, and anxiety.</p> <p>Review of the resident's admission MDS, located in the Resident Assessment Instrument (RAI) tab of the EMR, with an assessment reference date (ARD) of 04/29/24, showed the resident was severely cognitively impaired.</p> <p>Review of the resident's Physician Orders, located under the orders tab in the EMR, dated 04/29/24, showed an order for lorazepam (an antianxiety medication) .5 mg tablet every two hours PRN and was scheduled to be discontinued on 10/24/24.</p> <p>Review of the resident's Pharmacist Recommendation to Prescriber, for the months of May of 2024, showed no review of lorazepam and no recommendation for the scheduled order to discontinue the PRN order after initial 14-day order.</p> <p>During an interview on 05/22/24, at 4:23 P.M., RX said he completed all the resident's monthly medication reviews. He said he was unable to state why there has not been any documentation asking for a rationale or justification for the continued use of the PRN Xanax. He said that the resident is under hospice care and did not need the same rationale for PRN Lorazepam.</p> <p>During an interview on 05/23/24, at 1:15 P.M., the DON said they just noticed there wasn't a stop date for the resident's PRN Lorazepam order until 10/24/24.</p>		