STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265236	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mark Twain Nursing	11988 Mark Twain Lane Bridgeton, MO 63044

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42247 Based on interview and record review, the facility failed to ensure professional standards of practice were met, when the facility failed to ensure one out of three resident's labs were obtained per physician orders (Resident #108). The census was 80. Review of the facility's Laboratory Services and Reporting Policy, dated reviewed/revised on 8/18/2023, showed: -Policy: The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law; -The facility must provide or obtain laboratory services to meet the needs of its residents. Review of Resident #108's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 7/15/24, showed: -Cognitively intact; -Diagnoses included: heart failure, high blood pressure, urinary tract infection (UTI) past 30 days, diabetes, Chronic Obstructive Pulmonary Disease (COPD, lung disease) and adult failure to thrive (term used to describe a decline in an elderly person's health that's characterized by a number of symptoms, including: weight loss, decreased appetite, poor nutrition, inactivity, dehydration, depression, impaired immune function, low cholesterol, cognitive impairment, and social isolation). Review of the progress notes dated 8/20/24 at 3:37 P.M., showed the resident refused morning finger stick (a medical procedure that involves pricking a finger with a lancet to collect a small amount of blood for testing), yelled at nurse no, doctor was here today to visit resident, new order for Complete Blood Count (CBC, determines general health status and screens for and monitors for a variety of disorders including anemia), Comprehensive Metabolic Panel (CMP, measurement of blood sugar, electrolytes, fluid balance, kidney and liver function), Thyroid Stimulating Hormone (TSH, blood test to monitor treatment of hypothyroidism), Hemoglobin A1C (A1C, blood test that measures a person's average blood sugar level over the past three months), Urinalysis (UA, analyzes a urine sample for its appearance, concentration, and content) with culture and sensitivity (C&S, test checks for bacteria or other germs in a urine sample), nurse will attempt to get urine for UA, lab orders entered in the Emed lab (computer program for the lab); (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation showing the family was notified of the new orders. Review of the doctor's progress notes dated 8/20/24, showed: -Chief complaint/nature of presenting problem: per provider (a licensed individual or organization that provides health care services) add on related to confusion/agitation/ankle pain; -Plan: Confusion, check UA; -Senile dementia: CBC, CMP, TSH, Lipids (laboratory test that measures cholesterol level in the blood), A1C. Review of the physician order sheet, undated, showed: -An order for check CBC, CMP, TSH, Lipids, A!C, next lab day, revision date was 8/20/24; -An order for UA and C & S for dysuria (painful or difficult urination) and agitation, revision date was 8/20/24. Review of the progress notes dated 8/21/24 through 8/25/24, showed: -On 8/21/24 at 11:53 P.M., resident was straight catheter (intermittent catheter or in-and-out catheter, is a small, flexible tube used to drain urine from the bladder) earlier tonight without successful results. Resident was hydrated for later attempts; -On 8/22/24 at 9:16 P.M., resident still needed UA specimen, straight catheter attempted on this shift, but resident was already wet. Fluids was offered and encouraged; oncoming nurse notified; -On 8/25/24 at 7:05 P.M., lab would be here at any time to get UA; -No documentation to show the labs were drawn or if the resident refused to have his/her blood drawn; -No documentation showing the facility followed up with the lab to see if the labs were drawn or not. Review of the labs, showed: -On 8/25/24 the UA was completed, and no C & S was indicated; -There were no other lab results for the labs ordered on 8/20/24. Review of the doctor's progress note dated 8/27/24, showed: -UA available-positive for epidermal cells (cells that make up the outer most layer of skin) and not indicated for C & S. Patient is non-verbal at baseline, confused; -Labs: 8/26/24 no new labs. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes dated 8/26/24 through 8/30/24, showed: -On 8/27/24 at 3:54 P.M., The resident was seen by the doctor today and labs reported. No new orders. Will continue to monitor; -On 8/30/24 at 8:39 P.M., resident sent to the hospital per family request; -No documentation to show the labs were drawn or the resident refused to have his/her blood drawn; -No documentation showing the facility followed up with the lab to see if the labs were drawn or not. During an interview on 9/25/24 at 11:40 A.M., a representative from the lab said the facility was responsible for entering lab orders into the computer. For routine blood draws, the facility should print the requisition after the order was entered into the computer and place it into a folder or whatever system they had sat up. When the phlebotomist (person who draws the blood) went to the facility, they checked the book/folder to see what labs needed to be drawn and draw them. Routine labs were drawn Monday through Friday. Lab results were faxed to the facility. The lab representative checked the computer and saw the resident had a UA completed on 8/25/24, but he/she did not see any labs entered to be drawn between 8/20/24 and 8/30/24. During an interview on 9/25/24 at 12:03 P.M., Licensed Practical Nurse (LPN) B said the nurse who obtained the order for the lab was responsible for entering the order into the computer and ordering the lab. Once the lab results were received, the nurse should fax the results to the doctor's office and call them to ensure they received it. If a resident refused to have their blood drawn, the nurse should try to talk to the resident and report it to the doctor and document it in the progress notes. The only labs in the medical record were from 7/17/24 and the UA from 8/25/24. There was no documentation to show the resident refused or the doctor was notified the labs were not drawn. During an interview on 9/25/24 at 12:17 P.M. and 2:35 P.M., The Director of Nursing (DON) said she talked with the nurse who entered the order for the labs and the nurse said he/she entered the labs into the medical record to be drawn. The DON did not see the labs on the website, and she called the lab. The lab told the DON they dropped the ball, and the labs were not drawn. Review of the lab requisition, provided by the facility, showed on 8/20/24 at 3:24 P.M., the following labs were ordered for 8/21/24: CBC, CMP and a UA with C & S if indicated. During an interview on 9/25/24 at 2:35 P.M., the DON said she was sure there was another requisition for the other labs because the nurse would not order only part of the labs. The DON said the facility always checked for the lab results every day. They were constantly looking at it. This one must have just have slipped through or the resident refused to have his/her blood drawn. The resident was refusing some of his/her medications and finger sticks and may have refused to have his/her blood drawn. The DON did not know for sure if the resident refused to have his/her blood drawn. The lab should have told the nurse if they could not draw the resident's blood. The DON would expect for staff to follow physician orders and follow the facility's policies and procedures. MO00241443 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00241395