STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265253	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Healthcare & Rehabilitation Center	206 West First Street Lamar, MO 64759

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide services per standards of practice when the facility staff did not transcribe an order for a urine analysis (UA - a routine diagnostic test that evaluates the physical, chemical, and microscopic properties of your urine. It is primarily used to screen for kidney disease, liver issues, diabetes, and urinary tract infections (UTIs)) timely, when staff did not obtain a sample for the UA timely, and when staff did not notify the physician or document the reason for the delay in obtaining the UA for one resident (Resident #1) resulting in a\\n eight day delay in obtaining the UA sample. The facility census was 104.Review of the facility's policy titled, Lab and Diagnostic Test Results- Clinical Protocol, dated 11/2018, showed the following:-The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs;-The staff will process the test requisitions and arrange for the tests;-The laboratory, diagnostic radiology provider, or other testing sources will report results to the facility.1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed an admission date of 03/27/25. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/24/26, showed the following:-Significant cognitive impairment;-Required moderate assistance for transfers.Review of the resident's Family Nurse Practitioner (FPN) note, dated 04/27/26, showed the following:-Visit type acute/follow-up;-Chief complaint of physical aggression;-The resident has bi-polar disorder and required a follow-up for aggressive behaviors. The resident continued to have aggressive behaviors and wandering behaviors;-Staff Obtain a UA with culture and sensitivity;-Follow-up with the resident on 04/30/26 for review of the results of the UA and see if behaviors have improved.Review of the resident's order form, dated 04/27/26, showed an order for a UA with culture signed by the FNP.Review of the resident's care plan, revised 05/04/26, showed staff did care plan related the ordered UA and follow-up. Review of the resident's FNP note, dated 04/30/26, showed pending UA with culture to investigate potential causes of increased behaviors;Review of the resident's physician order sheet (POS) showed an order, dated 04/30/26, for a UA culture and sensitivity and send to the lab (three days after the initial order.) Review of the resident's April 2026 Treatment Administration Record (TAR) showed the following:-An order, dated 04/30/26, for a UA culture and sensitivity and send to the lab;-Staff noted on 04/20/26, the order was not complete due to resident sleeping; t was sleeping;-Staff did not document any other attempts to obtain the urine sample for the UA.Review of the resident's FNP note, dated 05/04/26, showed the following:-He/she saw the resident for a follow up of the UA results that he/she ordered on 04/27/26 and increased agitation;-Staff had not obtained the UA;-Follow up once UA results are received. Review of the resident's May 2026 TAR showed staff did not document attempts to complete the UA order.Review of the resident's nurse notes, dated 04/27/26 to 05/06/26, showed staff did not document attempts made by the nursing staff to complete the UA order. During an interview on 05/06/26, at 12:32 P.M., the resident's FNP said the following:-He/she writes new orders on an order sheet and gives the order to the nurse;-The nurse enters the orders into the electronic medical record;-He/she ordered a UA for the resident due to increased aggressive behaviors that could be caused by a UTI;-He/she came to the facility on (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] and asked about the UA. Registered Nurse (RN) B told him/her that it had not been completed, and they would make sure the order was put in and the UA was completed;-He/she asked about it again on 05/04/26 due to not getting any results back;-The Director of Nursing (DON) told him/her the UA had not been completed. The DON said they would make sure it was completed. Staff gathered the urine sample on 05/05/26 (eight days after original order);-He/she was not sure why the UA was not completed timely. He/she did not know the staff had not completed the UA until she asked about it. The nurses did not tell him/her of any failed attempts to get the urine sample for the UA;-He/she expected to be contacted if the staff cannot get the urine sample in a timely manner.During an interview on 05/06/26, at 1:30 P.M., Medical Records/Certified Medication Technician (CMT) said the following:-He/she checked physician orders to make sure they were entered by the nurse;-She entered the orders if they were not already entered by the nurse;-He/she did not see the resident's order for a UA until 04/30/26 because the FNP asked if the UA had been completed;-He/she did not know why it was not entered by the nurse;-He/she told the DON the order had not been entered by staff, and it was entered;-The FNP gives the resident's nurse paper orders, the nurse is supposed to enter into the electronic medical record.During an interview on 05/06/26, at 3:21 P.M., Registered Nurse (RN) A said the following:-The FNP puts orders on an order sheet and then gives it to the resident's nurse to enter the computer;-The nurse should attempt to get the urine sample as soon as possible so it can be sent to the lab timely;-He/she lets the FNP know if they were unable to get the urine sample within 24 hours for further instructions;-He/she documents any unsuccessful attempts to get the UA completed and why it was unsuccessful. He/she lets the oncoming nurse for the next shift know if they were unable to get the UA. The next nurse is expected to make more attempts to get the urine sample;-He/she does not consider it timely for a urine sample to take more than 24 hours to collect.During an interview on 05/07/26, at 8:15 A.M., the RN B said the following:-The FNP gives the nurse any new orders for labs and the nurse enters it into the computer;-He/she did not remember the FNP giving him/her the order sheet for the resident. She remembered the FNP telling him/her that she wanted a UA completed on the resident on 04/30/26;-He/she did not enter the order into the computer;-He/she placed a hat to collect the resident's urine on the resident's toilet. The resident was incontinent sometimes and can be noncompliant;-He/she was not successful in collecting the resident's urine;-He/she did not document his/her attempts to collect the resident's urine;-He/she told the oncoming nurse for the next shift that he/she was not able to collect the urine;-He/she expected there to be more attempts made to collect the resident's urine;-He/she was off after 04/30/26 and did not follow up to see if the UA was completed.During an interview on 05/06/26, at 2:04 P.M., the Assistant Director of Nursing (ADON) said the following:-The FNP gives new or updated orders to the resident's nurse or to a nursing supervisor on an order sheet. The nurse enters the orders into the computer;-The nurse should attempt to get a urine sample pretty soon after getting an order for a UA, at least during their shift;-The nurse should let the FNP know if they are unable to get the sample within 24 hours;-The nurse should inform the oncoming nurse for the next shift if they could not get the sample, for the next nurse to try;-The nurses document attempts to get the urine sample in a nurses note or on the TAR;-He/she did not know why there was a delay in collecting the UA sample. He/she did know the resident has behaviors and believed it may have been difficult to get it;-He/she did not know why there were no attempts documented in the chart;-He/she collected the sample from the resident on 05/05/26 with the DON. He/she did not know that the order for the UA from 04/27/26 was not entered into the computer until 04/30/26. He/she would have expected the UA order to be put in as soon as possible and at least by the end of the shift. During an interview on 05/06/26, at 3:45 P.M., the Administrator said the following:-The FNP gives the nurse new orders on a paper order sheet;-The nurse enters the orders into the computer;-The nurse should attempt to get the urine sample for a UA as soon as possible;-The nurse should document any attempts made to get the urine sample in the resident's medical record;-The nurse should have multiple attempts to get the urine sample. The nurse needs to inform the FNP if they cannot get the UA completed.Complaint 3000706