STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265491	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Nursing	914 Chickesaw Street Seneca, MO 64865

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to have services in place to ensure the accurate document of administration of controlled pain medications for three resident's (Resident #2, Resident #3, and Resident #4). The facility census was 45.Review of the facility's policy titled Medication Storage in the Facility, dated 06/01/18, showed the following:-Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations;-The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met;-Current controlled substance accountability records are kept in the Medication Administration Record (MAR), or designated book.1. Review of Resident #2's face sheet (admission data) showed the following:-admission date of 11/16/21;-Diagnoses included low back pain, muscle weakness, and cognitive communication deficit.Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated comprehensive assessment tool completed by facility staff), dated 12/29/25, showed the following:-Cognitive skills intact;-Received scheduled and as needed (PRN) pain medications.Review of the resident's care plan, revised on 02/16/26, showed the following:-The resident complained of chronic back and leg pain related to diabetic neuropathy (nerve damage caused by long-term high blood sugar), cervical disc degeneration, gout (a form of arthritis that causes pain and swelling in joints), and restless legs syndrome;-The resident required pain management.Review of the resident's current Physician Order Sheet (POS) showed the following:-An order, dated of 12/15/25, for hydrocodone-acetaminophen (APAP) (prescription medication containing an opioid and a non-opioid used to treat moderate to severe pain) oral tablet 7.5-325 milligrams (mg), staff to give one tablet by mouth every four hours as needed (PRN) for pain related to restless legs syndrome and low back pain;-An order, dated of 12/15/25, for hydrocodone-acetaminophen oral tablet 7.5-325 mg, for staff to give one tablet by mouth three times a day for pain related to restless legs syndrome and low back pain.Review of the resident's Controlled Substance Record (the form used to account for each dose of a controlled substance), dated 12/29/25, showed on 01/08/26, staff documented administration of one tablet of hydrocodone/apap at 5:24 A.M.Review of the resident's January 2026 MAR showed on 01/08/26, staff did not document administration of the resident's hydrocodone/apap. Review of the resident's January 2026 MAR showed on 01/09/26, staff documented administration of the resident's hydrocodone/apap. Review of the resident's Controlled Substance Record, dated 12/29/25, showed on 01/09/26, staff did not document administration of the resident's hydrocodone/apap at 6:00 A.M. Review of the resident's Controlled Substance Record, dated 12/29/25, showed on 01/12/26 at 11:59 P.M., staff documented administration of the hydrocodone/apap.Review of the resident's January 2026 MAR showed on 01/12/26, staff did not document administration of the resident's hydrocodone/apap at 11:59 P.M.Review of the resident's Controlled Substance Record, dated 12/29/25, showed on 01/13/26 at 9:00 A.M., staff documented administration of the resident's hydrocodone/apap PRN, with a note of the resident out of the building.Review of the resident's January 2026 MAR showed on 01/13/26, staff did not document (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration of the resident's PRN hydrocodone/apap.Review of the resident's Controlled Substance Record, dated 12/29/25, showed on 01/20/26, at 8:50 A.M., staff documented administration of the resident's hydrocodone/apap with a note of the resident out of the building.Review of the resident's January 2026 MAR showed on 01/20/26, staff did not document administration of the resident's hydrocodone/apap PRN.Review of the resident's January 2026 MAR showed on 1/30/26, staff documented administration of the hydrocodone/apap at 6:00 A.M. Review of the resident's Controlled Substance Record, dated 01/10/26, showed on 01/30/26, staff did not document administration of the resident's hydrocodone/apap at 6:00 A.M.Review of the resident's Controlled Substance Record, dated 01/10/26, showed on 02/04/26, at 10:20 P.M., showed staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/04/26, staff did not document administration of the resident's hydrocodone/apap at 10:20 P.M. Review of the resident's Controlled Substance Record dated 01/10/26 showed on 02/12/26, no time, showed staff administration of the resident's hydrocodone/apap with a note of the resident out of the building. Review of the resident's February 2026 MAR showed on 02/13/26, at 6:00 A.M., staff documented administration of the resident's hydrocodone/apap.Review of the resident's Controlled Substance Record, dated 01/10/26, showed on 02/13/26, at 6:00 A.M., staff did not document administration of the resident's hydrocodone/apap.Review of the resident's Controlled Substance Record, dated 2/16/26, showed on 02/27/26, at 9:59 P.M., staff documented administration of the resident's hydrocodone/apap. Review of the resident's February 2026 MAR showed on 02/27/26, staff did not document administration of the resident's hydrocodone/apap at 9:59 P.M.Review of the resident's Controlled Substance Record, dated 02/24/26, showed on 02/28/26, at time not readable, staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/28/26, staff did not document administration of the resident's hydrocodone/apap. 2. Review of Resident #3's face sheet showed the following:-admission date of 06/04/25;-Diagnoses included major depressive disorder, difficulty in walking, and muscle weakness.Review of the resident's care plan, dated 06/25/25, showed the following:-The resident had pain;-Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Review of the resident's quarterly MDS assessment, dated 02/25/26, showed the following:-Moderately impaired cognitive skills;-The resident received PRN pain medications. Review of the resident's POS, dated 01/01/26, showed an order, start date of 12/12/25, for oxycodone (opioid medication used to manage pain), 5 mg, for staff to give one capsule by mouth every four hours as needed for moderate to severe pain.Review of the resident's Controlled Substance Record, dated 12/06/25, showed on 01/19/26, at 7:45 P.M., showed staff administered the resident's oxycodone.Review of the resident's January 2026 MAR showed on 01/19/26, staff did not document administration of the resident's oxycodone at 7:45 P.M.Review of the resident's Controlled Substance Record, dated 12/06/25, showed on 02/03/26, at 5:00 P.M., staff documented administration of the resident's oxycodone.Review of the resident's February 2026 MAR on 02/03/26, showed staff did not document administration of the resident's oxycodone at 5:00 P.M.Review of the resident's Controlled Substance Record dated 12/15/25, showed on 02/05/26, at 11:00 P.M., staff documented administration of the resident's oxycodone.Review of the resident's February 2026 MAR showed on 02/05/26, showed staff did not document administration of the resident's oxycodone at 11:00 P.M.Review of the resident's Controlled Substance Record, dated 12/15/25, showed on 02/11/26, at 9:35 P.M., staff documented administration of the resident's oxycodone. Review of the resident's February 2026 MAR showed on 2/11/26. staff did not document administration of the resident's oxycodone at 9:35 P.M.Review of the resident's Controlled Substance Record dated 12/15/25, showed on 02/15/26 at 8:00 P.M., staff documented administration of the resident's oxycodone.Review of the resident's February 2026 MAR showed on 2/15/26, staff did not document administration of the resident's oxycodone at 8:00 P.M.Review of the resident's Controlled Substance Record dated 12/15/25 showed on 02/16/26, at 11:45 P.M., staff documented (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration of the resident's oxycodone.Review of the resident's February 2026 MAR showed on 02/16/26, staff did not document administration of the resident's oxycodone at 11:45 P.M.Review of the resident's Controlled Substance Record dated 12/15/25 showed on 02/17/26, at 7:45 P.M., staff documented administration of the resident's oxycodone.Review of the resident's February 2026 MAR showed on 02/17/26, staff did not document administration of the resident's oxycodone at 7:45 P.M.Review of the resident's Controlled Substance Record dated 12/15/25, showed on 02/18/26, at 8:40 P.M., staff documented administration of the resident's oxycodone.Review of the resident's February 2026 MAR showed on 02/18/26, staff did not document administration of the resident's oxycodone at 8:40 P.M.Review of the resident's Controlled Substance Record dated 12/15/25 showed on 02/23/26, at 7:20 P.M., staff documented administration of the resident's oxycodone.Review of the resident's February 2026 MAR showed on 02/23/26, staff did not document administration of the resident's oxycodone at 7:20 P.M.Review of the resident's Controlled Substance Record dated 12/15/25, showed on 02/24/26, at 7:20 P.M., staff documented administration of the resident's oxycodone.Review of the resident's February 2026 MAR showed on 02/24/26, staff did not document administration of the resident's oxycodone at 7:20 P.M.Review of the resident's Controlled Substance Record dated 12/15/25, showed on 02/26/26, at 8:30 P.M., staff documented administration of the resident's oxycodone. Review of the resident's February 2026 MAR showed on 02/26/26, staff did not document administration of the resident's oxycodone at 8:30 P.M.Review of the resident's Controlled Substance Record, dated 12/15/25, showed on 03/02/26, at 7:10 P.M. staff documented administration of the resident's oxycodone.Review of the resident's March 2026 MAR showed on 03/02/26, staff did not document administration of the resident's oxycodone at 7:10 P.M.Review of the resident's Controlled Substance Record, dated 12/15/25, showed on 03/03/26, at approximately 7:00 P.M. (minutes unreadable), staff documented administration of the resident's oxycodone.Review of the resident's March 2026 MAR showed on 03/03/26, staff did not document administration of the resident's oxycodone.Review of the resident's Controlled Substance Record, dated 12/15/25, showed on 03/04/26, at 2:00 A.M., staff documented administration of the resident's oxycodone.Review of the resident's March 2026 MAR showed on 03/04/26, staff did not document administration of the resident's oxycodone at 2:00 A.M. 3. Review of Resident #4's face sheet showed the following:-admission date on 01/08/25;-Diagnoses included cognitive communication deficit, muscle weakness, and chronic kidney disease. Review of the resident's significant change in status MDS assessment, dated 03/02/26, showed the following:-Severely impaired cognitive skills;-Received as needed pain medications.Review of the resident's care plan, revised 03/08/26, showed the following:-The resident required routine pain management for complaints of lower back pain;-Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Review of the resident's current POS showed an order, dated 12/18/25, for hydrocodone acetaminophen 5-325 mg, for staff to give one tablet by mouth every four hours as needed for pain control. Review of the resident's Controlled Substance Record, dated 09/09/25, showed on 02/02/26, at 11:30 P.M., staff documented administration of the resident's hydrocodone/apap. Review of the resident's February MAR showed on 02/02/26, showed staff did not document administration of the resident's hydrocodone/apap.Review of the resident's Controlled Substance Record, dated 09/09/25, showed on 02/05/26 at 11:40 P.M., staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/05/26, staff did not document administration of the resident's hydrocodone/apap for 11:40 P.M.Review of the resident's Controlled Substance Record, dated 09/09/25, showed on 02/06/26, at 11:30 P.M., staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/06/26 staff did not document administration of the resident's hydrocodone/apap for 11:30 P.M. Review of the resident's Controlled Substance Record, dated 09/09/25, showed on 02/07/26, at 3:30 P.M., staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/07/26, staff did not document administration of (continued on next page)

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Seneca Nursing	914 Chickesaw Street Seneca, MO 64865

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's hydrocodone/apap for 3:30 P.M.Review of the resident's Controlled Substance Record, dated 09/09/25, showed on 02/09/26, at 8:18 P.M., staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/09/26, staff did not document administration of the resident's hydrocodone/apap for 8:18 P.M.Review of the resident's Controlled Substance Record, dated 09/09/25, showed on 2/14/26, at 8:25 P.M., staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/14/26, staff did not document administration of the resident's hydrocodone/apap for 8:25 P.M.Review of the resident's Controlled Substance Record, dated 09/09/25, showed on 2/15/26, at 8:10 P.M., staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/15/26, staff did not document administration of the resident's hydrocodone/apap for 8:10 P.M.Review of the resident's Controlled Substance Record, dated 09/09/25, showed on 02/16/26, at 8:20 P.M., staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/16/26, staff did not document administration of the resident's hydrocodone/apap for 8:20 P.M.Review of the resident's Controlled Substance Record, dated 09/09/25, showed on 02/17/26, at 8:00 P.M., staff documented administration of the resident's hydrocodone/apap.Review of the resident's February 2026 MAR showed on 02/17/26, staff did not document administration of the resident's hydrocodone/apap for 8:00 P.M.Review of the resident's Controlled Substance Record, dated 9/09/25, showed on 02/18/26, at 6:55 P.M., staff documented administration of the resident's hydrocodone/apap. Review of the resident's February 2026 MAR showed on 02/18/26, staff did not document administration of the resident's hydrocodone/apap for 6:55 P.M. Review of the resident's current POS showed an order, dated 02/25/26, for hydrocodone/apap 5-325 mg, for staff to give one tablet by mouth every four hours as needed for pain control. Review of the resident's Controlled Substance Record, dated 02/18/26 showed on 03/02/26, at 7:30 P.M., staff documented administration of the resident's hydrocodone/apap. Review of the resident's March 2026 MAR showed on 03/02/26, staff did not document administration of the resident's hydrocodone/apap at 7:30 P.M. 4. During an interview on 030/4/26, at 11:44 A.M., Certified Medication Technician (CMT) D said staff should sign administration of pain medications on the MAR and on the controlled drug form.During an interview on 03/05/26, at approximately 11:30 A.M., CMT E said the following:-Staff administer pain medications to residents as scheduled or upon resident request;-Staff should check the order, document on the MAR and in the narcotic book;-The resident's MAR and controlled drug form should match with documentation.During an interview on 03/05/26, at 1:19 P.M., Registered Nurse (RN) A said the following:-The nurses or CMT's pass narcotics;-Staff administer pain medications if a resident requests. Nurses assess the resident for pain;-Staff should document pain medications administered on the MAR and controlled drug form;-The residents' MAR and controlled drug forms should match with staff signatures/initials.During an interview on 03/05/26, at 1:55 P.M., RN F said staff should document administered pain medications on the MAR and narcotic sheets. During interviews on 03/06/26, at 4:01 P.M., and on 03/07/26, at 10:06 A.M., the administrator said the following:-She expected staff to document on the MAR as a medication given and document the pain medication on the narcotic sheet;-If staff did not sign out on the MAR, it is easy to forget. She felt it was a documentation issue. #2734672 and #2792822

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to promptly notify the ordering physician of labs out of normal ranges when staff failed to notify one resident's (Resident #1) physician of critical lab results. The facility census was 45.Review of the facility's policy titled Significant Condition Change and Notification, undated, showed the following:-To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below:-A significant change in the resident's physical, mental, or psychosocial status including abnormal lab values;-When the above situation exists, the licensed nurse will contact the resident's representative and their medical practitioner;-Calls will be made to the resident's representative until they are reached. A message may be left on an answering machine that does not give specifics but leaves a request for the facility to be called;-The medical practitioner will be contacted immediately for any emergencies regardless of the time of day. Non-emergency notifications may be made the next morning if the situation occurs on the late evening or night shift. This applies to any day of the week including holidays. If the medical practitioner cannot immediately be reached in any emergency, the medical director will be called. If the medical practitioner cannot be reached, the Director of Nursing (DON) or the charge nurse can make arrangements for transportation to the emergency department;-Each attempt will be charted as to the time the call was made, who was spoken to, and what information was given to the medical practitioner. In a non-emergency situation, the primary medical practitioner will be called unless he/she has left an alternate name to call. If after two attempts, there is no response to the calls, the medical director will be contacted;-All significant changes will be recorded on the communication board in the computer and in the resident record. Charting will include an assessment of the resident's current status as it relates to the change in condition. Charting will be done each shift for 72 hours for resident with change of condition. Change of condition is reviewed by DON or designee for the continued need for additional documentation. Review of the facility's policy titled Charting and Documentation, dated February 2021, showed the following:-Chart all pertinent changes in the resident's condition, reaction to treatments, medication as well as routine observations;-Be concise, accurate, and complete and use objective terms. Document only the facts. Use on approved abbreviations and symbols;-For lab work document date and time specimens were obtained (when drawing blood, document site) and date and time physician notified of lab results. 1.Review of Resident #1's face sheet (admission data) showed the following:-admission date of 11/15/25;-Diagnoses included Type 2 diabetes mellitus (when the body cannot use insulin properly), heart failure, essential hypertension (HTN-high blood pressure), hypokalemia (abnormally low levels of potassium in the bloodstream), hyperlipidemia (high levels of lipids (fats) in the blood) and chronic kidney disease stage 3 (moderate kidney damage). Review of the resident's physician order sheet showed an order, dated 11/15/25, for admission labs; complete blood count (CBC), complete metabolic panel (CMP), TSH (thyroid-stimulating hormone), BNP (B-Type Natriuretic Peptide-a test to measure amount of hormone produced by the body when the heart is enlarged) and valproic acid level. Review of the resident's laboratory report, dated 11/21/25, showed the following:-Lab specimen collected on 11/19/25 at 6:23 A.M.;-Resident had a hemoglobin (protein found in the red blood cells responsible for oxygen throughout the body) count of 5.1 (reference range for hemoglobin is 11.2 to 15.7 grams per deciliter (g/dl);-Resident had a hematocrit (measures red blood cells in the total amount of blood) count of 18.7 low (reference range for hematocrit of 34.1 to 44.9%);-The hemoglobin and hematocrit results were in the critical range column of the lab report;-A signature (unable to read) was on the final page (page 3) of the laboratory results with no date. Review of the resident's medical record showed staff did not document notification of the resident' s family member or physician of the resident's critical lab results. Review of the physician's note, dated 12/10/25, showed the line which listed labs did not have documentation regarding lab review. Review (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the resident's progress notes dated 12/23/25, at 4:07 P.M. showed the dietician documented no labs located from the electronic medical record. Review of the physician's note, dated 01/14/26, showed the line which listed labs did not have documentation regarding lab review. Review of the physician's note, dated 02/11/26, showed the line which listed labs did not have documentation regarding lab review. Review of the resident's progress note dated 02/19/26, at 2:11 P.M., showed the dietician documented the resident's recent weight and noted no new labs located. Review of the resident's nurse's note dated 03/01/26, at 1:09 P.M., showed a nurse documented the resident acted outside of his/her baseline. Blood pressure of 84/62 millimeters of mercury (mm/Hg) (low). The resident's family was at the facility and requested the resident to go to the hospital for further evaluation. Staff contacted emergency services to transport the resident to the hospital. Review of the resident's hospital emergency department physical exam, dated 3/01/26, showed the CBC with differential laboratory results showed abnormal results of hemoglobin at 3.1 and hematocrit at 13.4. Review of the resident's care plan, revised 03/03/26, showed the following:-The resident had a diagnosis of chronic kidney disease;-Monitor lab reports of electrolytes and report to physician.During interviews on 03/16/26, at 11:22 A.M. and 12:55 P.M. Registered Nurse (RN) A said the following:-Staff obtain admission labs for CBC, CMP, TSH, and lipid for new admissions to determine baseline results to see where a resident is at to ensure they are on proper medications;-The physician orders laboratory work;-The nurse enters the lab orders into the computer, and it goes directly to the lab;-The lab company comes to the facility twice a week;-The nurse checks the lab portal for results and prints them out;-Staff should report to the physician of an urgent lab result;-Staff sends lab results through the facility message system if an urgent manner. Staff fax the physician if the lab results are not urgent;-The physician sends a message back to the facility after review of the lab results and signs the lab;-Staff can take a picture of the lab results, download it into the computer and send it to the physician; -Staff should notify the physician of lab results;-The lab should notify the facility of a critical result;-He/she did not recall a conversation with the physician of the resident's critical lab results of the hemoglobin and hemotocrit;-He/she assumed if the physician saw the resident's lab results. The physician would have wanted to recheck the resident's lab or send the resident out for an evaluation;-He/she did not see any information on the computer of a message to the physician of the resident's lab results;-Staff should had called the physician and documented the resident's critical lab results of the hemoglobin and hematocrit.During an interview on 03/16/26, at 3:44 P.M., the Medical Director said the following:-She orders new admission labs of CBC, CMP, lipids, thyroid, and a Hemoglobin A1C if a resident is a diabetic;-Staff send her lab results through the message system or fax to her office. She comes to the facility on visits and signs any lab results in her box;-Staff can attach the lab results when they send it to her on the message system;-Agency nurses do not always have access to lab results, so they fax the results to her office;-On 3/16/26, the Medical Director reviewed the resident's 11/21/25 lab. The resident's lab results were critical, and staff should have called her. She was not aware of the resident's low hemoglobin and hematocrit results;-The lab should call the facility with critical results and staff should notify her;-She would have ordered anemia labs or sent the resident out for a blood transfusion;-She said the signature on the resident's third page of the lab results was not her signature;-She reviews every page of laboratory results and signs every single page;-She did not see in the computer staff notifying her of the resident's critical lab results;-She expected staff to document reviewing the lab results and notifying her.During an interview on 03/18/26, at 9:19 A.M., the DON said the following:-She expected nurses to review laboratory results;-She expected the nurses to notify the physician through the message system or make a phone call of critical lab results;-She expected nurses to document notification of the physician of critical lab results;-The facility had too many agency nurses and communications were not passed along.During an interview on 03/16/26, at 3:15 P.M. the Administrator said the facility had standing orders for labs. The nurses enter orders into the computer. The lab company comes to facility to draw lab orders. Nurses are responsible for (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring lab results. The lab company should notify the facility of critical lab results. The nurse should notify the physician through the message system in the computer. Nurses should document notification of the physician of critical lab results. #2792822 and #2798251

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265491	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Nursing	914 Chickesaw Street Seneca, MO 64865

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure all residents' records were complete and accurate when staff failed to document one resident (Resident #1) sliding out of a chair. The facility census was 45.Review of the facility's policy titled, Significant Condition Change and Notification, undated, showed the following:-All significant changes will be recorded on the communication board in the computer and in the resident record. Charting will include an assessment of the resident's current status as it relates to the change in condition. Charting will be done each shift for 72 hours for resident with change of condition. Change of condition is reviewed by Director of Nursing (DON) or designee for the continued need for additional documentation. Review of the facility's policy titled Charting and Documentation, dated February 2021, showed the following:-Chart all pertinent changes in the resident's condition, reaction to treatments, medication as well as routine observations;-Be concise, accurate, and complete and use objective terms. Document only the facts. Use on approved abbreviations and symbols.1.Review of Resident #1's face sheet (admission data) showed the following:-admission date of 11/15/25;-Diagnoses included Type 2 diabetes mellitus (when your body cannot use insulin properly), heart failure, essential hypertension (HTN-high blood pressure), Hypokalemia (abnormally low levels of potassium in the bloodstream), Hyperlipidemia (high levels of lipids (fats) in the blood) and chronic kidney disease stage 3 (moderate kidney damage). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 02/13/26, showed the following:-Cognitive skills intact;-The resident required substantial/maximal assistance with toileting, showering and personal hygiene;-No falls.Review of the resident's care plan, revised 02/22/26, showed the following:-The resident had potential for falls due to weakness and medication side effects;-Ensure the resident's call light is within reach and encourage the resident to use if for assistance as needed. Review of the resident's progress note dated 02/24/26, at 7:48 P.M., showed Licensed Practical Nurse (LPN) C documented fall follow-up. The resident had no latent injuries noted from his/her earlier fall. Staff should continue to monitor. Review of the resident's medical record showed staff did not document a fall.During an interview on 03/16/26, at 2:13 P.M., LPN C said he/she documented the resident's fall follow up due to staff informing him/her of the fall in the shift report. Staff should document in the resident's progress notes of a fall. During an interview on 03/16/26, at 2:47 P.M., Registered Nurse (RN) A said the following:-Staff should document in the nurses' notes of a resident's fall;-He/she worked at the facility on 02/24/26 and the resident did not have a fall. The resident was in his/her recliner and slid out. RN A and another aide entered the resident's room and saw the resident slide slow to the ground out of his/her recliner onto the floor. The resident did not hit his/her head and did not have an injury;-He/she should have documented the resident's sliding out of his/her recliner. During an interview on 03/18/26, at 9:19 A.M., the DON said the following:-She considered it a fall if a resident slid out of a chair;-She expected staff to document in the progress notes if a resident falls or slides out of a chair and to notify the resident's responsible party.During an interview on 03/16/26, at 3:15 P.M., the Administrator said she expected nurses to document in the progress notes if a resident slides out of a chair. She considered it a fall if a resident slid out of a chair. #2734672 and #2798251