STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265520	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webco Manor	1687 West Washington Marshfield, MO 65706

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** 34871 Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to address and notify the provider of a change in condition for one resident (Resident #1) whose knees became swollen, red, warm, and painful. The facility census was 52. Review showed the facility did not provide a policy related to change of condition. 1. Review of Resident #1"s face sheet (brief resident profile sheet) showed the following: -admitted [DATE]; -Diagnoses included cognitive communication deficit, rheumatoid arthritis (a chronic autoimmune disease that causes inflammation in the joints, resulting in pain, swelling, stiffness, and tenderness), osteoarthritis (a degenerative joint disease that causes the cartilage and bone in joints to break down over time), and chronic pain syndrome. Review of the resident's care plan, dated 03/16/23, showed the following: -The resident had activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) functional problems as evidenced by the need for staff assistance with his/her ADLs due to diagnosis of arthritis. The resident's balance was not always steady. The resident was only able to stabilize with staff assistance; -The resident required extensive assistance for ambulation, bathing, mobility, dressing, grooming, hygiene, locomotion, toileting, and transfers. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/16/24, showed the following information: -Moderately impaired cognitive skills; -No impairment to upper and lower extremities; -Supervision required with toileting hygiene and showers; (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Nurse Practitioner's (NP) progress note, dated 10/29/24, showed the NP saw the resident for leg pain at the request of the nursing staff. The resident did not have injuries or falls. The resident has issues with chronic pain. NP assessed for full range of motion to all extremities. The resident used a wheelchair. The resident had significant arthritic changes in all joints. All of the resident's joints were painful with decreased range of motion. The resident was alert and oriented with cognitive deficits noted. NP ordered medications change for increased pain. NP reviewed the resident's medications, progress notes and treatment plan. Review of the resident's progress note dated 10/30/24, at 3:08 A.M. showed Registered Nurse (RN) A documented new orders for pain medication and the resident's right knee was swollen, red, and warm to touch. The resident required two staff for assistance at this time. (The RN did not document notifying the resident's physician of the change in the resident's knee.) Review of the resident's Comprehensive Certified Nurse Aide (CNA) Shower Review Sheet, dated 10/31/24, showed CNA B documented the resident's right knee was red, swollen, and hot to touch. Review of the resident's progress note dated 11/01/24, at 3:29 P.M. (recorded as a late entry on 11/03/24 at 1:42 P.M.), showed LPN D documented the resident continued to complain of right knee pain. The resident's right knee was swollen, slightly red, and warm to touch. The resident required more assistance for ADLs than his/her baseline. The resident's doctor was aware. (The LPN did not document specifically what the physician was aware of or when the physician was notified.) Review of the resident's progress note dated 11/02/24, at 9:05 A.M. (recorded as late entry on 11/03/24 at 12:31 P.M.), showed RN E documented a CNA called him/her to the resident's room. The resident stated he/she wanted to request a second opinion for his/her knee. The resident stated he/she made more than one request to be seen by his/her doctor for his/her knee pain and swelling. The resident felt his/her knee was not being treated with sufficient urgency. RN E informed the resident that it is his/her right to request and receive a second medical opinion and he/she would forward his/her request to the Social Service Director (SSD) and Director of Nursing (DON) to follow up on. The resident verbalized understanding and appreciation. At this time the resident's knee was swollen as compared to his/her left knee. The resident's right knee was reddened and warm to the touch. The resident screamed in pain from passive range of motion to his/her right leg. A CNA reported the resident was unable to bear weight and his/her ability to participate in transfers had declined this shift. RN E offered the resident hot/cold packs which the resident declined. The resident repositioned and verbalized slight alleviation of pain. (The RN did not document notifying the physician or NP of the resident's knee.) Review of the resident's progress note dated 11/02/24, at 1:01 P.M. (edited by RN F on 11/02/24 at 01:09 P. M. due to more data available), showed RN F documented staff replaced the resident's fentanyl patch which was currently on his/her left shoulder and verified by two nurses. The resident complained of pain to his/her right knee today. The resident's knee was red, warm, and swollen at this time. Today the resident was upset with the current physician and voiced he/she would like a second opinion and would like a physician to see him/her in the building due to he/she did not feel he/she could make it to see a physician in the office. (The RN did not document notifying the physician or NP of the resident's knee.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note dated 11/03/24, at 12:40 P.M., showed RN E documented a CNA called him/her to the resident's room this morning at the resident's request to speak with a nurse. The resident reported pain to his/her right knee which had increased a lot since yesterday. The resident was tearful and sat in his/her wheelchair and stated he/she just wanted to know what was going on in reference to his/her knee pain. The resident's knee remained hot to touch, reddened, and swollen compared to his/her left knee. The CNA reported the resident was unable to bear weight and this morning required two staff with maximum assistance with a third CNA as standby for safety. RN E notified the provider and obtained an order to transfer at the resident's request and status as his/her own decision for medical. The resident requested for RN E to call his/her family member and discuss before he/she made a final determination. RN E called the resident's family member with an update and the family member verbalized agreement and insisted the resident needed to be seen if he/she experienced that much pain and unable to transfer. The resident stated he/she was ready. Staff notified the non-emergency transfer and emergency services transferred the resident at 12:17 P.M. Review of the resident's orthopedic consultation dated 11/03/24, at 3:45 P.M., showed the resident presented to the emergency department with complaints of severe knee pain. The resident stated he/she believed the pain started on Monday (10/28/24) and had not gotten better. The resident denied any fall or trauma to his/her knee, though there is some underlying dementia. The resident described the pain as a sharp shooting pain, particularly with movement. Review of the resident's progress note dated 11/03/24, at 4:51 P.M., showed RN E documented he/she received an update from the emergency room . The resident was diagnosed with a fracture of the right patella (a small, plate-shaped bone located in front of the knee joint) and scheduled for surgical repair. Review of the resident's hospital history and physical dated 11/03/24, at 4:58 P.M. showed the following: -The resident had right knee pain for one week and was unable to bear weight. The resident denied a fall. Bruising noted to right side. The resident's right knee was hot, swollen, and reddened. The resident was alert and oriented times three; -The resident had a history of rheumatoid arthritis. The resident noted to have right-sided knee pain and swelling. The resident denied a fall, but was confused. The resident had evidence of falls based on bruising on his/her chest as well as deformed knee and patellar fracture. The resident's knee is painful and difficult to move with some swelling. During an observation and interview on 12/05/24, at 9:12 A.M., the resident lay in bed with his/her eyes open and closed at times during the interview. The resident said he/she did not know what happened to his/her knee and it just got that way. He/she may have twisted it. He/she told the nurse it hurt and they looked at it a few times. It was a few days that it hurt and he/she needed help. During an interview on 12/05/24, at approximately 10:45 A.M., Certified Medication Technician (CMT) G said the following: -The resident required standby by assistance and limited one assistance before his/her fracture; -The resident could stand and pivot and sometimes did not ask staff for help; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she noticed the resident's right knee was swollen, red, and fumigating heat; -He/she informed LPN D who stated the staff were aware and obtained Lyrica for pain; -The resident was more dependent and more confused. -Signs of an injury or fracture include broken skin, redness, swelling and hot to touch. Staff should report to the nurse of signs of an injury or fracture. During an interview on 12/05/24, at 11:00 A.M., CNA H said the following: -He/she did not know the exact date of the start of the resident's pain in the right knee, but heard in shift change report that the resident had a lot of pain in his/her right knee and did not transfer himself/herself; -On 11/02/24, the resident was already up in his/her wheelchair and dressed. He/she took the resident to the bathroom after breakfast with a gait belt and two staff. The resident was dead weight and did not bear weight on his/her right side and said it hurt and ow when staff assisted the resident on the toilet and back in his/her chair; -CNA H informed RN E and RN F who assessed the resident. He/she informed the nurse the resident could not stand anymore and the resident did not want to bear weight on that leg; -It took him/her, another aide and RN E to place the resident in bed. The resident voiced he/she was not able to do on his/her own. -Signs of a change in condition include changes in behaviors, illness and skin breakdown; -Staff should inform the charge nurse of a change in condition; -Signs of a fracture of injury include skin breakdown, redness or a purple color; -Staff should inform the charge nurse of a sign of injury; -Signs of a change in ADLs include the resident is dependent, incontinent, lays in bed more often and transfer needs change; -Staff should inform the charge nurse of a change in a resident's ADLS. During interviews on 12/05/24, at 11:29 A.M., and 12/06/24, at 8:10 A.M., CNA B said the following: -He/she worked on the floor a few days before he/she gave the resident a shower on 10/31/24. The resident's right knee was red, but the resident stood and said it hurt a little bit; -On 10/31/24, he/she gave the resident a shower and the resident could not stand. It took two aides to stand the resident up and one aide pulled the resident's pants down; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's right knee was red and hot to touch. He/she informed the charge nurse. The charge nurse said the resident saw the physician and staff put the resident back on the physician list; -Several days after the resident's 10/31/24 shower, the resident's right knee was so red and swollen it was hard to see anything. The resident did not scream out in pain, but could not move his/her right knee and it was difficult to get the resident on the toilet. The resident got more confused; -Signs of injury include bruises, lacerations and changes in behaviors; -Staff should inform the charge nurse of any signs of injury; -On 10/31/24, he/she documented on the shower sheet that the resident's right knee was reddened and hot to touch; -He/she turned the shower sheet into a nurse who reviewed it; -The nurse came into the shower and looked at the resident's skin. The nurse said the resident was on the doctor list; -He/she contacted LPN C one day, not on a shower day, one time about the resident's knee and LPN C said the resident was on the doctor list; -On 10/30/24, a day before the resident's 10/31/24 shower, the resident's right knee was red, swollen and hot to touch. Staff left the resident in bed due to the resident hurt with his/her knee. The resident did not want to get up; -Every time staff mentioned the resident's knee pain to a nurse, the nurse said they would place the resident back on the doctor list; -On 10/31/24, the resident's shower was terrible because it took several aides to help and the resident could not bear weight on his/her right knee. The resident was unable to move his/her right knee in the shower on 10/31/24. During an interview on 12/06/24, at 11:50 A.M., CMT J said the following: -He/she assisted the resident one evening, (Tuesday or Wednesday 10/29/24 or 10/30/24) in the bathroom and pulled the resident's pants down. The resident's right knee was red and swollen. He/she felt heat on the resident's right knee. He/she asked the resident if he/she had done something to it and the resident said it was just like that; -CMT J informed the nurse who said he/she was aware the the physician saw it the beginning of the week. During an interview on 12/06/24, at 1:08 P.M., CMT K said the following: -The facility physician was at the facility on 10/28/24 and the NP was at the facility on 10/29/24; -The physician did not come any other time to the facility that week. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 12/05/24, at 11:49 A.M. and 2:07 P.M., RN F said the following: -On 11/02/24, an aide called him/her to the resident's room; -The resident complained of pain. He/she uncovered the resident's leg. The resident was in bed. The resident's right knee was swollen, red, and tender to touch; -The resident was in his/her bed and stated his/her leg hurt; -The resident did not want his/her right leg moved and barely wanted it touched; -RN E called the physician on 11/02/24; -Staff should monitor the resident and report to the nurse of any signs of a change in ADLS; -Nurses should assess a resident for a change in condition and call the physician; -Signs of an injury or fracture include displacement and pain; -Staff should notify the physician to get an X-ray and notify the responsible party of a sign of a fracture or injury; -Staff should document in the progress notes when the physician is notified. During interviews on 12/05/24, at 1:32 P.M., and on 12/06/24, at 12:07 P.M., LPN C said the following: -The resident complained of pain to his/her right knee prior to 10/29/24; -He/she did not know when the resident's knee started hurting, but knew it was before 10/29/24 because staff placed the resident on the list for the NP to see; -He/she assessed the resident's right knee (on 10/29/24) and it looked like a cyst, which was not red but swollen; -The NP comes to the facility on Tuesdays; -He/she heard staff the resident was having trouble with his/her ADL's; -He/she knows someone should had called the doctor if the resident continued to have problems; -He/she did not know if the physician was aware of the resident's condition after 10/29/24. He/she did not contact the physician. -On 10/31/24, he/she left his/her shift and did not sign the shower sheet; -On 10/29/24, the resident's right knee was swollen but no redness; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did not look at the resident's knee again; -Staff should call the physician if a resident had continued redness and swelling to the knee. During an interview on 12/06/24, at 10:27 A.M., LPN D said the following: -On 10/31/24 and 11/01/24, he/she worked as an aide on the floor and got the resident dressed and in the wheelchair ready for breakfast. The resident was unable to do what he/she normally does. The resident normally did everything for himself/herself and could not hardly stand. It took two aides to put the resident in his/her wheelchair; -The resident had complained of his/her right knee hurting for several days; -Staff put the resident on the list for the physician to see. Nurses write in the doctor book of anything needed to address; -The resident's right knee was a little swollen and the resident said it hurt; -The resident grimaced with pain and said oh, oh and did not want his/her knee messed with; -Staff discussed the resident's pain and did not understand why the resident hurt. Staff passed on that the physician was supposed to see the resident; -He/she did not know if the physician saw the resident for his/her right knee pain; -He/she wrote the note on 10/01/24. He/she knew the NP saw the resident and he/she was under the impression that the facility physician saw the resident. This was from other conversations with nursing staff. He/she did not personally call the physician; -The resident's right knee continued to be red and swollen. The resident declined with his/her ADLS; -Staff should had called the physician or NP ; -Signs of a change in condition include vital signs are different from baseline, changes in eating, sleeping or behaviors; -Staff should notify the physician if a resident has change in pain or mobility from baseline; -Staff should notify the resident's physician of a change in condition or increased pain and document it in the nurses' notes; -Nurses should review the completed shower sheets for any skin issues, assess and see if any changes need addressed, sign off and put in the DON box; -Nurses should report to the DON if they have questions or clarifications needed of doctor visits or orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24, at 2:40 P.M., RN A said the following: -He/she did not not notice redness on the resident's right knee until 10/28/24; -The resident's knees are always swollen. On 10/28/24, the resident's right knee was pink all around the patella at the joint and slightly warm to touch; -On 10/28/24, he/she wrote a note in the doctor book of the resident's right knee was red and more painful more than usual and could the resident get an X-ray; -He/she thought the resident was confused and had trouble transferring to the bathroom; -The NP saw the resident on 10/29/24; -On 10/29/24, an aide said the resident had more trouble with transfers and stated oh my arms, my knees; -The resident was more lethargic. On 10/30/24, the resident transferred himself/herself to the bathroom and had more trouble. The resident complained of his/her right knee; -The resident could not transfer himself/herself, was tearful and frustrated because the resident could usually do for himself/herself; -He/she did not remember if he/she called the physician and it should be documented in progress notes; -On 10/30/24, the resident did not bear weight on his/her right knee. He/she thought it was popped out of joint maybe when the resident had went to the toilet. During an interview on 12/05/24, at 4:05 P.M., RN E said the following: -On 11/02/24 a CNA asked him/her to see the resident; -Multiple staff said the resident requested to see the physician for about a week for his/her knee; -On 11/02/24, he/she assessed the resident; -He/she found that the NP saw the resident on 10/29/24. The resident's NP saw the resident for general aches in all joints and was asymptomatic for an infection; -The resident's right knee was very large, definitely swollen, warm to touch, and red. He/she did not find mild findings, very obvious; -He/she asked another nurse who said the resident was placed on the provider list twice and was unaware of a follow up; -The resident said it had been awhile of requesting to see a physician for his/her knee; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to comprehensively assess pain, follow-up on effectiveness of pain medication, failed to try additional steps when pain was not relieved, and failed to notify the physician of the pain, ineffectiveness of the current pain medication regimen, and when an order for a new pain medication was not received from the pharmacy for one resident (Resident #1) in a review of four sampled residents. The facility census was 52. Review of the facility's policy titled 'Pain Assessment and Management, revised March 2015, showed the following: -The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain; -Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals; -Pain management is multidisciplinary care process that includes the following: assessing the potential for pain, effectively recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of the pain, developing and implementing approaches to pain management, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of intervention, and modifying approaches as necessary; -Assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain; -Document the resident's reported level of pain with adequate detail (enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program; -Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record; -Report the following information to the physician or practitioner: significant changes in the level of the resident's pain, adverse effects from pain medications and prolonged, unrelieved pain despite care plan interventions. 1. Review of Resident #1''s face sheet (brief resident profile sheet) showed the following: -admitted [DATE]; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webco Manor	1687 West Washington Marshfield, MO 65706

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Diagnoses included cognitive communication deficit, rheumatoid arthritis (a chronic autoimmune disease that causes inflammation in the joints, resulting in pain, swelling, stiffness, and loss of function), osteoarthritis (a degenerative disease that worsens over time, often resulting in chronic pain), and chronic pain syndrome. Review of the resident's care plan, initiated 03/16/23, showed the following: -The resident has activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) functional problems as evidenced by the need for staff assistance with his/her ADLs due to diagnosis of arthritis. -The resident's balance is not always steady and the resident is only able to stabilize with staff assistance. -The resident required extensive assistance for ambulation, bathing, mobility, dressing, grooming, hygiene, locomotion, toileting and transfers. -Remind the resident to not transfer without assistance. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/16/24, showed the following information: -Moderately impaired cognitive skills; -No impairment to upper and lower extremities; -Supervision required with toileting hygiene and showers; -Pain with pain intensity of 5 on a 1 to 10 pain scale. Review of the resident's October 2024 Physician Order Sheet (POS) showed the following: -An order, dated 03/08/23, for staff to ask the resident every shift if if he/she has any pain and document the pain number on a pain scale of 0 to 10; -An order, dated 03/08/23, for acetaminophen suppository 650 milligrams (mg) rectal every four hours as needed (PRN) for general discomfort, restlessness, or temperature above 100.5 degrees Fahrenheit (F). Do not exceed 3,000 mg acetaminophen per 24 hours for chronic pain syndrome; -An order, dated 03/08/23, for acetaminophen tablet 325 mg two tablets oral every four hours PRN for general discomfort, restlessness, or temperature above 100.5 degrees F. Do not exceed 3,000 mg acetaminophen per 24 hours for chronic pain syndrome; -An order, dated 11/02/23, for fentanyl patch (medication used to treat severe pain) 25 micrograms (mcg) transdermal (application of a medicine through the skin) once a day every three days for chronic pain syndrome; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-An order, dated 11/03/23, for staff to apply Hempvana (a brand of pain relief creams and posture correctors that use hemp seed oil and other ingredients to provide temporary relief from pain and other issues) cream two times per day (BID) to effected areas (hands and/or knees and or back and or shoulders); -An order, dated 05/17/24, for acetaminophen over the counter (OTC) 325 mg two tablets oral once a day. Do not exceed 3,000 mg acetaminophen per 24 hours for chronic pain; -An order, dated 09/18/24, for duloxetine capsule (can be used to treat osteoarthritis pain) delayed release 40 mg oral once a day. Review of the facility's communication form for the physician to review upon visit, dated 10/28/24, showed Registered Nurse (RN) A documented the resident had increased pain in his/her legs/knees and was unable to transfer for four days related to pain. The resident stated he/she twisted it (right knee). Review of the resident's medical record showed staff did not document related to the resident's increased pain or inability to transfer himself/herself the prior four days (10/23/24 to 10/27/24). Review of the resident's October 2024 Medication Administration Record (MAR) showed the following: -On 10/28/24, on the 6:00 A.M. to 2:00 P.M. shift, staff documented the resident had pain level of a 3 on a pain scale of 0 to 10. -On 10/28/24, on the 6:00 A.M. to 4:00 P.M. shift, staff documented administration of the Hempvana to the resident's right knee. (Staff did not document follow-up on the resident's pain and effectiveness of the pain medications.) -On 10/28/24, on the 2:00 P.M. to 10:00 P.M. shift, staff documented the resident had pain level of a 0 on a pain scale of 0-10; -On 10/28/24 on the 4:00 P.M. to 10:00 P.M. shift, staff documented administration of the Hempvana to the resident's right knee; -On 10/28/24 on the 7:00 P.M. to 10:00 P.M. shift, staff documented administration of the acetaminophen; -On 10/28/24, on the 10:00 P.M. to 6:00 A.M. shift, staff documented the resident had pain level of a 10 on a pain scale of 0-10. Staff documented PRN medication given and cream. (Staff did not document follow-up on the resident's pain and effectiveness of the pain medications.) (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's nurse practitioner's (NP) progress note, dated 10/29/24, showed the NP saw the resident for leg pain at the request of the nursing staff. The resident did not have injuries or falls. The resident had issues with chronic pain. The NP assessed for full range of motion to all extremities. The resident used a wheelchair. The resident had significant arthritic changes in all joints. All of the resident's joints painful with decreased range of motion. The resident was alert and oriented with cognitive deficits noted. Staff to increase duloxetine to 60 milligrams (mg) and trial Lyrica (a controlled substance that can be used to treat pain) as well. The resident also had a fentanyl patch. NP reviewed the resident's medications, progress notes, and treatment plan. Review of the resident's October 2024 MAR showed the following: -On 10/29/24, at 4:10 A.M., staff administered acetaminophen 325 mg two tablets as needed medication for right knee pain. Staff documented on 10/29/24 at 8:40 A.M. somewhat effective results. (Staff did not document additional steps taken to address continued pain.) -On 10/29/24, on the 6:00 A.M. to 02:00 P.M. shift, staff documented the resident had pain level of a 8 on a pain scale of 0-10. (Staff did not document follow-up on the resident's pain.) -On 10/29/24, on the 2:00 P.M. to 10:00 P.M. shift, staff documented the resident had pain level of a 5 on a pain scale of 0-10. (Staff did not document follow-up on the resident's pain.) -On 10/29/24, at 6:44 P.M., staff documented did not administer as other/not completed of the Hempvana. -On 10/29/24, on the 7:00 P.M. to 10:00 P.M. shift, staff administered the acetaminophen 325 mg two tablets. (Staff did not document follow-up on the resident's pain and effectiveness of the pain medications.) -On 10/29/24, on the 10:00 P.M. to 06:00 A.M. shift, staff documented the resident had pain level of a 0 on a pain scale of 0-10. Review of the resident's medical record showed staff did not document notification of the resident's physician or NP of the increased pain. Review of the resident's progress note dated 10/30/24, at 3:08 A.M., showed RN A documented new orders to increase duloxetine back to 60 mg and to start Lyrica 50 mg three times per day for chronic pain. The resident's right knee was swollen, red, and warm to touch. The resident required two staff for assistance at this time. Review of the resident's October 2024 POS showed the following: -An order, dated 10/30/24 for duloxetine capsule delayed release 40 mg; amt: 60 mg oral once a day; -An order, dated 10/30/24, for Lyrica capsule 50 mg oral three time a day. Review of the resident's October 2024 MAR showed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-On 10/30/24, on the 6:00 A.M. to 2:00 P.M. shift, staff documented the resident had pain level of a 0 on a pain scale of 0-10; -On 10/30/24, on the 6:00 A.M. to 4:00 P.M. staff documented administration of the Hempvana to the resident's neck/shoulder; -On 10/30/24, on the 6:00 A.M. to 3:30 P.M. shift, staff administered fentanyl patch to the resident's right upper back; -On 10/30/24 at 8:22 A.M., Certified Medication Technician (CMT) I documented the Lyrica was not administered due to the drug/item unavailable; -On 10/30/24, at 11:40 A.M., CMT I documented the Lyrica not administered due to the drug/item unavailable; -On 10/30/24, on the 2:00 P.M. to 10:00 P.M. shift, staff documented the resident had pain level of a 6 on a pain scale of 0-10 (Staff did not document follow-up on the resident's pain.); -On 10/30/24, on the 4:00 P.M. to the 10:00 P.M., staff documented administration of the Hempvana to the resident's right knee; -On 10/30/24, on the 7:00 P.M. to 10:00 P.M. shift, staff administered the duloxetine; -On 10/30/24, at 7:05 P.M. CMT J documented the Lyrica not administered due to the drug/item unavailable; -On 10/30/24, on the 07:00 P.M. to 10:00 P.M. shift, staff documented administration of the acetaminophen tablet 325 mg two tablets; -On 10/30/24, on the 10:00 P.M. to 6:00 A.M. shift, staff documented the resident had pain level of a 4 on a pain scale of 0-10. (Staff did not document follow-up on the resident's pain.) Review of the resident's medical record showed staff did not document notifying the physician or NP of the Lyrica not being available. Review of the facility's document titled 'Medication Unavailable, dated 10/30/24, showed the following: -The resident's name; -Date discovered: 10/30/24; -Medication and dose unavailable: Lyrica; -What date was the medication ordered?-left blank; -CMT I signed the form; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-To be completed by charge nurses of why was the medication unavailable for administration? Charge nurse did not state the reason, document a signature or date; -Medication has been received and is ready for administration with date and DON signature - not completed. Review of the resident's October 2024 MAR showed the following: -On 10/31/24, on the 6:00 A.M. to 2:00 P.M. shift, staff documented the resident had pain level of a 0 on a pain scale of 0 to 10; -On 10/31/24, on the 6:00 A.M. to 4:00 P.M., staff administered the Hempvana cream to the resident's neck and shoulders; -On 10/31/24, at 8:30 A.M., staff administered acetaminophen 325 mg two tablets as needed medication. Staff documented somewhat effective results; -On 10/31/24, at 8:39 A.M., CMT I documented the Lyrica not administered due to the drug/item unavailable; -On 10/31/24, at 11:14 A.M., CMT I documented the Lyrica not administered due to the drug/item unavailable; -On 10/31/24, on the 2:00 P.M. to 10:00 P.M. shift, staff documented the resident had pain level of a 6 on a pain scale of 0-10. (Staff did not document follow-up on the resident's pain.) -On 10/31/24, on the 4:00 P.M. to 10:00 P.M. shift staff administered the Hempvana cream to the resident's knees; -On 10/31/24, on the 7:00 P.M. to 10:00 P.M., staff documented administration of the acetaminophen tablet 325 mg two tablets; -On 10/31/24, on the 7:00 P.M. to 10:00 P.M., staff administered the duloxetine; -On 10/31/24, on the 10:00 P.M. to 6:00 A.M. shift, staff documented the resident had pain level of a 5 on a pain scale of 0-10 (Staff did not document follow-up on the resident's pain.); -On 10/31/24, at 7:35 P.M. CMT K documented the Lyrica not administered due to the drug/item unavailable. Review of the facility's document titled 'Medication Unavailable, dated 10/31/24, showed the following: -The resident's name; -Date discovered: 10/30/24; -Medication and dose unavailable: Lyrica; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-What date was the medication ordered?-left blank; -CMT I signed the form; -To be completed by charge nurses of why is this medication unavailable for administration? Staff marked pharmacy had not delivered; -RN F signed and dated the form; -Medication has been received and is ready for administration with date and DON signature - not completed. Review of the resident's medical record showed staff did not document notification of the NP or physician of the resident's increased pain and the Lyrica not received from the pharmacy. Review of the resident's November 2024 MAR showed the following: -On 11/01/24, on the 6:00 A.M. to 2:00 P.M. shift, staff documented the resident had pain level of a 0 on a pain scale of 0-10; -On 11/01/24, on the 6:00 A.M. to 4:00 P.M. shift, staff administered Hempvana cream to the resident's neck and shoulders; -On 11/01/24, at 9:55 A.M., showed staff administered acetaminophen for general discomfort and documented the medication was effective; -On 11/01/24, on the 4:00 P.M. to 10:00 P.M shift, staff administered Hempvana cream to the resident's left knee; -On 11/01/24, on the 2:00 P.M. to 10:00 P.M. shift, staff documented the resident had pain level of a 0 on a pain scale of 0-10; -On 11/01/24, on the 10:00 P.M. to 6:00 A.M. shift, staff documented the resident had pain level of a 9 on a pain scale of 0-10. (Staff did not document follow-up on the resident's pain.); -On 11/01/24, at 9:48 A.M., staff documented Lyrica was not administered due to the medication was unavailable; -On 11/01/24, at 11:49 A.M., staff documented Lyrica was not administered due to the medication was unavailable; -On 11/01/24, at 9:51 P.M., staff documented Lyrica was not administered due to the medication was unavailable. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress note dated 11/01/24, at 3:29 P.M. (recorded as a late entry on 11/03/24 at 1:42 P.M.), showed Licensed Practical Nurse (LPN) D documented the resident continued to complain of right knee pain. The resident's right knee was swollen, slightly red, and warm to touch. The resident required more assistance for ADLs than his/her baseline. The resident's order for Lyrica continued to be unavailable. The resident's doctor was aware. (Staff did not specify if the physician was aware of the increased pain or Lyrica not received. Staff did not document when the physician was made aware.) Review of the resident's November 2024 MAR showed the following: -On 11/02/24, on the 6:00 A.M. to 2:00 P.M. shift, staff documented the resident had pain level of a 0 on a pain scale of 0-10; -On 11/02/24, at 7:05 A.M., staff documented Lyrica was not administered due to the medication was unavailable;. -On 11/02/24, at 11:38 A.M., staff documented Lyrica was not administered due to the medication was unavailable;. -On 11/02/24, on the 6:00 A.M. to 3:30 P.M. shift, staff administered a fentanyl patch to the left resident's left shoulder; -On 11/02/24, on the 6:00 A.M. to 4:00 P.M. shift, staff administered Hempvana cream to the resident's knee. -On 11/02/24, on the 4:00 P.M. to 10:00 P.M. shift, staff administered Hempvana cream to the resident's knees; -On 11/02/24, at 9:20 P.M., staff documented Lyrica was not administered due to the medication was unavailable;. -On 11/02/24, on the 2:00 P.M. to 10:00 P.M. shift, staff documented the resident had pain level of a 0 on a pain scale of 0-10; -On 11/02/24, on the 10:00 P.M. to 06:00 A.M. shift, staff documented the resident had pain level of a 4 on a pain scale of 0-10. (Staff did not document follow-up on the resident's pain.) (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress note dated 11/02/24, at 9:05 A.M. (recorded as late entry on 11/03/24 at 12:31 P.M.), showed Registered Nurse (RN) E documented a certified nurse aide called him/her to the resident's room. The resident stated he/she wanted to request a second opinion for his/her knee. The resident stated he/she made more than one request to be seen by his/her doctor for his/her knee pain and swelling. The resident felt his/her knee was not being treated with sufficient urgency. RN E informed the resident that was his/her right to request and receive a second medical opinion and he/she would forward his/her request to the Social Service Director and Director of Nursing (DON) to follow up on. The resident verbalized understanding and appreciation. At this time the resident's knee was swollen as compared to his/her left knee. The resident's right knee was reddened and warm to the touch. The resident screamed in pain from passive range of motion to his/her right leg. A CNA reported the resident was unable to bear weight and his/her ability to participate in transfers had declined this shift. RN E offered the resident hot/cold packs which the resident declined. The resident repositioned and verbalized slight alleviation of pain. (Staff did not document notification of the resident's physician or NP of the resident's increased pain, request for a second opinion, resident response to the range of motion to the right leg, and decline in ADLs.) Review of the resident's progress note dated 11/02/24, at 1:01 P.M. (edited by RN F on 11/02/24 at 01:09 P. M. due to more data available), showed RN F documented staff replaced the resident's fentanyl patch which was currently on his/her left shoulder and verified by two nurses. The resident complained of pain to his/her right knee. The resident's knee was red, warm, and swollen at this time. Today the resident was upset with the current physician and voiced he/she would like a second opinion and would like a physician to see him/her in the building due to he/she did not feel he/she could make it to see a physician in the office. (Staff did not document notification of the resident's physician or NP of the resident's increased pain, request for a second opinion, or resident's concern of inability to go to a physician's office.) Review of the resident's November 2024 MAR showed the following: -On 11/03/24, on the 6:00 A.M. to 2:00 P.M. shift, staff documented the resident had pain level of a 6 on a pain scale of 0-10; -On 11/03/24, on the 6:00 A.M. to 4:00 P.M. shift, staff administered Hempvana cream to the resident's right knee; -On 11/03/24, at 7:41 A.M., staff administered acetaminophen and documented the medication was effective; -On 11/03/24, at 7:41 A.M., staff documented Lyrica was not administered due to the medication was unavailable; -On 11/03/24, at 11:09 A.M., staff documented Lyrica was not administered due to the medication was unavailable; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-On 11/03/24, on the 2:00 P.M. to 8:00 P.M. shift, staff documented the resident had pain level of 8 on a pain scale of 0-10. (Staff did not document follow-up on the resident's pain.) Review of the resident's progress note dated 11/03/24, at 10:28 A.M., showed RN E documented the resident's scheduled Lyrica was unavailable. RN E called the pharmacy and left a message and requested a call back to discuss current status. At last known update, the pharmacy waiting for the provider to sign for the controlled medication. (Staff did not document notification of the NP or physician of the resident's Lyrica not received from the pharmacy) Review of the resident's progress note dated 11/03/24, at 12:40 P.M., showed RN E documented a CNA called him/her to the resident's room this morning at the resident's request to speak with a nurse. The resident reported pain to his/her right knee which had increased a lot since yesterday. The resident was tearful and sat in his/her wheelchair and stated he/she just wanted to know what was going on in reference to his/her knee pain. The resident's knee remained hot to touch, reddened, and swollen compared to his/her left knee. The CNA reported the resident was unable to bear weight and this morning required two staff with maximum assistance with a third CNA as standby for safety. RN E left a message with the pharmacy earlier this morning in regard to the Lyrica order. The medication was ordered on 10/29/24, but the pharmacy did not deliver the medication yet. RN E notified the provider and obtained an order to transfer at the resident's request and status as his/her own decision for medical. The resident requested for RN E to call his/her family member and discuss before he/she made a final determination. RN E called the resident's family member with an update and the family member verbalized agreement and insisted the resident needed to be seen if he/she experienced that much pain and unable to transfer. The resident stated he/she was ready. Staff notified the non-emergency transfer and emergency services transferred the resident at 12:17 P.M. Review of the resident's orthopedic consultation dated 11/03/24, at 3:45 P.M., showed the resident presented to the emergency department with complaints of severe knee pain. The resident stated he/she believed the pain started on Monday (10/28/24) and had not gotten better. The resident denied any fall or trauma to his/her knee, though there was some underlying dementia. The resident described the pain as a sharp shooting pain, particularly with movement. Review of the resident's progress note dated 11/03/24, at 4:51 P.M., showed RN E documented he/she received an update from the emergency room . The resident was diagnosed with a fracture of the right patella (a small, plate-shaped bone located in front of the knee joint) and scheduled for surgical repair or soonest or availability. Review of the resident's hospital history and physical dated 11/03/24, at 4:58 P.M., showed the following: -The resident had right knee pain for one week and unable to bear weight. The resident denied a fall. Bruising noted to right side. The resident's right knee was hot, swollen, and reddened. The resident was alert and oriented times three; -The resident had a history of rheumatoid arthritis. The resident noted to have right knee pain and swelling. The resident denied a fall, but is confused. The resident had evidence of falls based on bruising on his/her chest as well as deformed knee and patellar fracture. The resident's knee is painful and difficult to move with some swelling. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 12/05/24, at 9:12 A.M., the resident lay in bed with his/her eyes open and closed at times during the interview. The resident said he/she did not know what happened to his/her knee it just got that way. He/she may have twisted it. He/she told the nurse it hurt and they looked at it a few times. It was a few days that it hurt and he/she needed help. He/she informed the staff his/her knee was painful and on a scale from one to ten was a nine. He/she told the nurse and aides that his/her knee hurt. During an interview on 12/05/24, at approximately 10:45 A.M., Certified Medication Technician (CMT) G said the following: -The resident required standby by assistance and limited one assistance before his/her fracture. The resident could stand and pivot and sometimes did not ask for help. He/she noticed the resident's right knee was swollen, red and fumigating heat; -He/she informed LPN D who stated the staff were aware and obtained Lyrica for pain; -He/she was unable to pull the Lyrica from the emergency kit and administered Tylenol to the resident; -The resident was very uncomfortable and reported pain to all staff; -The resident was more dependent and more confused; -Staff should review the resident's medications, offer a snack, hydration and report to the nurse if a resident complaints of pain. During an interview on 12/05/24, at 11:00 A.M., CNA H said the following: -He/she did not know the exact date, but heard in shift change report that the resident had a lot of pain in his/her right knee and did not transfer himself/herself. It was a weekend he/she heard about it. -On 11/02/24, the resident was already up in his/her wheelchair and dressed. He/she took the resident to the bathroom after breakfast with a gait belt and two staff. The resident was dead weight and did not bear weight on his/her right side. The resident said it hurt and ow when staff assisted the resident on the toilet and back in his/her chair. -CNA H informed RN E and RN F who assessed the resident. He/she informed the nurse the resident could not stand anymore and the resident did not want to bear weight on that leg. It took him/her another aide and RN E to place the resident in bed. The resident voiced he/she was not able to do on his/her own. -Staff should inform the charge nurse or CMT if a resident complains of pain. During interviews on 12/05/24, at 11:29 A.M., and on 12/06/24, at 8:10 A.M., CNA B said the following: -He/she worked on the floor a few days before the resident's shower on 10/31/24; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265520	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webco Manor	1687 West Washington Marshfield, MO 65706

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-The resident's right knee was red, but the resident stood and said it hurt a little bit; -On 10/31/24, he/she gave the resident a shower and the resident could not stand. It took two aides to stand the resident up and one aide pulled the resident's pants down; -The resident's right knee was red and hot to touch. He/she informed the charge nurse; -The charge nurse said the resident saw the physician and staff put the resident back on the physician list; -The nurse said the physician wanted to lay the resident down and rest; -Several days after he/she gave the resident a shower on 10/31/24, the resident's right knee was so red and swollen it was hard to see anything. The resident did not scream out in pain, but could not move his/her right knee and it was difficult to get the resident on the toilet. The resident got more confused; -On 10/31/24, he/she documented the resident's right knee was reddened and hot to touch on the shower sheet; -He/she turned the shower sheet into a nurse who reviewed it; -The nurse said the resident was on the doctor list; -He/she contacted LPN C one day, about the resident's knee and LPN C said the resident was on the doctor list; -On 10/30/24, a day before the resident's 10/31/24 shower, the resident's right knee was red, swollen and hot to touch; -Staff left the resident in bed due to the resident hurt with his/her knee. The resident did not want to get up; -Staff should inform the charge nurse of any signs of pain. During an interview on 12/06/24, at 11:31 A.M., CMT I said the following: -He/she called the pharmacy on the resident's Lyrica. The pharmacy said they needed the doctor to sign the prescription; -He/she did not know if the nurses called the physician to try something different from the Lyrica; -Staff informed the former DON who said the NP looked at the resident's right knee; -Staff asked the nurses about the resident's pain and medication and the nurses said the NP saw the resident. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Staff fill out a form if a medication is unavailable and give to the supervisor or charge nurse; -Staff fill out a medication unavailable form every shift a medication is unavailable. During an interview on 12/06/24 at 11:50 A.M. CMT J said the following: -He/she called the pharmacy twice in a row and was informed a prior authorization was needed. It was an insurance issue; -He/she assisted the resident one evening, (Tuesday or Wednesday 10/29/24 or 10/30/24) in the bathroom and pulled the resident's pants down. The resident's right knee was red and swollen. He/she felt heat on the resident's right knee. He/she asked the resident if he/she had done something to it and the resident said it was just like that; -CMT J informed the nurse who said he/she was aware the the physician saw it the beginning of the week; -Staff complete a form if a medication is unavailable and give to the nurse. During an interview on 12/06/24 at 11:59 P.M. CMT K said the following: -He/she called the pharmacy after 10/30/24 or 10/31/24 who needed a pre authorization. He/she submitted the preauthorization under the physician; -On 11/13/24, the medication was not covered unless approved by insurance. The preauthorization was sent on 10/30/24 or 10/31/24 and was denied on 11/04/24. The form said can request an appeal and the resident was in the hospital at the time and was not sure if he/she would come back to the facility on the Lyrica. The resident returned from he hospital on 11/07/24 and the NP wrote an order to hold the Lyrica on 11/08/24 until it was available from the pharmacy. During interviews on 12/06/24, at 11:50 A.M. and 1:08 P.M., CMT K said the following: -The facility physician was at the facility on 10/28/24 and the NP was at the facility on 10/29/24; -Staff should complete a form if a medication is not available and give to the nurse. The nurse should follow up and then the DON gives to him/her to file in medical record. During interviews on 12/05/24, at 11:49 A.M. and 12:07 P.M., RN F said the following: -On 11/02/24 an aide called him/her to the resident's room. The resident complained of pain. He/she uncovered the resident's leg; -The resident was in bed. The resident's right knee was swollen, red, and tender to touch; -The resident was in his/her bed and stated his/her leg hurt; -The resident did not want his/her right leg moved and barely wanted it touched; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-RN E notified the physician; -The resident was up for breakfast and was not tearful. The resident said he/she was in pain; -He/she did not know about the Lyrica or why it was not available; -Staff use a pain scale and if the resident cannot communicate pain, staff assess for facial grimacing and body movement; -Staff should check for scheduled and PRN pain medication; -Staff should call the physician if a resident has pain and obtain an order for a pain medication; -Staff should send the order to the pharmacy which usually is delivered that day or a few hours; -The physician signs the order for narcotics; -The physician signs for Lyrica; -The pharmacy handles the order if it is an insurance issue; -Staff should document in the progress notes when the physician is notified. During interviews on 12/05/24, at 1:32 P.M., and on 12/06/24, at 12:07 P.M., LPN C said the following: -The resident complained of pain to his/her right knee prior to 10/29/24; -He/she did not know when the resident's knee started hurting, but knew it was before 10/29/24 because staff placed the resident on the list for the NP to see; -The resident's Lyrica did not come in due to insurance reasons. -He/she did not receive reports of pain from the other nurses; -He/she did not know if the physician was aware of