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	07/28/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent and treat urinary tract infections when staff failed to notify the physician of and provide treatment for suspected urinary tract infections (UTI) two residents (Resident #17 and #51). The facility also failed to ensure proper catheter (a thin, flexible tube inserted into the body to drain fluid) use for residents when staff failed to obtain appropriate physician orders to place a catheter, to provide catheter care, and to change the catheter for one resident (Resident #43) with an indwelling urinary catheter. The facility census was 57.Review of the facility policy titled, “Urinary Tract Infections (UTI)/Bacteriuria-Clinical Protocol,” revised June 2014, showed the following:-The staff and practitioner will identify individuals with signs and symptoms suggesting a possible UTI;-The physician will help nursing staff interpret the significance of signs, symptoms, and lab test results;-The physician will order appropriate treatment for verified or suspected UTIs based on pertinent assessment. 1. Review of Resident #17’s face sheet showed:-admission date of 07/26/24;-Diagnoses included of Alzheimer’s disease, urinary tract infection, urinary incontinence, and congestive heart failure. Review of the resident’s quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff). dated 04/15/25, showed the following:-Severe cognitive impairment;-Resident ambulated with walker and independent with mobility and transfers;-Required partial to moderate assistance of staff with toileting hygiene, personal hygiene, upper and lower body dressing;-Frequently incontinent of bowel and bladder. Review of the resident’s physician orders showed an active order, dated 07/26/24, to straight catheterize as needed (PRN) to obtain urinalysis (UA), if unable to obtain by clean catch method. Review of the resident’s care plan, dated 08/06/24, showed the following:-Resident needs staff assistance with his/her activities of daily living (ADL) due to diagnosis of dementia;-Observe resident for signs or symptoms of a UTI, foul or strong urine, pain or burning with urination, or dark colored urine;-Report any symptoms to the charge nurse. Review of the resident’s nurse progress note dated 06/25/25, at 6:53 P.M., showed Registered Nurse (RN) Q documented a new order for UA with culture and sensitivity due to increased confusion. Review of the resident’s physician orders showed staff did not document a specific order for a urinalysis on 06/25/25. Review of the resident’s nurse progress note dated 06/26/25, at 5:21 A.M., showed a nurse documented UA obtained by clean catch and in fridge awaiting lab pick up. Review of the resident’s final urine culture results, reported on 06/29/25, showed the following:-Result of 10,000-49,000 colony-forming units (CFU)/milliliter (mL) of Proteus Mirabilis (a bacteria commonly associated with infections of the urinary tract);-An accompanying list of antibiotics for the bacteria with sensitivity and resistance listed. Review of the resident’s medical record, dated 06/29/25 to 07/10/25, showed staff did not document notification of the physician regarding the urine culture results. Review of the resident’s nurse progress note dated 07/11/2025, at 9:09 P.M., showed RN Q documented new orders for antibiotics. Resident started on Cefdinir (an antibiotic) 300 milligrams (mg) two times a day (BID) for a urinary tract infection (UTI). The resident received his/her first dose of therapy at 9:05 P.M. The resident will receive therapy for 7 days. Review of the resident’s physician orders showed the following orders:-An order, dated 07/11/25, for Cefdinir, capsule 300 mg, amount of 300 mg, oral twice a day for 7 days;-An order, dated 07/11/25, for acidophilus (a probiotic) capsule give 2 capsules with meals, orally two times per day, while the resident is on antibiotics. During an interview on 07/22/25, at 12:11 P.M., the Director of Nursing (DON) said the following: -The resident's urinalysis with culture and sensitivity, dated 06/29/25, was the most recent urinalysis completed on the resident;-The facility's laboratory was supposed to call the facility with critical lab results including the positive culture results, but they did not do so in this situation;-The lab results were reported to the facility via a computer portal;-The facility nurses must then print and scan a paper copy into each resident's electronic health record and place a paper copy in the physician's book for the physician to review when he/she made resident rounds at the facility;-If a culture result shows bacteria in the urine, the nurse should call the physician with the positive culture results;-The facility had an issue with the nurses not being able to view the portal results;-The issue was with laboratory portal access;-He/she was currently working on the issue;-The DON was printing the lab results off the lab portal and reviewing all results two times per week. During an interview on 07/25/25, at 1:07 P.M., Certified Medication Technician (CMT) U/Medical Records said the following:-He/she thought the facility had some

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident’s nurse progress note dated 07/01/25, at 6:32 P.M., showed CMT U/Medical Records documented the following:-Family Nurse Practitioner (FNP) here and saw the resident;-Received an order to discontinue the resident’s Foley catheter;-Resident aware of the new order. Review of the resident’s physician orders showed the following: -A previous order for Foley catheter (an indwelling urinary catheter) care every shift and as needed. The order was discontinued on 07/02/25;-No current order for a urinary foley catheter or catheter care. Review of the resident’s nurse progress note dated 07/02/25, at 1:02 P.M., showed the following:-The resident was refusing to allow the licensed practical nurse (LPN) to discontinue his/her Foley catheter as ordered by the physician at this time;-The resident said the physician did not talk with him/her about discontinuing his/her catheter and he/she would like to speak to the physician first;-Placed a request for the physician to talk with the resident about discontinuing the resident’s Foley catheter in the physician’s book. Observation and interview on 07/21/25, at 11:30 A.M., showed the following:-The resident on his/her bed;-The resident said he/she had an indwelling urinary catheter;-The resident said he/she completed his/her own catheter care;-The resident’s catheter drainage bag with yellow urine present was attached to the resident’s bed frame, suspended off the floor. During an interview on 07/25/25, at 1:43 P.M., CMT U/Medical Records said the following:-The physician gave an order to discontinue (remove) the resident’s urinary catheter, but the resident refused to allow staff to remove the catheter;-The resident wanted to speak with the physician about the pros and cons of the catheter and the physician encouraged the resident to allow nursing to remove the catheter, but the resident refused;-The resident had a diagnosis of neurogenic bladder (a condition where the nerves that control the bladder do not function properly, leading to difficulty with urination), so the physician agreed to allow the resident to keep his/her catheter. The physician told the resident nursing would change his/her catheter monthly;-Any resident with a catheter should have a physician’s order for the catheter to include size and changing frequency;-The CMT viewed the resident’s medical record and said he/she could not find a current physician’s order for the resident’s catheter or an order to change the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/28/25, at 2:18 P.M., RN Q said the following:-The physician or nurse practitioner discontinued the resident’s urinary catheter, but the resident refused to allow the catheter to be removed;-The resident did have a diagnosis of neurogenic bladder which qualified him/her to keep the catheter;-The nurse notified the Administrator and the resident’s physician;-The physician said the resident could keep due the indwelling urinary catheter due to his/her diagnosis a neurogenic bladder;-The nurse did not realize the resident did not have a current catheter order;-The resident should have an order for his/her indwelling urinary catheter;-The order should include catheter size, [NAME] size, and frequency of change;-The nurse said he/she thought the facility policy was for monthly changes of a urinary catheter. did not have an order, the order should include catheter size, balloon and frequency of change. During an interview on 07/28/25, at 9:40 AM, the Administrator said the following:-Nursing should obtain a physician’s order for any resident with a catheter. The order should include size of catheter and [NAME] and frequency of changing the catheter;-The physician gave staff an order to discontinue the resident’s catheter, but the resident refused removal of the catheter;-A nurse discontinued the catheter order and failed to request a new physician’s order for the catheter. 3. Review of Resident #51's face sheet showed the following:-admission date of 08/07/24;-Diagnoses included essential hypertension (HTN-high blood pressure), major depressive disorder, and chronic kidney disease stage III (moderate kidney damage). Review of the resident's progress note dated 05/07/25, at 1:01 A.M., showed a nurse documented the resident complained to the nurse that he/she voided excessively. The resident was incontinent. The resident stated that his/her bladder was low but not prolapsed. The resident would like to speak to the doctor to see if anything could be done. The resident was concerned about his/her voiding excessively. The resident did not complain of pain due to this. Review of the provider's note, dated 05/07/25, showed the provider documented urinary frequency per nursing staff and history of bladder prolapse. Check with urinalysis. Review of the resident's progress note dated 05/08/25, at 5:39 P.M., showed a nurse documented the laboratory called the facility with the urinalysis results. The white blood count was greater than 100. The nurse practitioner ordered to wait on the culture results. Review of the resident's laboratory results showed the following:-On 05/08/25, the lab was ordered;-On 05/14/25, the laboratory was verified;-Result of greater than 100,000 CFU/ml of Proteus mirabilis. Review of the resident's nurse practitioner's note, dated 05/20/25, showed the following:-Follow up on dysuria (a medical term for pain, discomfort, or a burning sensation during urination) and lab results;-Urine culture positive for proteus;-Cefdinir 300 mg twice a day for five days;-Diagnosis of UTI. Review of the resident's May 2025 Physician Order Sheet (POS) showed an order, dated 05/20/25, for Cefdinir 300 mg twice a day. (Staff documented the antibiotic order six days after the urine culture results were received.) Review of the resident's May 2025 Medication Administration Record (MAR) showed the following:-An order, dated 05/20/25, for Cefdinir 300 mg twice a day;-On 05/20/25 on the 10:00 P.M. to 10:00 A.M., shift staff administered the medication to the resident. Review of the resident's progress note dated 05/21/25, at 1:58 A. M., showed a nurse documented as a late entry for 10:00 P.M. at 05/20/25 a new order for an antibiotic for Cefdinir 300 mg to be started for treatment of a UTI. Staff administered initial dose at this time tonight. The resident had no complaints of dysuria or flank pain but did complain of urinary frequency. Review of the resident's quarterly MDS assessment, dated 05/29/25, showed the following:-Cognitive skills intact;-Substantial/maximal assistance required with toileting;-Frequently incontinent with urinary continence. Review of the resident's care plan, revised 06/03/25, showed the following:-The resident was at risk for skin breakdown and odor due to bowel and bladder incontinence;-Monitor for incontinence frequently. During an interview on 07/24/25, at 02:00 P.M., the ADON said the following:-The resident's UA culture did not result until 05/14/25 and the results were greater than 100,00, so the resident had a UTI. Staff should had called the physician right away;-The laboratory did not notify the facility of the resident's UA results and he did not think the nurses were checking the laboratory results. During an interview on 07/24/25, at 4:04 P.M., the DON said the following:-The resident's UA results were on 05/08/25, and the NP wanted to wait for results of the urine culture which was on 05/14/25. The lab should had called the facility with the resident's abnormal culture results. The resident's urine culture was in the lab portal and staff would have to search the resident in the lab portal for the culture results. Staff should had started the resident's antibiotic before 05/20/25. During an interview on 07/25/25, at 9:41 A.M., the resident said a few months ago, he/she thought in May