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	03/23/2026

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a system in place to ensure each resident's code status preference was clear and accurate when staff failed to update a full code (every possible measure, including cardiopulmonary resuscitation (CPR - an emergency procedure that is done when a person stops breathing or heart stops, to save a person's life)) to a do not resuscitate (DNR - an order that instructs providers not to start CPR if a person stops breathing or heart stops) for one resident (Resident #1). The facility census was 61. On [DATE], Social Services Director (SSD) notified the Administrator that staff provided CPR to Resident #1, who wished to be a DNR. On [DATE], the facility completed an audit of all residents' code status. On [DATE] the facility implemented a new process and in-serviced all staff. The non-compliance was corrected on [DATE]. Review of the facility's Advanced Directive Policy, revised [DATE], showed the following information:-Upon admission, the resident will be provided with written information regarding the right to refuse or accept medical treatment and to formulate an advance directive if he or she chooses to do so;-If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives;-The resident will be given the option to accept or decline assistance;-Nursing staff will document in the medical record;-The resident has the right to refuse treatment, whether or not he or she has an advance directive;-A resident will not be treated against his or her own wishes.Review of the facility's Do Not Resuscitate Order Policy, revised [DATE], showed the following information:-The facility will not use CPR and related emergency measures to maintain life functions on a resident when there is a DNR order in effect;-DNR orders must be signed by the physician, on the physician's order sheet maintained in the resident's medical record;-A DNR order form must be completed and signed by the physician and resident and placed in front of the resident's medical record.1. Review of Resident #1's face sheet (a brief resident profile sheet) showed the following information:-admission date of [DATE];-Resident expired on [DATE];-Resident was a full code;-Diagnoses included atrial fibrillation (irregular heart rate and rhythm), cardiac disease, stroke, and lung disease.Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated [DATE], showed the resident had normal cognition.Review showed staff did not provide a care plan for the resident. Review of the resident's Physician Order Sheet (POS) showed an order, dated [DATE], for full code.Review of resident's Outside Hospital Do-Not-Resuscitate (OHDNR) Order, dated [DATE], showed the order signed and dated by the resident and the physician.Review of the resident's progress notes showed the following information:-On [DATE], at 9:56 P.M., the resident was found unresponsive. The nurse was immediately called to the room. Staff initiated CPR and called 911;-On [DATE], at 10:04 P.M., emergency medical services (EMS) arrived and took over CPR for over an hour;-On [DATE], at 11:00 P.M., staff notified the family and physician of the code.Review of the admission Director's handwritten statement, undated, showed the following: -He/she went to the resident's room on [DATE] to complete the admission paperwork;-After completion, all forms were put in a folder on his/her desk. He/she left the facility for the weekend;-He/she returned to the (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE] and gave the folder to the Social Services Director (SSD);-It did not occur to him/her to make copies for the nursing charts;-It was his/her responsibility to ensure all admissions paperwork was completed and the next steps taken care of before leaving for the weekend.During an interview on [DATE], at 9:35 A.M., the Admissions Director (AD) said the following information:-The resident admitted from the hospital to the facility on [DATE] around 5:00 P.M.;-On [DATE], he/she completed the admission paperwork with the resident;-After completing the admission paperwork, he/she normally gave the paperwork to the SSD, however, he/she had already left the facility for the weekend;-On [DATE], staff found the resident unresponsive and CPR was initiated;-On [DATE], the admission packet was given to the SSD;-He/she said he/she realized the mistake of not letting nursing staff know that the resident changed his/her code status.Review of the Social Services Director (SSD) handwritten statement, undated, showed the following: -The resident admitted on [DATE];-When the resident was accepted to the facility, the SSD created a profile in electronic medical records (EMR) and listed the resident as a full code;-The facility's policy is to default to full code until staff have spoken to the resident and/or family to determine preferred code status;-On [DATE], the admission Director gave the SSD signed admission paperwork;-On [DATE], the SSD began reviewing the admission packet to scan into the EMR when he/she discovered a signed DNR form;-The SSD immediately notified the Administrator.During an interview on [DATE], at 10:00 A.M., the SSD said the following:-The resident admitted to the facility on [DATE] in the evening;-On [DATE], the AD completed the admission paperwork;-On [DATE], the resident and the physician signed the DNR paperwork;-The SSD didn't receive the admission paperwork, including the DNR until [DATE];-All residents are admitted as a full code, that is the facility's default;-The resident's orders had not been up-dated in the hard chart, EMR , or the green/red sticker outside the resident's door prior to his/her death;-On [DATE], the SSD seen the DNR order in the admission paperwork and notified the Administrator.During an interview on [DATE], at 10:53 A.M., Licensed Practical Nurse (LPN) A said the following:-Resident code status can be found in the code book. This is where the resident's DNR OHDNR order form is located;-Code status can also be found on the resident's face sheet;-Red or green sticker outside the resident's door on the resident's name tag;-The resident was a full code.During an interview on [DATE], at 11:03 A.M., Certified Nursing Assistant (CNA) B said the following:-A resident's code status is on the resident's door. [NAME] sticker means full code and red sticker means DNR;-A resident's code status is also in the EMR, on the face sheet;-He/she would get the nurse if the resident appeared to need CPR.During an interview on [DATE], at 11:44 A.M., the Director of Nursing (DON) said the following information:-The resident admitted on [DATE] in the evening;-The Admissions Director completed the admission packet on [DATE] and included signing contracts, going over vaccination records and code status;-Normally the AD will give the code status paperwork to the DON to update in the EMR and the SSD will up-date the red and green stickers out-side the door. That did not happen this time;- The DON said that he/she did not receive any DNR paperwork on the resident prior to the resident coding on [DATE];-Staff called the DON when the resident coded;-The DON came to the facility and contacted family that the resident was coding;-EMS also arrived at the facility and took over CPR.During an interview on [DATE], at 1:30 P.M., the Administrator said the following information:-The resident admitted late on [DATE];-The Admissions Director completed the resident's admission paperwork on [DATE];-The resident changed his/her wishes from a full code to a DNR. DNR paperwork was completed and signed by the resident and the physician;-The Admissions Director did not pass that DNR paperwork onto the SSD or the DON to in-put into the medical record, therefore, nursing staff were not aware that the resident wanted to be a DNR.#2788102