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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all resident care plans were completed and current when staff failed to care plan related to a relationship and restrictions involving two residents (Resident #20 and #2) and when the staff failed to care plan new falls and new interventions for one resident (Resident #50). A sample of 20 residents was reviewed in a facility with a census of 57. Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised December 2016, showed the following:-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident;-Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process;-Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making;-When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers;-Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions changes. 1. Review of Resident #20's face sheet showed the following:-admission date of 05/18/22;-Diagnoses included essential hypertension (HTN-high blood pressure), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and major depressive disorder. Review of the resident's progress note dated 06/17/25, at 3:15 P.M., showed the Social Service Director (SSD) documented a care conference with the resident's legal guardian. The interdisciplinary team spoke with the guardian regarding the relationship between the resident and Resident #2. Resident #2 expressed his/her desire to relocate to another state and asked for the resident (Resident #20) to move with him/her. The residents have requested permission to spend time together in one another's rooms, which staff advised is not permitted. The guardian confirmed his/her support for the interventions staff put in place and expressed willingness to speak with the resident regarding the importance of guardianship and the legal procedures involved should he/she wish to pursue its revocation. Review of the resident's quarterly Minimum Data Set (MDS – a federally mandated assessment completed by facility staff), dated 06/25/25, showed the following-Moderately impaired cognitive skills;-No behaviors. Review of the resident's revised care plan, dated 06/26/25, showed staff did not update the care plan of the resident's relationship with another resident and the restrictions of not able to be in each other's rooms. 2. Review of Resident #2's face sheet (resident's information at a quick glance) showed the following: -admission date of 09/17/21;-Diagnoses included post-traumatic stress disorder (mental health condition triggered by experiencing or witnessing a terrifying or traumatic event), major depressive disorder (persistent feelings of sadness), cognitive communication deficit, muscle weakness, and (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety disorder (worrying constantly and cannot control the worrying). Review of the resident's nurses' progress notes showed on 04/25/25, at 11:53 A.M., SSD met with Resident #2 to discuss appropriate boundaries during interactions between him/her and another resident (Resident #20). The importance of maintaining public settings for conversations. SSD advised he/she should refrain from entering the room of the resident, emphasizing that discussions should take place in common areas to ensure comfort, mutual respect, and the avoidance of misunderstandings. Review of the resident's annual MDS, dated [DATE], showed the following information: -Adequate vision and hearing;-Clear speech, makes self understood and understands others;-Responds adequately to simple, direct communication only;-No cognitive impairment. Review of the resident's care plan, revised on 07/07/25, showed the following:-Independent with activities, and can be manipulative with staff at times to get his/her way;-History of mood problems. Establish trusting relations, verbalize feelings, concern and fears;-Identify relationships he/she can draw on and explore with me past effective and ineffective coping mechanisms.(Staff did not care plan related to the resident's current relationship with another resident, or the restrictions on the relationship.) 3. During an interview on 07/24/25, at 9:50 A.M., Certified Nurse Aide (CNA) T said the following:-Nurses state the residents cannot be in each other's rooms and he/she did not know why;-Staff monitor the residents daily. Resident #2 and Resident #20 usually sit by the sunroom. During an interview on 07/24/25, at 1:53 P.M., the MDS Coordinator/Assistant Director of Nursing (ADON) said the following:-The residents should not be in the same room together;-During the last care plan meeting, Resident #20's guardian informed staff of his/her view of things and the relationship. The guardian stated Resident #20 did not have the capacity to consent to sex;-Resident #20's guardian was ok with the residents in public together;-The restrictions of the residents not in each other's rooms should be included on the care plan. During an interview on 07/24/25, at 2:43 P.M., Certified Medication Tech (CMT) U said Resident #2 and Resident #20's care plans should include them to not be in the same room together. Resident #20's guardian stated Resident #20 is not able to make decisions of his/her personal care. During an interview on 07/28/25, at 2:08 P.M., the SSD said Resident #20's guardian said it is ok for both residents to be in public but did not want them in a room in private and if the court deemed Resident #20 not capable, he/she was not capable to consent to make decisions for intimacy. During an interview on 07/24/25, at 04:04 P.M., the Director of Nursing (DON) said the following:-Resident #20 has restrictions to not be in the same room together with Resident #2 and it should be on both of the residents' care plan;-Resident #20's guardian states the resident is not capable of maintaining a safe environment. During an interview on 07/28/25, at 9:20 A.M., the Administrator said the following:-She spoke with Resident #20's guardian who said the resident is not capable of making his/her own decisions and cannot consent to sex and did not want the resident placed in that situation;-Resident #20's guardian had concerns with Resident #2 being manipulative with Resident #20;-She expected staff to update the residents' care plans of not allowed in each other's rooms. 4. Review of Resident #50's face sheet showed the following:-admission date of 05/08/25;-Diagnoses included heart failure, hypotension (low blood pressure), respiratory failure (lungs can't adequately provide oxygen to the blood), kidney failure (kidneys can no longer adequately filter waste and excess fluid from the blood), use of coagulants (medication that thins the blood), and conversion disorder with seizures or convulsions (episodes of weakness, difficulty walking and loss of muscle control). Review of the resident's entry MDS, dated [DATE], showed the following information:-Severe cognitive impairment;-Required partial assistance with toileting, showers, upper and lower body dressing, personal hygiene, lying to sitting and chair to chair transfer;-Used wheelchair;-Did not use bed rail. Review of the resident's progress note dated 06/01/25, at 7:06 P.M., showed the nurse was called to resident room by CNA. CNA had answered call light and found resident sitting on the floor, leaning (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	against the wall. The nurse entered to find the resident in this position with the CNA at his/her side. Resident denied pain, interacted appropriately, and functioned at baseline status. Resident assisted to seated position on edge of bed with three staff assisting. No injuries noted at this time. Neuros initiated and resident placed in provider book for next visit. Review of the June 2025 Facility Event Reports showed an event report started on 06/01/25 and included documentation of unwitnessed fall in room and neurological assessments. Review of the resident's care plan showed staff did not update the care plan with the falls and new interventions put in place after the fall. Review of the resident's progress note dated 06/07/25, at 9:07 A.M., showed writer alerted to resident room by CNA. Resident found lying on right side in the floor next to his/her bed, wheelchair behind him/her. The nurse asked resident what happened, and resident stated he/she fell. When asked if he/she was trying to get back into bed, resident shook his/her head yes. Resident rubbed his/her right elbow and when asked if he/she has any pain resident stated that his/her elbow is hurting. Noted redness and nickel size bruise to right elbow. No further injuries noted. Range of motion intact to extremities times four. No outward rotation or shortening noted. Resident denied striking head. Neuro checks initiated with no deviation from baseline. Vitals obtained. Resident assisted out of the floor with three staff assisting into bed. Call light within reach. Nurse reminded resident to use his/her call light and wait for staff to assist before transferring. Will continue to monitor per facility protocol. Review of the June 2025 Facility Event Reports showed an event report, dated 06/07/25, included documentation of an unwitnessed fall and neurological assessments. Review of the resident's care plan showed staff did not update the care plan with the falls and new interventions put in place after the fall. Review of the resident's progress note dated 06/28/25, at 8:45 P.M., showed the resident's roommate came into the hall to tell staff the resident was on the floor. Resident was found to have stripped all clothes off, attempted to stand, urinated on the floor, and then slipped in the urine. Bed was saturated and changed. No apparent injuries noted. Resident cleaned and assisted back into bed. Vitals obtained. Call placed to nurse practitioner and informed of event with no new orders. More frequent toileting will be necessary. Will continue to monitor. Review of the June 2025 Facility Event Reports showed an event report, dated 06/28/25, included documentation of fall with neuros, and neurological assessment. Review of the resident's care plan showed staff did not update the care plan with the falls and new interventions put in place after the fall. Review of the resident's care plan, revised 07/23/25, showed the following information:-The resident required limited assistance for ambulation, bathing, bed mobility, dressing, grooming, hygiene, locomotion, toileting, and transfers;-Observe for safe ambulation and remind resident to not ambulate without assistance until therapies approve him/her to do so;-At risk for falling;-Keep bed in the lowest position, keep personal items within reach, fall risk assessment at least quarterly, and verbal reminders not to ambulate/transfer without assistance;-Assist rails (one to two) as needed to enable bed mobility;-Give resident verbal reminders not to ambulate or transfer without assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encourage resident to use environmental devices such as hand grips, hand rails, etc.(Staff did not update the care plan to reflect falls and new interventions from falls on 06/01/25, 06/07/25 and 06/28/25.) During an interview on 07/24/24, at 9:53 A.M., the SSD said the following:-Prior administration had been updating care plans when the resident would have a fall;-The care plans should have the falls listed and any new interventions;-The resident is a fall risk. He/she doesn't know if the resident's care plan has been updated with new interventions. During an interview on 07/24/25, at 1:54 P.M., CNA A said the following:-When a resident falls, they add new interventions;-The resident has fallen multiple times; -They have the resident on a low bed, making sure his/her wheelchair is near the bed, and toileting resident more often;-The falls are discussed during weekly meetings and care plan meetings. He/she believed they would update the care plan with the falls and new interventions. During an interview on 07/24/25, at 1:00 P.M., CMT C said falls are documented in the care plans and new interventions are added, such as low bed, fall mats, toileting before laying down. During an interview on 07/24/25, at 1:58 P.M., the CMT Supervisor said the following:-Residents have a fall risk assessment completed upon admission;-When a resident falls they go over them in morning meetings. The meetings include the administrator, DON, SSD, Activities Director, and MDS Coordinator;-The interventions are discussed and the MDS Coordinator is supposed to update the care plan with the information. During an interview on 07/24/25, at 2:40 P.M., Registered Nurse (RN) D said when residents have falls, nursing completes a fall assessment and the MDS Coordinator should update the fall interventions for the care plans. During an interview on 07/24/25, at 3:42 P.M., the ADON said the following:-He/she has updated several care plans but did not know if the resident's care plan has been updated recently;-Falls should be listed in the care plan and updated as falls occur with new interventions. During an interview on 07/25/25, at 10:19 A.M., CNA B said the following:-They do have interventions for falls, such as ensuring the floor is clean, low bed, and fall mats;-The resident likes to self-transfer, so they have his/her bed in the low position;-He/she believed the care plan should be updated with falls. During an interview on 07/25/25, at 2:00 P.M., the DON said the following:-When a resident falls the nurse completes a fall report, fall investigation, and should place immediate interventions;-Staff have weekly meetings will all upper staff present to discuss falls;-The MDS Coordinator should be updating the care plan with falls and new interventions;-He/she was not sure if the resident's care plan had been updated to reflect the three falls from June 2025. During an interview on 07/28/25, at 10:12 A.M., the Administrator said they have daily morning meetings with all department head attending. They review falls and whose at risk. Interventions are discussed and the MDS Coordinator is in the meeting and responsible for updating the care plan with falls and the discussed interventions. He/she is not sure if the resident's care plan had been updated to reflect any of the falls from June 2025. 5. During an interview on 07/24/25, at 9:50 A.M., CNA T said the following:-The MDS Coordinator/ADON completed the care plans;-If there is a change that needed to be made to the care plan, staff should notify the nurse;-Staff find care plans in the care plan books and/or computer;-Care plans include how a resident transfers, diagnosesm or restrictions. During an interview on 07/24/25, at 1:53 P.M., the MDS Coordinator/ADON said the following:-He/she completed the MDS assessments and care plans; -Care plans should include behaviors, medications, fall interventions, and assistive devices. During an interview on 07/24/25, at 4:04 P.M., the DON said the following:-The interdisciplinary team meets weekly, morning stand up meetings, and in clinical meetings;-Staff conduct care plan meetings with residents and family;-The interdisciplinary team includes the Administrator, DON, ADON, medical records, SSD, Dietary Manager, activities, business office, and human resources;-The ADON is the current care plan coordinator.

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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. **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 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 issues with not being able to access the laboratory results;-For a time, only the DON and Assistant Director of Nursing (ADON) could access the laboratory results from the portal;-The facility had a few urinalysis results that nursing needed to address with the physician, but the results were delayed;-When the facility contacted the lab about the delays, the lab said the results had been sent to the facility, but he/she was unsure if the facility received those results;-The laboratory calls the facility with critical laboratory results, but he/she was unsure if the laboratory was calling urinalysis culture and sensitivity results to the facility. During an interview on 07/25/25, at 2:16 P.M, the ADON said the following:-The facility had experienced delays in obtaining urinalysis culture and sensitivity results from the laboratory;-The laboratory should call abnormal culture results to the facility;-He/she was unsure where the disconnect occurred, but the facility did not notify the physician timely of the laboratory results.-Nurses should notify the physician of culture and sensitivity results right away and the resident should be started on antibiotics within two hours of receiving the physician’s order for treatment. During an interview on 07/28/25, at 9:40 AM, the Administrator said the following:-The facility had an issue with nurses not reviewing laboratory results daily, which included urinalysis and urine culture and sensitivity results;-He/she informed the Director of Nursing (DON) he/she needed to review laboratory results at the morning meetings (Monday to Friday) to ensure timely reporting of results to the physician;-Reporting results timely to the physician, would help prevent delays in residents starting on antibiotics for infections. 2. Review of Resident #43’s face sheet showed the following:-admission date of 06/21/25;-Diagnoses included urinary retention, unspecified symptoms and signs involving the genitourinary system (two kidneys, two ureters, one urinary bladder, and one urethra), type 1 diabetes mellitus, and amputation or right lower leg. Review of the resident’s admission MDS, dated [DATE], showed the following:-Cognitively intact;-Rejected care one to three days in last week;-Required partial to moderate assistance of staff with toileting hygiene, showers, upper and lower body dressing, and transfers;-Presence of an indwelling urinary catheter;-Always incontinent of bowel and bladder. 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 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 2025, he/she had a UTI. Staff sent the UA and he/she asked a staff member what the results were. The staff member said nothing was wrong. He/she knew there was something wrong because he/she had to urinate a lot and it burned. The physician got involved and staff sent another UA out for a culture he/she thought. It was decided he/she had a UTI and the antibiotic helped. He/she was concerned for how long the results did not come back. During an interview on 07/28/25, at approximately 04:00 P.M., CMT U/Medical Record Staff said he/she did not find the physician order for the resident's 05/08/25 UA. 4. During an interview on 07/24/25, at 02:00 P.M., the ADON said the following:-Signs and symptoms of a UTI include frequency of urination, lethargy, temperature, and strong foul-smelling urine;-Staff should call the physician for an order for a UA;-Nurses complete a lab requisition, place it in the laboratory binder, collect the UA, and the laboratory staff pick up the UA the next morning;-The laboratory company comes to the facility Monday through Friday and checks the binder for lab requisitions;-The facility receives UA results pretty quickly;-Staff find the laboratory results on the laboratory portal;-He started checking the laboratory portal every day to find results; -The nurses just quit looking for the laboratory results and they did not know how to do it and had not been showed how;-A UA culture and sensitivity report usually takes about three days for the results to come back; -Nurses should check the urine culture along with the UA on the laboratory requisition form;-Nurses notify the physician of the UA and/or culture results who orders an antibiotic if needed;-Nurses enter the antibiotic order into the computer and informs the CMTs who go to the machine and see if it is in the emergency kit. Staff should call the pharmacy if it is not in the emergency kit;-Nurses call the pharmacy for an antibiotic which is delivered within a two-hour window. During an interview on 07/28/25, at 11:30 A.M., the physician said he expected staff to inform him of the laboratory results for urinalysis and culture and sensitivity results. During an interview on 07/24/25, at 10:58 A.M., CMT K said the following:-Signs of a UTI include confusion and odors;-Staff should notify the nurse if a resident has signs of a UTI;-Nurses enter orders for labs. During an interview on 07/24/25, at 2:43 P.M., CMT U/Medical Records said the following:-Staff enter an order for a UA in the computer;-Staff collect the urine and give it to the nurse who documents clean catch in the computer;-Nurses complete a laboratory requisition form and place it in the binder and on the calendar;-The laboratory company comes to the facility Monday through Friday and take out the requisition form for the requested lab;-The facility usually receives the UA results that evening or the next morning;-A urine culture takes five days;-The laboratory company calls the facility (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if it is a critical lab;-If there is just slightly infection, the lab will do a culture before they send it, if it shows high in bacteria, the lab will call the facility;-Bacteria shows on the culture and not on the UA;-Nurses check the lab portal every day for results;-The facility had a lot of change in staff over the years and had with new nurses understanding the lab process;-The ADON and DON check the lab portal;-He/she rounds with the physician and places the lab results in his book;-The physician and NP signs every lab order and it is placed in the paper chart along with the lab results;-Nurses should notify the physician of a urine culture results;-Nurses place the lab results in a folder at the nurses’ desk which is taken on weekly rounds with the provider;-The physician and NP review the lab results and initial it;-Nurses should document critical level lab results, notification of the physician, and any medication change in the resident medical record;-Nurses should administer an antibiotic within two hours of receiving the order;-If an antibiotic is not in the emergency kit, they should notify the pharmacy to have it delivered with two hours. During an interview on 07/24/25, at 04:04 P.M., the DON said the following:-Signs of a UTI include a change in behaviors, mental status, and/or a change in activities of daily living;-The nursing staff should notify the physician of a possible UTI;-Nurses complete a lab requisition and place in the binder at the nurses' desk;-Nurses enter a lab order in the computer which triggers the MAR for staff to check each shift for the lab to be completed and continues until it is discontinued;-Nursing staff collect the UA and place it in the refrigerator;-The lab company comes to the facility Monday through Friday;-The lab company enters the lab results in the lab portal;-The nursing staff are supposed to check the lab portal daily for results;-Staff print off the lab results and report anything abnormal to the provider;-Staff should enter the physician order for an antibiotic, fax the order sheet to the pharmacy and pull it from the emergency kit and wait for the pharmacy to deliver it. During an interview on 07/28/25, at 9:20 A.M., the Administrator said the following:-Staff should monitor residents for signs of a UTI;-She expects staff to notify the physician with lab results and obtain the ordered antibiotic timely. Complaint 2562350

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program when the facility failed to ensure the required two step tuberculosis (TB - a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing) screening test was administered timely for six staff members (Certified Nursing Assistant (CNA) E, Certified Medication Technician (CMT) F, Licensed Practical Nurse (LPN) G, CMT K, LPN G, and Dietary Aide (DA) I) of ten sampled staff members. The facility census was 57.Review of the facility's policy titled Tuberculosis, Employee Screening, revised July 2010, showed the following:-All employees shall be screening for tuberculosis (TB), infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening, prior to beginning employment;-Each newly hired employee is screened for TB infection and disease after an employment offer has been made, but prior to the employee's duty assignment;-The employee health coordinator (or designee) will accept documented verification of two-step TST or BAMT results within the preceding 12 months. If the TST or BAMT result was negative, the employee will not be given another skin test prior to beginning employment. If the previous skin test result was positive or unavailable, the employee must have additional verification of absence of the TB;-The facility's Employee Health Coordinator will administer a TST to all newly hired employees except those who have a documented positive TST or BAMT results, and those who provide documented verification of having had a negative TST or BAMT within the preceding 12 months;-The initial TB testing will be a two-step TST performed by injecting 0.1 mL (5 tuberculin units) of purified protein derivative intradermally (under the skin). If the reaction to the first skin test is negative, the facility will administer a second skin test one to two weeks after the first test. The employee may begin duty assignments after the first skin test, if negative;-If the reaction to the TST is positive, the employee will be referred for a chest X-ray and symptom screening, which must be completed prior to employment. Review of 19 CSR 20-20.100 showed the following:-Long-term care facilities shall screen their staff for tuberculosis;-Each facility shall be responsible for ensuring that all test results are completed, and that documentation is maintained for all employees and volunteers;-All long-term care facility employees and volunteers who work ten or more hours per week are required to a complete a TB test within one month prior to starting employment in the facility;-If the initial test is zero to nine millimeters (mm), the second test should be given as soon as possible within three weeks after employment begins;-Employees and volunteers with an initial negative two-step TB test shall be one-step tested annually and the results recorded in a permanent record.1. Review of CNA E's personnel file showed the following:-Hire and start date of 03/06/24;-The first TST was administered on 03/04/24 and with no results documented; -The second TST was administered on 05/22/24 (79 days after the first test was administered) and read on 05/24/24 with a result of 0 mm. During an interview on 07/25/25, at 12:31 P.M., the Human Resource Staff (HR) reviewed CNA E's file and said he/she did not know why the first two step TST wasn't read, or why the second two step TST wasn't done timely. During an interview on 07/25/25, at 2:00 P.M., the Director of Nursing (DON) said he/she was not aware CNA E's first TST test was not read, and that staff did not have a second TST test timely. During an interview on 07/28/25, at 10:12 A.M., the Administrator said he/she was not aware that CNA E's first TST skin test was not read, and that CNA E did not have a second TST test timely. During an interview on 07/28/25, at 2:30 P.M., the Assistant Director of Nursing (ADON) said he/she was not aware that CNA E's first TST skin test was not read, and that CNA E did not have a second TST test timely prior to working the floor. 2. Review of CMT F's personnel file showed the following:-Hire and start date of 11/06/24;-The first TST was administered on 11/06/24 with no results documented; -The second TST was administered on 01/12/25 (67 days after the first TST test was administered) and read on 01/15/25 with no redness. Staff did not document the induration or the size. During an interview on 07/25/25, at 12:31 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P.M., HR reviewed CMT F's file and indicated the facility ran out of serum during the time the second TB test was to be administered. The staff probably did continue working the floor. During an interview on 07/25/25, at 2:00 P.M., the DON said he/she was not aware CMT F's first TST test was not read and that CMT F did not have a second TST test timely. During an interview on 07/28/25 at 10:12 A.M., the Administrator said he/she was not aware that CMT F's first TST skin test did not have a size and that CMT F did not have a second TST test timely. During an interview on 07/28/25 at 2:30 P.M., the ADON he/she was not aware that CMT F's first TST skin test did not have a size and that CMT F did not have a second TST test timely. 3. Review of LPN G"s personnel file showed the following:-Hire and start date of 06/09/25;-The first TST was administered on 06/09/25 (the LPN's start date) and staff documented reading the results with no induration or redness, but did not document the size;-The second TST was administered on 07/17/25 (38 days after the first TST test was administered) and read on 07/19/25 with no redness or induration. Staff did not document the size. During an interview on 07/25/25, at 12:31 P.M., HR reviewed LPN G's file and said he/she did not know why the second TB test was not administered timely. During an interview on 07/25/25, at 2:00 P.M., the DON said he/she was not aware LPN G's first TST test did not have a size, and that LPN G did not have a second TST test timely. During an interview on 07/28/25, at 10:12 A.M., the Administrator said he/she was not aware that LPN G's first TST skin test did not have a size, and that LPN G did not have a second TST test timely. During an interview on 07/28/25, at 2:30 P.M., the ADON said he/she was not aware that LPN G's first TST skin test did not have a size, and that LPN G did not have a second TST test timely. 4. Review of CMT K's personnel file showed the following:-Hire and start date of 09/04/24;-The first TST was administered on 09/04/24 and staff documented reading the results on 09/06/24 (two days after the CMT's start date), but did not document the induration, site redness or the size;-The second TST was administered on 11/19/24 (66 days after the first TST test was administered) and read on 11/22/24, with no redness, induration, or size. During an interview on 07/25/25, at 12:31 P.M., HR reviewed CMT K's file and said the facility ran out of serum during the time the second TB test was to be administered. The staff probably did continue working the floor. During an interview on 07/25/25, at 2:00 P.M., the DON said he/she was not aware CMT K's first TST test did not have the induration, site redness, or size, and that CMT K did not have a second TST test timely. During an interview on 07/28/25, at 10:12 A.M., the Administrator said he/she was not aware that CMT K's first TST skin test did not have the induration, redness, or size, and that CMT K did not have a second TST test timely. During an interview on 07/28/25, at 2:30 P.M., the ADON he/she was not aware CMT K's first TST skin test did not have the induration, skin redness, or size, and that CMT K did not have a second TST test timely. 5. Review of LPN H's personnel file showed the following:-Hire and start date of 07/31/24;-The first TST was administered on 07/31/24 with no documentation the TST was read;-The second TST was administered on 01/12/25 (67 days after the first TST test was administered) and read on 01/15/25 with no redness. Staff did not document the induration or the size. During an interview on 07/25/25, at 12:31 P.M., HR reviewed LPN H's file and said the LPN H was hired for an as needed position and had worked elsewhere. The staff was supposed to bring in the prior TB test, but never provided that to the facility. The staff probably did continue working the floor. During an interview on 07/25/25, at 2:00 P.M., the DON said he/she was not aware LPN H's first TST test was not read, and that LPN H did not have a second TST test completed timely. During an interview on 07/28/25, at 10:12 A.M., the Administrator said he/she was not aware that LPN H's first TST skin test was not read, and that LPN H did not have a second TST test timely. During an interview on 07/28/25, at 2:30 P.M., the ADON he/she was not aware that LPN H's first TST skin test was not read, and that LPN H did not have a second TST test timely. 6. Review of DA I K's personnel file showed the following:-Hire date of 11/06/24 and start date of 11/08/24;-The first TST was administered on 11/05/24 and staff documented reading the results 24 hours later, with documentation of no site redness, no induration and 0 mm;-The second TST was administered on 01/14/25, (67 days after the first TST test was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure all residents were free from possible chemical restraints when staff failed to implement a physician approved pharmacy recommendation to decrease an antipsychotic in a timely fashion for one resident (Resident #4) out of a sample of five residents. The facility census was 57. Review showed the facility did not provide a policy regarding pharmacy consultations or pharmacy recommendations. 1. Review of Resident #4's face sheet (resident's information at a quick glance) showed the following:-admission date of 12/08/22;-Diagnoses included cognitive communication deficit, unspecified dementia, and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/12/25, showed the following:-Severe cognitive impairment;-No behaviors;-The resident took antipsychotic medication. Review of the resident's care plan, revised 05/20/25, showed the following:-The resident was at risk for adverse reactions to psychotropic medications as evidenced by receiving antianxiety, antidepressant, and antipsychotic medications;-Pharmacy consultant review at least monthly;-Attempt to give the lowest dose possible unless contraindicated;-Attempt a gradual dose reduction per pharmacy recommendation and/or as clinically needed per provider.Review of the resident's Physician Order Sheet (POS), dated 07/23/24, showed an order for Zyprexa (an antipsychotic) 5 milligrams (mg) once a day. The order did not indicate a diagnosis for administration of Zyprexa. Review of the resident's pharmacy recommendation, created between 12/09/24 and 12/11/24, showed the following:-The following psychotropic medication was due for a gradual dose reduction consideration for the resident;-Zyprexa 5 mg once daily for dementia with agitation;-Recommendation to reduce Zyprexa to 2.5 mg in the evening was marked;-The provider signed on 12/26/24.Review of the resident's medical record showed staff did not document a reduction in the resident's Zyprexa as approved by the physician. Review of the resident's pharmacy recommendation, dated 05/13/25, showed the following:-The following psychotropic medication was due for a gradual dose reduction consideration for the resident;-Zyprexa 5 mg once daily for dementia with agitation;-Recommendation to reduce Zyprexa to 2.5 mg in the evening was marked;-Prescribers comments: Trial the resident's reduction to see how it goes;-The provider signed on 05/16/25. Review of the resident's POS, dated 05/19/25, showed an order for Zyprexa 2.5 mg once a day. The order did not indicate a diagnosis for administration of Zyprexa. Review of the resident's May 2025 Medication Administration Record (MAR) showed an order, dated 05/19/25, for staff to administer Zyprexa 2.5 mg once a day. During interviews on 07/24/25, at 3:46 P.M., and on 07/25/25, at 10:52 A.M., the Assistant Director of Nursing (ADON) said the resident's Zyprexa should had been decreased per the December 2024 pharmacy recommendation. During an interview on 07/24/25, at 2:43 P.M., the Certified Medication Technician (CMT) U/Medical Records staff said the following:-Staff give the provider a list of medications that are recommended to be changed;-The nurse contacts the resident and/or representative of a medication change and documents in the progress notes. During an interview on 07/25/25, at 10:30 A.M., Licensed Practical Nurse (LPN) J said the following:-Staff give the pharmacy recommendations to the physician;-If the physician changes a medication, the nurses should notify the resident and/or representative and enter the new order in the computer. During interviews on 07/24/25, at 3:46 P.M., and on 07/28/25, at 11:18 A.M., the ADON said staff the following:-Staff should have called the physician and pharmacy to clarify the recommendation of the reduction of the Zyprexa to 2.5 mg that he signed 12/26/24; -The pharmacy comes to the facility monthly and emails the completed monthly medication reviews and recommendations;-The medical records staff and the Director of Nursing (DON) review the recommendations and places them in a folder for the physician to review who comes to the facility weekly;-The physician decides to agree with the recommendation or not;-The physician checks the box on the pharmacy recommendation and (continued on next page)

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Webco Manor	1687 West Washington Marshfield, MO 65706

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs if he agrees for any medication changes;-Some nurses who no longer work at the facility placed the pharmacy recommendation in the medical record staff box and did not say anything. Facility staff found out a few months ago some recommendations did not get addressed. During an interview on 07/28/25, at 1:06 P.M., the physician said the following:-He said if he signed the resident's pharmacy recommendation on 12/26/24 to reduce the Zyprexa, it should had been reduced;-The diagnosis for the medication is dementia with agitation;-Staff give him the pharmacy recommendations when he comes to the facility;-Staff tell him if a resident is stable on current regimen;-He reviews the pharmacy recommendation;-Staff inform him if a resident has any behaviors or issues. During an interview on 07/28/25, at 2:00 P.M., the DON said the following:-Staff should had reduced the resident's Zyprexa to 2.5 mg per the December 2024 pharmacy recommendation;-The pharmacy recommendation must had been overlooked;-The pharmacy emails him the monthly medication reviews and he prints them off to review;-He places the recommendations on the physician's desk;-The physician comes to the facility weekly;-The physician reviews the pharmacy recommendations and gives them to the nurses with his decision and nurses enter the order. During an interview on 07/28/25, at 9:20 A.M., the Administrator said staff should follow pharmacy recommendations if the physician agrees and signs it.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview, observation, and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion when facility staff failed to obtain an order for the use of a brace, failed to document use of a brace, failed to monitor the use of a brace, and failed to care plan the use of brace to the right-hand brace for one resident (Resident #8) with a contracture. The facility census was 57.Review of a facility policy titled Assistive Devices and Equipment, dated July 2017, showed the following:-The facility provides, maintains, trains, and supervises the use of assistive devices and equipment for residents;-Devices and equipment that assist with resident mobility, safety, and independence are provide for residents;-Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan;-Staff will be trained and demonstrate competency on the use of devices;-The following factors will be addressed to the extent possible to decrease the risk of avoidable accidents: appropriateness for resident condition; personal fit measured to resident's size and weight; devices will be maintained on a schedule and defective or worn devices will be discarded or repaired; and staff competency on the device in use. Review of a facility policy titled Medication Orders, dated July 2017, showed the following:-A current list of orders must be maintained in the clinical record of each resident;-Orders must be written and maintained in chronological order;-When recording treatment orders, specify the treatment, frequency, and duration of the treatment. 1. Review of Resident #8's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 06/06/25;-Diagnoses included cerebral infarction (sudden loss of brain function that occurs when blood flow to the brain is interrupted), hemiplegia (paralysis of one side of the body) of right side, muscle weakness, and aphasia (language disorder that affects a person's ability to communicate).Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 06/06/25, showed the following:-Severe cognitive impairment;-Dependent on staff for transfers, mobility, dressing, and showering;-Resident was not receiving restorative services;-Resident did not use splint or a brace. Review of the resident's care plan, revised on 06/19/25, showed the resident had impaired function and requires staff assistance with self-care and mobility.Observation on 07/22/25, at 10:11 A.M., showed the resident resting in bed. The resident had a blue splint on the dresser next to his/her bed. Observation on 07/22/25, at 10:55 A.M., showed the resident wearing a blue splint on his/her right hand and wrist. Observation on 07/23/25, at 12:53 P.M., showed the resident sitting up in a chair watching television with a blue brace on his/her right hand and with a gauze roll in the palm of his/her right hand. Observation on 07/24/25, at 2:48 P.M., showed the resident sitting in a chair watching tv with a blue brace on the dresser. Observation on 07/25/25, at 9:27 A.M., showed the resident resting in bed with no brace on his/her right hand. A blue brace was observed on the dresser next to the bed.Review of the resident's July 2025 Physician Order Sheet (POS) showed no order to apply or monitor a right-hand brace. Review of the resident's nursing progress notes showed staff did not document regarding a right-hand brace of monitoring of the brace. Review of the resident's July 2025 Treatment Administration Record (TAR) showed no order for application or monitoring of right-hand brace.Review of the resident's current care plan showed staff did not care plan the use of a right hand brace. During an interview on 07/25/25, at 10:00 A.M., Certified Medication Technician (CMT) L said resident wears a brace to his/her right hand. The brace should be applied during the day and taken off at night. He/she did not know if the resident was admitted to the facility with the brace or acquired it during stay. There should be an order for a brace and it should be included in the care plan. There should also be an order to assess the skin under a brace due to possible skin breakdown.During an interview on 07/28/25, at 9:57 AM Licensed Practical Nurse (LPN) J said a resident should have an order for brace which (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should include times of application. Therapy would be responsible for ordering a resident a brace. The resident had a right-hand brace, but did not have an order for it. The CNA's were responsible for applying and removing braces. The nurses were responsible for monitoring skin under brace and ensuring the brace is on and off at designated times. A resident brace should be on the care plan.During an interview on 07/28/25, at 10:08 A.M., Certified Nurse Assistant (CNA) M said he/she would know if a resident required a brace during orientation. The trainer would educate the new employee on resident needs. Therapy will advise CNA's of any new assistive equipment or braces for residents. The resident care plan informed CNA's on how to take care of the resident. A resident with a brace should be included in the care plan. CNA's apply and remove the brace for the resident. He/she knew about the brace due to communication between the aides. There was no documentation that he/she does that indicate the brace had been applied or removed. There are no orders or charting required for the resident's brace.During an interview on 07/28/25, at 10:20 A.M., Certified Occupational Therapy Assistant (COTA) O said occupational therapy is responsible for hand braces. A resident will be recommended a brace while on therapy. A brace required an order and nursing obtained the order from the physician. He/she was not aware of the resident having a wrist brace. The resident came to the facility as a long-term resident and had not had occupational therapy. The resident was admitted to the facility with a blue arm brace from another facility. Nursing can obtain an order to continue a brace if a resident was admitted with one. An order was required for a resident to use a brace, and the nurse was responsible for the brace to be applied and removed.During an interview on 07/28/25, at 11:09 A.M., CNA N said he/she knew if a resident should wear a brace if they were wearing it or it was near them during cares. Therapy or the nurse will show aides how to apply a brace. The resident had a brace for his/her right arm. The resident has had a brace to the right arm as long as he/she had been caring for them. The use of a brace should be included in the care plan. The care plan showed staff what the resident needs are.During an interview on 07/28/25, at 11:46 A.M., the Assistant Director of Nursing (ADON) said a brace should have been included in the care plan and have an order. The order should indicate times of use and should include observation of skin under brace. He/she had never seen the resident wear a wrist brace. The resident does not have an order for a wrist brace. During an interview on 07/28/25, at 2:43 P.M., the Director of Nursing (DON) said there should be an order for a wrist brace. Therapy was responsible for assessing the resident and obtaining an order. The order should contain when to apply and remove the brace, to assess skin under the brace, and to check placement throughout day. Nurses or therapy should be applying any brace. A resident that used a brace should have it indicated in the care plan.During an interview on 07/28/25, at 2:35 P.M., the Administrator said residents should have an order for a brace and for the skin to be assessed under a brace. The brace should also be included on the care plan.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observation, record review, and interview, the facility failed to ensure residents who required colostomy (a surgical procedure that creates an opening, or stoma, in the abdominal wall to allow the colon to pass waste through the body) services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences when staff failed to obtain an order for a colostomy, colostomy care, and colostomy monitoring, failed to assess resident for ability to provide self-care for the colostomy, and failed to care plan self-care of the colostomy for one resident (Resident #49). The facility census was 57. Review of the facility's policy titled Colostomy/Ileostomy Care, revised October 2010, showed the following:-The purpose of the procedure was to provide guidelines that would aid in preventing exposure of the resident's skin to fecal matter;-Review the resident's care plan to assess for any special needs of the resident;-The following information should be recorded in the resident's medical record: the date and time the colostomy/ileostomy care was provided; the name and title of the individual(s) who provided the colostomy/ileostomy care; any breaks in resident's skin, signs of infection or excoriation of skin; how the resident tolerated the procedure, if the resident refused the procedure, the reasons(s) why and the interventions taken; and the signature and title of the person recording the data. 1. Review of Resident #43's face sheet (admission data) showed the following:-admission date of 02/01/25;-Diagnoses included acute cholecystitis (inflammation of the gallbladder), generalized anxiety disorder, and colostomy. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment completed by facility staff), dated 05/29/25, showed the following:-Cognitive skills intact;-No behaviors;-Impairment on both sides of upper extremity;-Independent with toileting and hygiene. Review of the resident's care plan, last revised on 06/29/25, showed the following:-Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) due to the resident has a colostomy;-Staff to use EBP (gloves, gowns) during bathing/showers/performing activities of daily living and hygiene tasks.(The care plan did not have the resident's self-care of his/her colostomy) Review of the resident's medical record showed staff did not document physician orders for the resident's colostomy, assessment of the resident for self-care of his/her colostomy, or skin assessments related to his/her colostomy. Observation and interview on 07/23/25, at 12:45 P.M., showed the resident sat in his/her recliner in his/her room. The resident said he/she had a colostomy, and the nurses did not look at it. It is red and sore. He/she emptied the colostomy bag two to three times a day. The colostomy bag was supposed to last a week and blows up (gets too full he/she explained) at times and he/she had to change it. Staff asked if he/she has changed the colostomy bag and if he/she had a bowel movement. Observation and interview on 07/25/25, at 10:20 A.M., showed the resident sat on the toilet in his/her bathroom. The resident changed his/her own ostomy wafer and bag. Upon removal, the skin around the stoma was reddened and excoriated to approximately one-inch surrounding area. Additionally, there was 1 1/2 area of excoriation to an area two inches below and lateral to the resident's stoma. The resident said he/she had stoma powder and stoma paste, but when he/she tried to use it the adhesive on the wafer it did not stick. The resident said he/she had not told anyone about the issue. Licensed Practical Nurse (LPN) J said he/she would follow up with the physician for other possible options to alleviate excoriation/leaking. LPN J stated due to the resident's self-care, he/she did not know of the issues with the skin areas. During an interview on 07/25/25, at 10:30 A.M., LPN J said he/she had not seen the resident's stoma area and did not know what nursing staff did with it. The resident performed his/her own colostomy care. The nurses should monitor for odor and irritation around the area. Nurses should look at the resident's skin around the stoma weekly if not more, when he/she changes the bag to see if it is irritated. It was (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	irritated and he has an area on his/her left side. It looks like it is from the adhesive from the wafer. During an interview on 07/24/25, at 09:32 A.M., Certified Medication Technician (CMT) K said the following:-Nurses inform staff of which residents have a colostomy;-The resident was able to perform his/her own colostomy care;-The resident emptied his/her colostomy bag. The resident prepped his/her skin and applied a new colostomy bag;-The resident appeared to perform his/her colostomy care ok;-The resident did not complain of pain or redness with his/her colostomy;-Staff asked the resident each day of how much he/she emptied out of the colostomy bag;-Staff find care plans in the computer;-If a resident performs his/her own colostomy care, it should be on the care plan. During an interview on 07/24/25, at 09:50 A.M. Certified Nurse Aide (CNA) T said the following: -The resident performed his/her own colostomy care;-Staff ask the resident daily if he/she emptied the colostomy bag;-The resident had not complained of pain or redness with his/her colostomy. During an interview on 07/25/25, at 9:46 A.M., CNA S said the resident changes his/her own colostomy. He/she asks the resident if he/she had a bowel movement per shift and if he/she has emptied the colostomy bag. The resident asks for staff assistance at times. During an interview on 07/25/25, at 10:10 A.M., CNA B said the resident completed his own colostomy care and changed his/her bag. The resident at times may need assistance with the wafer. One time it was too full, and he/she needed help with the cleanup and placing the colostomy bag on with the wafer the right angle. The resident needed help lining up the wafer at the correct angle. During an interview on 07/24/25, at 2:43 P.M., CMT U said the following:-The resident informed staff if he/she needed assistance with his/her colostomy care;-The nurses observe him/her, and the aides watched him/her to make sure he/she handled the colostomy properly;-He/she did not know if it was documented;-Staff assist residents with a bath twice a week and perform a skin assessment from head to toe;-If staff notice redness around the resident's colostomy site, they should report to the charge nurse;-The resident did not say anything about his/her colostomy site being sore or red;-The resident sometimes lets the colostomy bag get full, and he/she asks the staff for assistance;-The resident's self-care of his/her colostomy should be care planned. During an interview on 07/28/25, at 2:18 P.M., Registered Nurse (RN) Q said the following:-He/she did not know for sure if there should be orders for the resident's colostomy;-If the resident has an issue with his/her colostomy, he/she thought the resident would tell the nurses;-The resident should have a diagnosis of the colostomy;-The resident should have a weekly skin assessment and that should include an assessment of his/her colostomy site.-Last weekend (07/23/25 or 07/24/25), he/she saw the resident's site and it did not look bad at that time, but he/she looked at the site yesterday, (07/27/25) and it looked red and excoriated; -On 07/27/25, he/she contacted the provider about the condition of the resident's stoma site and the provider said to monitor the site and encourage the resident to use stoma powder;-The resident has not changed the type of appliances/wafers that he/she uses, so he/she is not sure why the resident's site is excoriated;-The resident's self-care of his/her colostomy should be on the care plan. During interviews on 07/24/25, at approximately 2:00 P.M., on 07/25/25, at 10:52 A.M., and on 07/28/25, at 2:12 P.M., the Assistant Director of Nursing (ADON) said the following:-He did not see an order for the resident's colostomy; -When the resident was first admitted , he/she did not let him/her observe his/her colostomy because the resident said he/she did his/her own colostomy care;-The resident's colostomy care should be on the TAR for nurses to monitor every day;-Nurses catch observations when the resident changes the colostomy bag;-The resident did not say anything about the site being red;-The weather was hot outside, and the resident goes to work outside of the facility;-Nurses complete weekly skin assessments and should document on forms or in the progress notes; -The resident should have an order for colostomy and the colostomy self-care; -At times, the resident had a problem letting the bag overfill;-The resident was admitted from an assisted living facility. The former DON should had assessed the resident for his/her self-care of the colostomy;-The resident has his/her own colostomy supplies. The resident informed the staff when he/she needed more supplies for his/her colostomy;-Staff should make sure the colostomy is on correctly and no breakdown of the (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's skin;-The resident informed the CMTs and aides the amount he/she emptied out of the colostomy bag; -Staff should have care planned the resident for self-care of his colostomy;-Nurses should look at the resident's skin to make sure the skin is not macerated. Nurses should make sure the stoma is beefy red and the peri wound areas is not macerated. Nurses should make sure the resident is not constipated. Nurses should make sure the consistency of the resident's stools are good;-Nurses should complete weekly skin assessment on residents and check their skin;-Nurses add physician orders in the computer which triggers on the MARs to assess residents daily;-He did not find documentation for the resident of an assessment for self-care of his/her colostomy;-He did not find a physician order for the resident's colostomy or physician orders on the resident's treatment administration record for staff to monitor the resident's colostomy. During an interview on 07/24/25, at 4:04 P.M., the Director of Nursing (DON) said the following:-The resident informed staff upon admission that he/she performed his/her own colostomy care;-Staff educated the resident on caring for his/her colostomy the proper way and staff should had documented it in a progress note;-Staff should have care planned the resident managing his/her own colostomy care;-Nurses should monitor the resident's colostomy with general interaction;-If an order is entered in the computer to check the colostomy, it would trigger on the resident's MAR for the nurses to check it;-Nurses should monitor the resident's colostomy supply usage, stoma, and output;-Nurses should monitor for signs of infection around the resident's stoma. During an interview on 07/28/25, at 9:20 A.M., the Administrator said the following:-Nurses should complete an assessment at the time of request to perform self-care of a colostomy;-Nurses should complete skin assessments for a resident with a colostomy;-She expects staff to monitor the resident for his/her colostomy care;-Staff should obtain a physician's order for a resident's colostomy;-Staff should have a care plan for the resident's self-care of his/her colostomy;-The staff did not complete an assessment for the self-care of his/her colostomy.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed document identification and use of possible alternatives prior to use of side rails; failed to document assessing risk versus benefits of side rail use; failed to obtain informed consent for the use of side rails prior to installation,; and failed to obtain physician orders for side rail usage, for one resident (Resident #50). The facility's census was 57. Review of the resident's quarterly fall risk assessment, dated 11/27/17, showed the resident to was a moderate risk with diminished safety awareness and poor recall and judgment.Review of the resident's entry Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/08/25, showed the following information:-Severe cognitive impairment;-Partial assistance with toileting, showers, upper and lower body dressing, personal hygiene, lying to sitting and chair to chair transfer.Review of the facility records showed on 05/12/25, staff completed a bed rail safety check. Review of the resident's care plan, last revised on 07/23/25, showed the following information:-The resident required limited assistance for ambulation, bathing, bed mobility, dressing, grooming, hygiene, locomotion, toileting, and transfers;-At risk for falling. Staff to keep bed in the lowest position and keep personal items within reach;-Assist rails (one to two) as needed to enable bed mobility (start date of 05/20/25);-Give verbal reminders not to ambulate or transfer without assistance. Encourage resident to use environmental devices such as hand grips, hand rails, etc.Observations showed the following:-On 07/22/25, at 10:18 A.M., the resident was in bed. The resident's bed had two quarter size side rails (one on each side) in the up position;- On 07/24/25, at 10:40 A.M., the resident was in bed. The resident's bed had two quarter size side rails (one on each side) in the up position;-On 07/25/25, at 1:05 P.M., the resident was in bed. The resident's bed had two quarter size side rails (one on each side) in the up position. Review of the resident's July 2025 Physician's Order Sheet (POS) showed staff did not have documentation of a physician's order for the side rail use. Review of the resident's medical record showed staff did not document identification and use of possible alternatives prior to use of side rails, assessing risk versus benefits of side rail use, obtaining informed consent for the use of side rails prior to installation, or routine ongoing assessments to ensure the side rails were appropriate for use. During an interview on 07/24/25, at 9:53 A.M., the Maintenance Director said the following:-The side rails were ordered by the doctor, and he/she waited for the nurses to let him/her know when to install the bars;-He/she just begun checking the side rails monthly in July;-He/she checked certain areas of the rail to ensure it's a certain distance, and he/she checked the headboard and mattress;-He/she had done a couple on the resident. During an interview on 07/24/25, at 1:00 P.M., Certified Medication Technician (CMT) C said the following:-The side rails are placed on a resident's bed to assist the resident with turning, or pulling themselves over;-He/she believed there was supposed to be a signed consent form by the resident or the representative and the doctor;-He/she didn't know anything about the assessment or measurements;-He/she believed the resident had the side rails to assist him/her in rolling over when he/she was being changed. Duirng an interview on 07/24/25, at 1:54 P.M., Certified Nurse's Aide (CNA) A said the following:-Residents use side rails to assist them in turning, rolling, and pulling up;-He/she didn't know the process for having side rails installed;-The resident did use the side rails to pull up, or help him/her get out of bed.During an interview on 07/25/25, at 10:19 A.M., CNA B said the following:-The residents use the side rails on their stronger side to assist with turning, it's resident specific;-He/she not seen the resident use the side rails;-He/she believed the side rails require a consent from the resident or the durable power of attorney;-He/she would go to maintenance if the resident requested a side rail. During an interview on 07/24/25, at 1:58 P.M., the CMT Supervisor said the following:-The resident had a risk assessment completed, This tells the pros and cons and whether it's safe or not;-If a resident or representative insists on having side rails, the (continued on next page)

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	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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility obtains consent from the resident or representative, and the doctor also signs the consent;-The residents used the side rails for turning over;-The documents are uploaded into the resident's electronic record;-He/she didn't know if the resident has a signed consent or risk versus benefits;-He/she did not find a signed consent. During an interview on 07/24/25, at 3:42 P.M., the Assistant Director of Nursing (ADON) said the following:-The prior administration felt all residents should have side rails, and they sent in work orders to have them installed;-They've removed several of the side rails that weren't needed;-Two assessments are completed on the residents, and they're saved in the file under observation. The assessments explain risks versus benefits and the consent;-The consent would need to be signed by the resident or the representative and the doctor;-They don't put the rails on unless the resident or representative is adamant;-The resident is his/her own person, staff should have a signed consent by the resident somewhere;-Maintenance is responsible for doing measurements on the bed and he/she is not sure how often this is done. During an interview on 07/25/25, at 2:00 P.M., the DON said the following:-The side rails have been an ongoing issue;-Prior to the DON coming on board, the prior Registered Nurse (RN) consultant went from resident to resident to add them;-The resident was required to have an assessment completed that's located under the observations;-The assessment had the risk versus benefits and requires the resident or representative's signature and the doctor;-Each resident should have the risk versus benefits and the consent prior to the side rails being installed on the resident's bed;-He/she was not sure if the resident signed a consent or if risk vs. benefits was completed. During an interview on 07/28/25, at 10:12 A.M., the Administrator said the following:-Residents should only be using the side rails for mobility improvements;-The resident should be assessed for other alternatives, and if the side rails are the method used, there should be a consent signed by the resident and/or representative prior to placing the rails on the bed;-Maintenance does the measurements when the rails are installed and checks them monthly or when a new bed or mattress is installed.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to prepare all food in a form designed to meet each resident's needs when staff failed to appropriately prepare thickened liquids to nectar consistency for one resident (Resident #27) in a selected sample of 20 residents. The facility census was 57. Review of the facility's policy titled 'Thickened Liquids, dated 2022, showed the following:-Liquids are categorized as thin - Level 0 (regular), mildly thick - Level 2 (nectar-like), moderately thick-Level 3 (honey-like), and extremely thick - Level 4 (pudding-like) for the purposes of this manual;-If liquids are to be thickened by nursing or dining service staff, proper training on the use of the thickening product and specific product instructions should be conducted by the Dining Services Manager, Speech Language Pathologist, or Registered Dietitian;-Proper preparation of thickened liquids improves acceptance and safety for individuals requiring thickened liquids;-The type of thickener, temperature of the liquid being thickened, and amount of thickening product used in the liquid will affect the rate of thickening;-It is imperative to follow the manufacturer's instructions carefully to understand how much of the thickener product to use, type of missing method necessary, and time required to reach the maximum thickness and desired consistency. Review of the instant food thickener container for mildly thick nectar consistency showed instructions to add one tablespoon to four ounces of liquid (water, clear juices, coffee, tea). Process for several seconds or until the thickener is thoroughly mixed. Allow four minutes to reach desired thickness. 1. Review of Resident #27's face sheet (a quick summary of important information) showed the following:-admission date of 01/31/25;-Diagnoses included dementia and aphasia (a language disorder that affects a person's ability to communicate).Review of the resident's significant change in status Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/30/25, showed the following:-Severe cognitive impairment;-Required set up with eating;-Swallowing loss of liquids and solids from mouth;-Mechanically altered diet.Review of the resident's care plan, revised 07/28/25, showed the following:-The resident had nutritional problems as evidenced by the need for mechanically altered diet;-The resident was on a puree diet with nectar thick liquids as ordered and to receive fortified foods.Review of the resident's May 2025 Physician Order Sheet (POS) showed an order, dated 05/02/25, for nectar-thickened liquids.Review of the resident's progress note dated 05/12/25, at 8:25 A.M., showed the Dietary Manager (DM) documented the resident received a puree texture with nectar thick liquids. Foods were presented in bowls and continued to receive double portions at his/her request. The resident sat on the assistance side of the dining room, and he/she was an aspiration risk. The resident ate large bites at a time and often gets choked on them.Observations on 07/22/25, at 11:56 A.M., showed the following:-The resident sat in his/her wheelchair in the main dining room with two cups. One cup contained a chocolate drink and one contained water (8-ounce cup);-The cup of water had thickener settled 1/4 way down of the cup with no thickener from 1/4 halfway up the cup of the water;-The resident coughed when he/she drank the water and chocolate drink;-The Assistant Director of Nursing (ADON) sat down beside the resident and talked to the resident. The ADON did not stir the water in the resident's cup. The ADON asked the resident if he/she had trouble swallowing. During observations and interview on 07/23/25, at 11:02 A.M., Dietary [NAME] R said the following:-He/she prepared breakfast and lunch in the morning;-He/she prepared a nectar thick liquid for another resident on thickened liquids and said the glass was a six-ounce glass;-He/she poured tea in the glass and added one tablespoon of thickener, stirred it and it dissolved fairly quickly. It did thicken some, but still appeared thin;-He/she said it thickens better in room temperature and lets the liquid sit for a minute;-He/she prepared the resident's water for lunch and prepared it the same way she did the other resident's tea this morning;-He/she placed one tablespoon in the six-ounce glass.(The directions on the container said to use one tablespoon for four ounces of liquid.) Observations on 07/23/25, at approximately 11:35 A.M., (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed the following:-The resident sat in his/her wheelchair in the main dining room for lunch;-The resident had cup of water with the top half of the glass clear and the bottom half of the glass with the thickener at the bottom of the glass;-The resident drank the liquid and coughed. During an observation and interview on 07/23/25, at 11:35 A.M., the Speech Therapist (ST) said the following:-The resident's water on his/her table should be stirred;-The resident is not good with swallowing drinks;-The resident was admitted from his/her home and started having aspiration signs and symptoms after admission;-The resident was on a regular diet upon admission. He/she downgraded the resident's diet to puree and nectar thickened liquids;-The resident has a six-ounce glass of water on his/her table;-The resident drinks four glasses of those at meals;-Nurses request an evaluation if a resident has issues with swallowing;-The physician gives an order for a swallowing evaluation;-Therapy completes the evaluation and gives the recommendations to nursing and dietary staff for puree or thickened liquids;-Nurses document the orders in the computer;-He/she educates the aides for nectar thickened liquids or if the resident needs cues to slow the rate of eating or drinking;-The registered dietician and he/she monitors the resident;-Nectar is consistent of tomato juice, syrup. (like the syrup in can goods);-Nectar thick liquids should drip off a spoon;-If nectar thick liquids sit in the refrigerator, staff should stir it;-Staff should follow directions on the container to prepare the thickened liquids for a six-ounce glass of water;-Dietary staff prepares the drinks for the aides;-The aides prepare thickened liquids if the resident requests more to drink. Review on 07/24/25, at 10:03 A.M., showed the resident's current nutritional diet card showed for staff to provide the resident with nectar thick liquids. During an interview on 07/23/25, at 12:12 P.M., the DM said the following:-The facility had two residents on thickened liquids;-The dietary staff prepared the thickened liquids;-The dietary staff usually prepare the liquids at least two hours before each meal so they can refrigerate and get to the proper temperature;-The registered dietician, speech therapist, and herself trains the dietary staff on preparing thickened liquids;-Staff should follow the instructions on the thickener can;-The water, tea, and chocolate milk glasses are all eight-ounce cups;-For every four ounces of water, juice, or tea, it is one tablespoon of thickener per four ounces;-Staff should use two tablespoons of thickener for eight ounces of water for nectar thick liquids;-Staff should shake the thickened liquids before serving the resident because it can settle.During an interview on 07/28/25, at 10:00A.M., the Registered Dietician said the following:-She expected staff to follow directions on preparing thickened liquids, but it also depends on if the thickener was a gel or powder;-The directions are a guide and staff should use their own judgment;-The thickener depends on the temperature and the amount of acidity will make a difference with the thickening;-She expects staff to stir the thickened liquid if it settles. During an interview on 07/23/25, at 12:45 P.M., the ADON said the following:-Kitchen staff are responsible for making the thickened liquids for residents;-Staff should stir the liquids if the thickener settles to the bottom of the glass;-He/she thought the resident's water looked too thin since it ran too fast off the spoon;-The nectar thick liquids appeared too runny today for the resident, if it's runny, staff should inform the dietary manager. During an interview on 07/24/25, at 9:32 A.M., Certified Medication Technician (CMT) K said the following:-The resident eats too fast and staff have to remind him/her to slow down. The resident chokes on his/her drinks and puree at times;-He/she did not know if the resident was at high risk for aspiration;-Speech therapy staff evaluates residents to determine if they need thick liquids or dietary modifications;-Dietary staff or aides can make the thickened liquids;-Staff should follow the directions are on top of the canister for how many tablespoons per ounce to make thick liquids;-Nectar thick should be the consistency of pudding;-Residents have colored diet cards for their diet. An orange diet card is for a resident for puree;-Staff should stir liquids if the thickener settles on the bottom of the glass. During an interview on 07/24/25, at 9:50 A.M., Certified Nurse Aide (CNA) T said the following:-The resident had issues with choking, it worried him/her when he/she drank liquids;-Staff remind the resident to slow down with eating and drinking;-The resident's thickened liquids should be the correct consistency;-Staff should follow directions with preparing the thickened (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	liquids for residents. During an interview on 07/23/25, at 12:40 P.M., CNA S said the following:-Nurses inform them of residents on thickened liquids;-Dietary staff prepare the thickened liquids for residents;-Staff should put two tablespoons in eight ounces of water;-Staff inform the kitchen staff if the nectar thick liquids did not look correct;-Staff should stir the liquids if the thickener settles to the bottom of the glass. During an interview on 07/24/25, at 4:04 P.M., the Director of Nursing (DON) said the following:-The resident was at high risk for aspiration;-The resident shoves food in his/her mouth and drinks liquids fast and did not care if he/she choked or not and could aspirate;-Staff should follow the directions on the container to prepare the thickened liquids;-Staff should stir the liquids if the thickener settles to the bottom of the glass. During an interview on 07/28/25, at 09:20 A.M., the Administrator said staff should follow the directions on the package to prepare a glass of thickened liquids and should stir the thickened liquids if it settles in the glass.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents were offered, and received if requested, the pneumococcal vaccine when one resident (Resident #55) requested the vaccine, but staff failed to administer the vaccine and when facility staff failed to offer one resident (Resident #17), or his/her responsible party, the vaccine. The facility census was 57.Review of the facility policy titled, Pneumococcal Vaccine, revised August 2016, showed the following:-All residents will be offered pneumococcal vaccines to aid in preventing pneumonia and pneumococcal infections;-Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated of the resident has already been vaccinated;-Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record;-Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the vaccination. 1.Review of Resident #55's face sheet showed the following:-admitted [DATE] and re-admitted [DATE];-Diagnoses included Parkinson's disease, Alzheimer's disease, and chronic kidney disease. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 06/12/25, showed the resident was cognitively intact. Review of the resident's vaccination consent form showed the following:-The resident checked declination of the Covid-19 and the influenza vaccine;-The resident checked yes to consent of the pneumonia vaccine (PSV20). Review of the resident's vaccination list showed staff did not document administration of a pneumonia vaccine. 2. Review of Resident #17's face sheet showed:-admission date of 07/26/24;-Diagnoses included Alzheimer's disease, urinary tract infection, urinary incontinence, and congestive heart failure.Review of the resident's quarterly MDS, dated [DATE], showed the resident had severe cognitive impairment.Review of the resident's vaccination consent form showed the following:-The resident's responsible party checked yes to consent of the influenza vaccine;-The resident's responsible party did not complete the consent or declination portion of the pneumococcal consent form. Review of the resident's vaccination list showed staff did not document administration of a pneumonia vaccine. 3. During an interview on 07/28/25, at 2:46 P.M., the Director of Nursing (DON) said he/she was unsure if facility staff administered pneumococcal vaccines to the residents or not. During an interview on 07/28/25, at 2:47 P.M., the Assistant Director of Nursing (ADON) said the following:-Facility staff did not offer residents and did not administer pneumococcal vaccines last year (2024) to the residents;-After the former DON resigned, staff were not able to locate resident pneumonia vaccine consents, therefore the facility did not administer the vaccinations to the residents. During an interview on 07/28/25, at 3:00 P.M., the facility Administrator said the following:-He/she was recently made aware that the facility staff had not offered pneumonia vaccines to all residents on admission in the past;-He/she had not yet had the opportunity to complete an audit to determine which residents were affected by the failure.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on interview, observation, and record review, the facility failed to maintain a complete call light system accessible to all residents when staff failed to consistently place the call light within the reach of one resident (Resident #8). The facility census was 57.Review of the facility policy titled Answering the Call Light, dated October 2010, showed the following:-The purpose of the procedure was to respond to the resident requests and needs;-Be sure the call light is plugged in at all times;-When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident;-Answer the resident's call as soon as possible. 1. Review of Resident #8's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 06/06/25;-Diagnoses included cerebral infarction (sudden loss of brain function that occurs when blood flow to the brain is interrupted), hemiplegia (paralysis of one side of the body) of right side, muscle weakness, and aphasia (language disorder that affects a person's ability to communicate). Review of the resident's care plan, revised on 06/19/25, showed the following:-Resident had impaired function and required staff assistance with self-care and mobility;-Resident was at risk for falls related to unsteady balance and a history of falls;-Staff to keep frequently used items within reach;-Required staff assistance for ambulation, bathing, bed mobility, dressing, grooming,hygiene, locomotion, toileting, and transfers;-Staff to keep call light within reach. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 06/06/25, showed the following:-Severe cognitive impairment;-Dependent on staff for transfers, mobility, dressing, and showering. Observation on 07/21/25, at 10:03 A.M., showed the resident resting in bed with the call light clipped to a curtain and out of reach of the resident.Observation on 07/23/25, at 12:45 P.M. showed the resident awake and sitting in a chair watching television. He/she held the television remote in his/her left hand and was pressing buttons to forward the playing television show. The call light was observed placed over the bedside table which was behind the resident out of reach.Observation on 07/24/25, at 2:51 P.M. showed the resident sitting in a chair with the call light resting on top of the chair out of the resident's reach.Observation on 07/25/25, at 9:28 A.M. showed the resident resting in bed with the call light draped over the head of the bed out of the resident's reach. During an interview on 07/28/25, at 11:09 A.M., the Certified Nurse Assistant (CNA) N said call lights should be within easy access to the resident. A call light should not be clipped to a curtain because the resident would be unable to reach it. The resident can use one of his/her hands. The resident should be able to use a call light if he/she is able to use a television remote. The resident had been known to yell out if help was needed.During an interview on 07/25/25, at 10:00 A.M., Certified Medication Technician (CMT) L said call lights should always be within reach of the resident. Call lights should not be clipped to a curtain. The resident could use a call light and should have one. During an interview 07/28/25, at 9:57 A.M., Licensed Practical Nurse (LPN) J said call lights should be within the resident's reach. Call lights should not be clipped to a curtain. The resident should be able to use a call light if he/she is able to use a television remote.During an interview on 07/28/25, at 10:08 A.M., CNA M said call lights should be within reach. Aides will clip the call light to a pillow or on a bed rail to allow residents easy access. The resident had occasionally used the call light. Staff should not clip a resident's call light to a curtain or out of reach.During an interview on 07/28/25, at 11:46 A.M., the Assistant Director of Nursing (ADON) said call lights should be within resident reach. Call lights should not be clipped to a curtain. The resident can use a call light and should have it placed within reach.During an interview on 07/28/25, at 2:43 P.M., the Director of Nursing (DON) said call lights should be within the reach of residents. Staff should place call lights right on chest where they can be reached. The call light should not be placed on a curtain out of reach. The resident can use a call light.During an interview on 07/28/25, at 2:35 P.M., the Administrator said call lights should be within the resident's reach.