STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265656	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strafford Care Center	505 West Evergreen Strafford, MO 65757

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (continued on next page)

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

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure each resident's right to privacy was maintained when a staff member posted a photo to social media that showed one resident's face (Resident #1) and private medical information of another resident (Resident #2). The census was 62.Review of the facility's policy named, Social Media, undated, showed the following:-The community recognizes the importance of social media websites as a form of communication in today's society and to a great extent respects the staffs privacy while off-duty. However, when the staff's use violates the facility policies, disrupts operations, interferes with a team members work, is used to harass a team member, creates a hostile work environment or harms the [NAME] and reputation among customers and the community, the facility may need to conduct an investigation and take appropriate corrective action as needed;-Prohibited activity included unauthorized disclosure of resident information on internet sites that violate Health Insurance Portability and Accountability Act (HIPPA), resident rights, and community policies,-Prohibited Activity included information in the context of their work environment regarding clients, residents, or other team members, including names, photos, or related information to any kind that violates privacy standards or release of confidential information;-The staff is required to report alleged violations of the policy to the Administrator/Executive director. Review of the facility's policy titled, HIPPA, what is it., undated, showed the following:-The facility tries to give the resident's the best healthcare. Part of the facility's job of caring for them is to keep their health information private;-Private information includes the resident's name address, age, social security number and any other personal information. Such as, why they are at the nursing home, their medications or treatments, or any other information about the resident's health condition, past or present;-The facility staff have to make sure they done give out private information to those who should not have it or don't have permission from the resident to have it, even if it is spoken to someone, over the phone, or information on the computer that could be seen or a fax;-Facility staff should use the need to know rule. If the facility staff need the information to their job, then they are allowed to see it. The staff should only look at the information they need to know and not share it with anyone. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date 10/03/23;-Diagnoses included cerebrovascular disease (a group of conditions that affect the blood vessels in the brain, leading to reduced blood flow and oxygen supply to the brain), Alzheimer's disease (a progressive, irreversible brain disorder that causes memory loss, confusion, and other cognitive decline), and heart failure.Review of the resident's care plan, dated 05/13/25, showed the following:-The resident had a communication problem;-Monitor for/record confounding problems, decline in cognitive status, mood, decline, in activities of daily living, deterioration in respiratory status, oral motor function,and hearing impairment. 2. Review of Resident #2's face sheet showed the following:-admission date of 02/09/24;-Diagnoses included dementia with anxiety (a group of conditions that cause a decline in cognitive functions, such as memory, thinking, problem-solving, and language, disorientation).Review of the resident's care plan, dated 05/19/25, showed the following:-The resident had impaired cognitive function/dementia or impaired thought processes;-Break tasks into small sub tasks to support short term memory deficits;-Engage the resident in simple, structured activities. and avoid overly demanding tasks. 3. During an interview on 09/11/25, at 3:30 P.M, Certified Nurse Aide (CAN) E said the following:-He/she saw that Licensed Practical Nurse (LPN) G, who used to work at the facility, had posted a picture to their own personal social media (Facebook) account that had Resident #1 sitting in the background. There was also some resident documentation on the table that was visible;-He/she did not report it to anyone;-He/she did not think it was appropriate to post photos or resident information on their own personal social media. He/she believed it is against the facility's policy and violates the resident's privacy; During an interview on 09/12/25, at 10: 28 A.M., CNA J said the following:-He/she saw, a few days ago, that LPN H had posted a photo to his/her social media page that was taken at the facility and posted on 08/31/25;-He/she noticed that Resident #1 was sitting in the background and was visible;-He/she was also able to see a neurological assessment with Resident #2's full name on it with vital signs documented;-He/she did not think it was appropriate to post photos of residents or pictures of their information to social media;-He/she had not told the Administrator, but he/she thought he/she probably should. Observations on 09/12/25, at 10:28 A.M., showed CNA J pulled up LPN H's social media page that showed a photo of a female resident that CNA J confirmed was Resident #1 and a piece of paper titled, Neurological Assessment

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	265656	A. Building B. Wing	12/10/2025

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure catheter (a tube that is inserted into the bladder allowing your urine to drain) use and care per standards of practice when staff failed to obtain complete catheter orders for one resident's (Resident #3's) self-catheterization, including specifications or monitoring. The facility census was 62.Review of the facility's policy, Catheter Care, Urinary, dated 12/24, showed the following:-The purpose of this procedure is to prevent catheter- associated urinary tract infections (CAUTI);-The following information should be recorded in the resident's medical record: the date and time that catheter care was given, any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain; any problems or complaints made by the resident related to the procedure; and if the resident refused the procedure, the reason(s) why, and the intervention taken; Review of the facility's policy, Catheter, Intermittent, dated 12/24, showed the following:-Verify that there is a physician's order for the procedure;-The following information should be recorded in the resident's medical record: the date and time the procedure was performed; the amount of urine drained, the character, clarity, and color of urine, any observation of obstruction; evidence of blood, pus, etc.; any change in the resident's condition; any problems or complaints made by the resident related to the procedure; and if the resident refused the procedure, the reason why and the intervention taken. 1. Review of Resident #3's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date 08/23/25;-Diagnosis included paraplegia (a condition characterized by the loss of voluntary movement and sensation in both lower limbs, typically resulting from an injury to the spinal cord), pressure ulcer of the right buttock, stage 4 (a severe form of pressure injury that involves full-thickness tissue loss, exposing bone, tendon, or muscle), neuromuscular dysfunction of bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should), muscle weakness, and need for assistance with personal care.Review of the resident's nurses' notes showed the following:-On 08/23/25, at 11:49 A.M., resident arrived to the facility from the hospital. The resident was incontinent of both bowel and bladder. The resident self-cathetered him/herself. The resident was doing that prior to admission. He/she periodically had stress incontinence;-On 08/24/25, at 12:40 P.M., the resident was incontinent of bladder, is on a toileting program for bladder incontinence, and did not have a urinary catheter. The resident used a self-catheter to assist with bladder control. Will continue to monitor;-On 08/25/25 at 2:43 P.M., the resident was incontinent of bladder, was on a toileting program for bladder incontinence, and did not have a urinary catheter. The resident self-catheterized to assist with bladder control;-On 08/25/25, at 5:00 P.M., the resident needed straight catheters to be able to self-catheterize and was told that the facility ordered some of the style he/she needed because facility was out. They were able to get two 16 French catheter tubes to give to the resident to use;-On 08/26/25, at 3:10 A.M., the resident was incontinent of bladder, was not on a toileting program for bladder incontinence, and did not have a urinary catheter. Resident uses the following items to assist with bladder control: self cath. Review of the resident's 5-Day Stay Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/27/25, showed the following: -The resident was cognitively intact;-Intermittent catheterization;-The resident was dependent for transfers. Review of the resident's care plan, dated 08/27/25, showed the following:-The resident has a catheter;-Monitor/ document for pain/discomfort due to catheter;-Monitor/record/report to the physician for signs symptoms of a urinary tract infection (UTI) including pain burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urine frequency, foul smelling urine, fever, chills, altered mental status, change in behaviors, and change in eating patterns.Review of the resident's nurses' notes showed the following:-On 08/27/25, at 1:52 A.M., the resident was incontinent of bladder, was not on a toileting program for bladder incontinence, and did not have a urinary catheter. The resident was experiencing the following urinary issues: none. The resident used the following items to assist with bladder control: self cath. -On 08/27/25, at 3:55 P.M., the resident went to a doctor's appointment and was admitted to the hospital. Review of the resident's August 2025 Physician Order Sheet (POS) showed staff did not document orders for urinary catheterization or monitoring of urinary catheterization by the staff or resident. Review of the resident's August 2025 Treatment Administration Record (TAR) showed staff did not document monitoring of urinary catheterization. During an interview on 09/11/25, at 12:28 P.M., Licensed Practical Nurse (LPN) C said the following: -The resident self-catheterized him/herself due to being paraplegic;-He/she was not sure if

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	265656	A. Building B. Wing	12/10/2025

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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 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. (continued on next page)

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	265656	A. Building B. Wing	12/10/2025

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and interview, the facility failed to provide food in a form to meet each resident's needs when staff failed to thicken all liquids as ordered for one resident (Resident #4). The facility census was 62.Review of the facility's policy Therapeutic diets, undated, showed the following:-Therapeutic diets shall be prescribed by the attending physician. The facility will strive for the fewest possible dietary restrictions;-Mechanically altered diets, as well as diets modified for medical nutritional needs will be considered therapeutic diets;-A therapeutic diet must be prescribed by the resident's attending physician. The physicians diet order must match the terminology used by food services. 1. Review of Resident #4's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date 12/20/24;-Diagnoses included gastro-esophageal reflux disease without esophagitis (a condition where stomach contents flow back into the esophagus (food pipe) but do not cause inflammation of the esophagus).Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/8/25, showed the following-Moderate cognitive impairment;-Required set-up or cleaning assistance for eating;-Complaints of difficulty of pain with swallowing. Review of the resident's current care plan showed the following:-The resident had impaired cognitive function/dementia or impaired thought processes;-The resident's dietary preferences will be honored;-The resident is on pureed with nectar thick diet with thin liquids;-The resident prefers to have extra chocolate pudding, extra thickened chocolate milk, apple sauce, and yogurt with his/her meals;-The resident had a potential for nutritional problem;-Staff to provide and serve diet as ordered;-The resident had a swallowing problem;-All staff to be informed of the resident's special dietary and safety needs;-The diet to be followed as prescribed. Review of the resident's Physician Order Sheet (POS), dated 9/11/25, showed an order, dated 08/31/25, for regular diet, pureed texture, nectar thick fluids consistency, for indigestion. Review of the resident's Hospice Nursing communication, dated 08/31/25, showed change of diet to puree and nectar thickened.Review of the resident's nurses' notes, dated 08/31/25, showed staff did not document regarding the new diet order. Review of the facility's Diet Roster- by Texture, dated 09/12/25, showed the resident texture was pureed and mildly thick/nectar. Review of the resident's diet card, dated 09/12/25, showed diet- regular, texture-pureed, and liquid- mildly thick/nectar. Observations on 09/11/25, at 12:00 P.M., showed the following:-Certified Nurse Aide (CAN) A poured two glasses of chocolate milk from a gallon jug and added it to the resident's tray;-The chocolate milk did not appear to be thickened, and CNA A did not add any thickener;-CNA A took the tray into the resident's room and placed the two glasses of chocolate milk within the resident's reach;-CNA asked the resident if he needed help and the resident's reply could not be heard;-The resident also had a water cup with a lid that was about half full of water and ice. During interviews on 09/11/25, at 12:21 P.M. and 2:21 P.M., CNA A said the following:-The resident usually only drinks chocolate milk. He/she was not aware of the resident being on thickened liquids. He/she did not thicken the chocolate milk or any other drinks that he/she gave the resident during his/her shift;-He/she generally finds out from the nurse if a resident has had a diet change. It should also say what diet a resident has on their diet card;-He/she did not look at the diet card for the resident, but he/she probably should have;-He/she was aware that he/she was on pureed food. Observations on 09/11/25, at 4:10 P.M., showed following:-The resident had two glasses of chocolate milk with straws, ice water and a nutritional shake sitting on the resident's bedside table that was pushed over his/her bed where he/she could reach it. The chocolate milk and the ice water did not appear to be thickened;-The resident demonstrated that he/she could pick up the cups but said he/she did not want to drink right now. Observations on 09/12/25, at 8:40 A.M. , showed a water jug on the resident's bedside table that did not appear to be thickened. During an interview on 09/11/25, at 4:12 P.M., Hospice Registered Nurse (RN) B said the resident should be on a puree diet with nectar thick liquids. They were hoping that this would improve his/her intake due to weight loss and overall decline. During an interview 09/11/28, at 12:28 P.M., Licensed Practical Nurse (LPN) C said the following:-The resident had been refusing to eat food but he/she will generally drink chocolate milk;-He/she would have to look up the resident's diet orders to see if he/she was on thickened liquids. During an interview on 09/11/25, at 12:43 P.M., CNA D said the following:-He/she brought the resident ice water today and left it on the bedside table where he/she could reach it;-He/she was not sure if the resident was on thickened liquids. During an interview on 09/11/25, at 4:05 P.M., Certified Medication Tech (CMT) F said the following:-He/she just gave the resident 90 milliliters of Boost (nutritional shake). The resident will sip on

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	265656	A. Building B. Wing	12/10/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain accurate and complete medical records for each resident when staff failed to fully document regarding a wound and treatments, including a wound VAC (a medical device that uses negative pressure to remove drainage from wounds and promote healing), for one resident (Resident #3) who admitted with the wound. The facility census was 62.Review of the facility's policy, Skin Identification, Evaluation, and Monitoring Policy, dated 01/25, showed the following:-The purpose of this policy is to outline a method of identification, evaluation, and monitoring for alterations in skin integrity. Communities will implement preventative measures, and an individualized care plan will be formulated upon completion of findings;-Review of resident medical record to identify risk factors that have the potential to cause alterations in skin integrity, provide privacy, and explain the purpose of a physical skin evaluation;-A licensed nurse will evaluate skin integrity through a physical skin evaluation upon admission, weekly, and when a significant change is identified. The nursing assistant will observe the resident's skin when assisting with activities of daily living and report changes to the nurse;-Upon admission the nurse should, complete physical skin evaluation, document findings;-If a skin condition is present on admission: Initiate protective dressing, notify health care provider of findings and for further treatment orders, notification/education of resident and resident or representative of findings and physician orders, document evaluation in the medical record, initiate preventative and/or treatment intervention as indicated, wound care nurse, notify Director of Nursing (DON) of pressure injury identification, document findings and notifications, and update baseline care plan with initial interventions, 1. Review of Resident #3's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date 08/23/25;-Diagnoses included paraplegia (a condition characterized by the loss of voluntary movement and sensation in both lower limbs, typically resulting from an injury to the spinal cord), pressure ulcer of the right buttock, stage 4 (a severe form of pressure injury that involves full-thickness tissue loss, exposing bone, tendon, or muscle), and need for assistance with personal care.Review of the resident's 5 day Stay Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/27/25, showed the following:-The resident was cognitively intact;-The resident was dependent for transfers. Review of the resident's care plan, dated 08/27/25, showed the following: -The resident had potential/actual impairment to skin integrity;-Administer treatments as ordered and monitor the effectiveness;-Monitor dressing when providing care to ensure it is intact and adhering. Report loose dressing to the nurse;-Monitor pressure areas for changes in color, sensation, temperature, and report any change to the nurse. Review of the resident's hospital discharge instructions, dated [DATE], showed wound VAC right ischial tuberosity (the pelvis part bearing weight when sitting) continuous therapy vacuum assisted closure with pressure setting of 125 millimeters of Mercury (mmhg). Review of the resident's Physician Order Sheet (POS), dated 09/12/25, showed the following: -An order, dated 08/26/25, for may use wet to dry dressing until a new wound VAC received;-Staff did not document orders for the wound VAC or monitoring of the Wound VAC. Review of the resident's Nursing Admission/readmission Data Collection, dated 08/23/25, showed the resident was admitted with right trochanter (hip), pressure sore. Review of the resident's August 2025 Treatment Administration Record (TAR) showed staff did not document wound treatments or monitoring for the stage 4 pressure ulcer. During an interview on 09/11/25, at 12:28 P.M., Licensed Practical Nurse (LPN) C said the following:-The resident had a wound VAC around his/her right buttock. The staff had to replace it numerous times because it would lose the seal or would get soiled;-He/she assisted in changing the wound VAC at least once while the resident was at the facility;-Any dressing changes should be documented in the chart. There should be an order for the wound VAC with the specifications of the pressure and how often it should be changed. During an interview on 09/11/25, at 3:30 P.M, Certified Nurse Aide (CNA) E said the resident had a wound VAC but it was removed while he/she was at the facility because it was not working properly. He/she had to ask the nurses to come change the wound VAC due to getting feces in it. During an interview on 09/12/25, at 11:20 A.M and 4:26 P.M., LPN G said the following: -He/she put on the resident's wound VAC after he/she admitted to the facility. He/she was not his nurse but was more familiar when wound VACs and he/she agreed to help;-The wound VAC worked correctly and was able to hold the correct suction for the first day or two but then started having trouble holding suction. They tried replacing the dressing, but it still did not work. They ordered a new one and had it overnighted;-The physician put in an order for wet to dry