STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265428	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lebanon South Nursing & Rehab	514 West Fremont Road Lebanon, MO 65536

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to ensure staff obtained, clarified, and followed physician's orders for the use of one resident's (Resident #1) implanted port (device placed under the skin that provides long-term access to a vein for treatments like chemotherapy, intravenous (IV) fluids, nutrition, or for drawing blood, eliminating repeated needlesticks through the skin) to administer an IV antibiotic when staff failed to de-access the port as ordered and failed to obtain orders regarding port site dressing changes. A sample of four residents were reviewed. The facility census was 65. Review of facility policies showed the facility did not provide a policy or procedure pertaining to the use of a port for treatments or medications. 1. Review of Resident #1's face sheet showed the following:-admission date of 07/17/24 with re-admission date of 01/05/26;-Diagnoses included chronic kidney disease, presence of vascular implants and grafts, altered mental status, chronic autoimmune liver disease, urinary retention, and urinary tract infection (UTI). Review of the resident's care plan, last updated 11/19/25, showed the resident had a port in the right upper chest due to history of cancer. Resident to have no issues from implanted device through next review. Review of the resident's discharge Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/03/26, showed the following information:-Mild cognitive impairment;-Dependent on others for most activities of daily living (ADLs - dressing, grooming, etc.);-Presence of indwelling catheter (tubing placed to drain the bladder to outside the body into a collection bag);-Indication for and use of an antibiotic. Review of the resident's Physician Order Sheet (POS), current as of 01/06/26, showed an order, dated 11/03/25, for meropenem (broad-spectrum antibiotic used to treat severe bacterial infections, typically administered IV in a hospital or clinic setting) reconstituted solution, 1 gram (gm), intravenous (in vein), every 8 hours for urinary tract infection (UTI). Review of the resident's electronic Medication Administration Record (eMAR), dated 11/01/25 to 11/30/25, showed staff documented administration of meropenem, 1 gm per IV as follows:-On 11/03/25 at 8:00 P.M.;-On 11/04/25 at 4:00 A.M. and 12:00 P.M.Review of the resident's nurses' progress notes dated 11/04/25, at 3:37 P.M., showed Registered Nurse (RN) A contacted the physician regarding access to resident's power port in right upper chest for current antibiotic therapy. Physician gave orders to access port and use for IV therapy and new order to access port monthly and flush with 10 cubic centimeters (cc) normal saline, then de-access. Staff updated orders accordingly. (Staff did not document orders or follow-up pertaining to dressing changes related to the use of the port.)Review of the resident's eMAR, dated 11/01/25 to 11/30/25, showed staff documented administration of meropenem, 1 gm per IV as follows:-On 11/04/25 at 8:00 P.M.;-On 11/05/25 at 4:00 A.M. Review of the resident's POS, current as of 01/06/26, showed an order, dated 11/05/25, to access port (once) for IV antibiotic therapy and then de-access once treatment was complete for diagnosis of urinary tract infection. (Staff did not document orders or follow-up pertaining to dressing changes related to the use of the port.) Review of (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's nurses' notes showed the following:-On 11/05/25, at 10:58 A.M., RN A successfully accessed resident's port to right upper chest on one attempt using a 20-gauge Huber needle (specialized for port access), sterile technique maintained for procedure. Flushed without difficulty. Resident tolerated procedure well, without complaint or concern;-On 11/05/25, at 12:36 P.M., resident complained of pain at port location upon beginning IV antibiotic therapy. Port flushes but resident complained of pinpoint pain with flushing and no blood return noted. RN A attempted to adjust needle placement with no avail. RN A de-accessed port related to continued complaint of pain/discomfort. Nurse contacted physician for further instruction, awaiting response.-On 11/05/25, at 5:16 P.M., staff noted resident's family insisted that he/she be transferred to the hospital for possible sepsis. Nurse contacted physician, who said the resident was stable on assessment earlier that day. Transported to hospital via ambulance at 5:22 P.M.;-On 11/07/25, at 5:21 P.M., resident readmitted via ambulance transport and assessment done and documented. Only medication change made was meropenem was reinstated for the 16 doses remaining ABT therapy. Staff will continue with the current orders;-On 11/07/25, at 10:46 P.M., ABT therapy continued for meropenem to end 11/11/25. IV ABT infused without difficulty. Review of the resident's POS, current as of 01/06/26, showed an order, dated 11/07/25, for meropenem reconstituted solution, 1 gram IV, every 8 hours. (Staff did not document orders or follow-up pertaining to dressing changes related to the use of the port.) Review of the resident's eMAR, dated 11/01/25 to 11/30/25, showed the following:-On 11/07/25, staff documented administration of meropenem, 1 gm per IV, at 8:00 P.M.;-On 11/08/25, staff documented administration of meropenem, 1 gm per IV, at 4:00 A.M., 12:00 P.M., and 8:00 P.M.;-On 11/09/25, staff documented administration of meropenem, 1 gm per IV, at 4:00 A.M., 12:00 P.M., and 8:00 P.M.;-On 11/10/25, staff documented administration of meropenem, 1 gm per IV, at 4:00 A.M., 12:00 P.M., and 8:00 P.M.;-On 11/11/25 staff documented administration of meropenem, 1 gm per IV, at 4:00 A.M., 12:00 P.M., and 8:00 P.M.;-On 11/11/25, 6:00 A.M. to 6:00 P.M. de-access port once final antibiotic dose was administered; frequency - one time. Staff documented Not administered: on hold and last dose is tomorrow evening;-On 11/12/25, staff documented administration of meropenem, 1 gm per IV, at 4:00 A.M. and 12:00 P.M. Review of resident's nurse's notes dated 11/12/25, at 11:05 A.M., showed physician in-house and gave orders to continue meropenem VI for UTI at 500 milligrams (mg) twice daily for one more week. IV site flushes well with dressing intact. (Staff did not document orders or follow-up pertaining to dressing changes related to the use of the port.) Review of the resident's POS, current as of 01/06/26, showed an order, dated 11/12/25, for meropenem reconstituted solution, 500 milligrams (mg), IV, twice a day for UTI,. (Staff did not document orders or follow-up pertaining to dressing changes related to the use of the port.) Review of the resident's eMAR, dated 11/01/25 to 11/30/25, showed the following:-On 11/12/25 staff documented administration of meropenem, 500 mg per IV, at 8:00 P.M.;Oon 11/13/25 staff documented administration of meropenem, 500 mg per IV, at 8:00 A.M. and 8:00 P.M.;-On 11/14/25 staff documented administration of meropenem, 500 mg per IV, at 8:00 A.M. and 8:00 P.M.;-On 11/15/25 staff documented administration of meropenem, 500 mg per IV, at 8:00 A.M.; medication refused at 8:00 P.M.;-On 11/16/25 staff documented medication refused at 8:00 A.M. and 8:00 P.M.;-On 11/17 25 staff documented medication refused at 8:00 A.M.; administered at 8:00 P.M.;-On 11/18/25 staff documented medication refused at 8:00 A.M. and 8:00 P.M.;-On 11/19/25 staff documented medication refused at 8:00 A.M. and 8:00 P.M.(Staff did not document a scheduled date/time to de-access the port after final antibiotic dose was administered.) Review of the nurses' noted showed staff did not document the port was de-accessed after the final antibiotic dose was administered. Observation and interview on 01/06/25, at 10:10 A.M., showed the resident said he/she had an implanted port previously used for cancer (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatments that the facility had used for administering antibiotics. The port was not currently in use, and the skin was bare over the site. During an interview on 01/06/25, at 1:20 P.M., Licensed Practical Nurse (LPN) B said an LPN was not allowed to access/de-access a port, only a RN could do so. LPN B said he/she did administer IV medications through the resident's port, but only after an RN accessed it and set it up for use. He/she said there was always a dressing in place during the port use, but he/she did not change that dressing. During an interview on 01/06/26, at 1:25 P.M., LPN C said he/she thought a port dressing should be changed every seven days or according to nursing standards. He/she did not access the resident's port; only an RN could do that. During an interview on 01/06/25, at 1:41 P.M., RN D said he/she had not worked with a port at this facility. The RN said the port dressing change frequency would depend on the type of access needle/kit was used; either every seven days or daily. RN D was unable to locate a facility policy pertaining to the use of a resident's port. During an interview on 01/06/26, at 2:05 P.M., RN E said he/she did access the resident's port on 11/05/25, but was unable to maintain the line access during that day. The resident was sent to the hospital that day and returned a couple of days later with a new access line in place. RN E said the port dressing should be changed every seven days and as needed. The RN said he/she was not asked to de-access the port before his/her last day working at the facility (on either 11/17/25 or 11/18/25). During an interview on 01/06/25, at 2:17 P.M., the Director of Nursing (DON) said the facility did not have a policy and procedure pertaining to the use of a resident's port for treatment. The DON said an LPN could not access or de-access a port; they would need to enlist the assistance of an RN for those processes. The DON said the port dressing should probably be changed with every dosing of the antibiotic or at least every 24-72 hours as is done with a central line dressing. The port should be de-accessed after the last dose of antibiotic is administered. Regarding the scheduled de-access of Resident #1's port, LPN B had used the space to document not done; on hold due to the physician's extension of the orders through the next day. Staff should have input a new scheduled date to de-access the port to alert other staff of that need. During an interview on 01/06/25, at 3:30 P.M., the Administrator and the DON both said they had not been able to locate a policy or procedure pertaining to the use of a resident's port. The DON said staff should get specific orders for a dressing change frequency and get clarification on orders as needed. Staff should follow all physician orders. If an LPN is not allowed to perform a procedure based on their scope of duties, they should ask one of the RN's to complete and document the procedure. The port dressing should be changed at least weekly, but possibly every 72 hours. During an interview on 01/20/26, at 10:51 A.M., the physician said the nursing staff should have done routine dressing changes to the accessed port and followed the physician order to de-access the port after the last dose of the antibiotic. Staff should obtain and/or clarify all orders regarding any treatment or dressing changes. Complaint 2683316