

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1145 East Cherry Street Troy, MO 63379	

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)
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care and services to maintain the highest practical well-being for one resident (Resident #1) with a diagnosis of vascular dementia (a person has problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), in a review of five sampled residents. The facility failed to identify situations that triggered the resident causing aggression and combativeness. The facility failed to identify non-pharmacological interventions to help the resident when he/she was combative or refused care. While staff provided incontinence care on 9/18/25, the resident became upset and combative. Staff continued to provide care and transferred the resident with a sit to stand lift while the resident continued to hit staff. The facility also failed to ensure staff received and understood dementia care training. The facility census was 80. The facility did not provide a dementia care policy upon request. 1. Review of Resident #1's undated face sheet showed the following:-The resident admitted to the facility on [DATE];-The resident had diagnoses that included vascular dementia. Review of the resident's care plan, dated 4/30/25, showed the following: -The resident had cognitive loss/dementia;-The resident may have difficulty understanding others at times related to presence of vascular dementia;-Face the resident when speaking, obtain the resident's attention before speaking, provide a quiet non-hurried environment free of background noises and distraction if he/she appears distracted, speak clearly and adjust tone as needed;-The resident had behavioral symptoms;-The resident was at risk for elopement due to confusion, independent locomotion in a wheelchair and medications that suppress the thought process;-Administer medication per physician's order;-Assess the resident quarterly and as needed. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 7/2/25, showed the following:-The resident's cognition was severely impaired;-The resident had no physical, verbal or other behaviors toward himself/herself or others;-The resident had no inattention, disorganized thinking or altered level of consciousness;-The resident did not reject cares;-The resident's behavior was the same as prior assessment;-The resident required substantial to maximum assist from staff for rolling left to right in bed;-The resident was dependent on staff for transfers to and from his/her wheelchair, sitting to standing positions, transfers to and from his/her chair and bed, showering, personal hygiene, and dressing. Review of the resident's progress note dated 7/19/25 at 10:30 A.M, showed the resident could become agitated at times and was alert and oriented to person and place. Review of the resident's progress note, dated 7/20/25 at 9:45 A.M., showed the resident could become agitated at times and was alert and oriented to person and place. Review of the resident's progress note, dated 7/25/25 at 8:24 A.M., showed the resident was combative with cares at times and was alert and oriented to person only. Review of the resident's psychiatric progress note, dated 8/22/25, showed the following:-The resident was seen for a follow up</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 265433	If continuation sheet Page 1 of 4

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