STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265491	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Nursing	914 Chickesaw Street Seneca, MO 64865

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on record review and interview, the facility failed to provide respiratory care per standards of practice when staff failed to clarify hospital discharge orders for pulse oximetry (a test used to measure the oxygen level of the blood), failed to have the resident's oxygen order on the Treatment Administration Record (TAR), and failed to document oxygen usage and pulse oximetry readings for one resident (Residents #1). The facility census was 50. Review of facility policy titled Oxygen Administration, dated February 2021, showed the following: -Verify there is a physician's order for oxygen administration; -After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: the date and time that the procedure was performed; the rate of oxygen flow, route; the frequency and duration of the treatment; the reason for as needed (PRN) administration; if the resident refused the procedure, the reason(s) why and the intervention taken; and the signature and title of the person recording the data. 1. Review of Resident #1's face sheet (a general information sheet) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), respiratory failure, unspecified with hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues), and chronic kidney disease (disease that causes progressive damage and loss of function to the kidneys). Review of resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/12/24, showed the resident's cognitive skills were intact and resident received oxygen therapy. Review of the resident's hospital discharge orders, dated 12/07/24, showed the following: -Oxygen home delivery concentrator with portability at two liters per minute via nasal cannula. Oxygen at a setting of two on a conserving device. Anticipated length of six months or greater; (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Non monitored home continuous pulse oximeter for spot checks. Anticipated length of need of one month. Resident's baseline pulse oximeter measurement was 95% on two liters/minute by nasal cannula; -If pulse oximeter reading goes below 90% call the hospital or if in distress call 911 immediately. Review of the resident's December 2024 Physician Order Sheet (POS) showed a physician order, dated 12/07/24 , for oxygen at two liters via nasal cannula (nc) PRN for shortness of breath. (Staff did not document an order regarding pulse oximeter monitoring or direction for when to notify the physician.) Review of the resident's December 2024 Treatment Administration Record (TAR) showed staff did not document the physician order for oxygen at two liters via nasal cannula PRN or monitoring for pulse oximeter readings. Review of the resident's baseline care plan, dated 12/09/24, showed the following: -Resident was alert and cognitively intact; -Special treatment/procedures include oxygen with no rate of administration listed. (Staff did not address the pulse oximeter monitoring on the care plan.) During an interview on 02/11/25, at 12:55 P.M., Certified Nurse Aide (CNA) E said the resident was at the facility for rehabilitation and was on oxygen. During an interview on 02/11/25, at 1:07 P.M., CNA F said the following: -The resident was on oxygen; -The resident would take off his/her oxygen during the day on his/her own per his/her choice; -He/she did not remember how often staff checked the resident's vital signs. During an interview on 02/11/25, at 1:35 P.M., Certified Medication Technician (CMT) G said the resident was on oxygen as needed. The aides check residents' vital signs based on the orders in the computer. During interviews on 02/13/25, at 2:29 P.M., and on 02/14/25, at 8:25 A.M., Licensed Practical Nurse (LPN) B said the following: -The resident had a pulse oximeter at his/her bedside and checked his/her pulse oximetry himself/herself; -He/she assumed spot checks meant for staff to check a resident's oxygen saturations each shift; -He/she did not remember if he/she called the physician to clarify the hospital discharge order; -He/she checked the resident's oxygen saturation at times and did not know if he/she documented it; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurses review hospital discharge orders and enter them in the computer; -Pulse oximetry checks should be on a residents' TAR and staff should document; -A PRN oxygen order should be on the TAR. During interviews on 02/11/25, at 11:47 A.M. and 2:11 P.M., Registered Nurse (RN) A said the following: -The resident had a diagnosis of COPD; -The resident said he/she used oxygen, but at times he/she refused to wear the oxygen; -The hospital discharge order showed an order for a home device pulse oximeter. The facility did not have a continuous pulse oximeter; -Staff should had clarified the hospital discharge order with the physician; -He/she assumed spot checks meant to check the resident's oxygen saturations every shift and should had been documented on the TAR; -Nurses review the discharge orders and enter them in the computer; -Nurses clarify physician orders with the physician if it did not seem right. During interviews on 02/11/25, at 1:03 P.M., and on 02/13/25, at 6:20 P.M., RN C said the following: -The resident said his/her oxygen was continuous, but he/she did not always wear it; -The resident had his/her own pulse oximetry machine and would use it from time to time; -The resident had an order for oxygen; -He/she did not know of the hospital order for spot checks of the resident's oxygen saturations; -Staff should have clarified the hospital discharge order with the physician; -A normal order would read oxygen PRN to keep oxygen saturations above 90%; -When he/she or the resident took oxygen saturations they were always above 90% and staff should have documented the oxygen saturations. During an interview on 02/13/25, at 2:48 P.M., RN D said the hospital discharge order for the continues pulse oximetry was an unusual order and the facility did not do continuous pulse oximetry checks. Staff should had called the physician to clarify the order. During an interview on 02/13/25, at 6:44 P.M., the Director of Nursing (DON) said the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff should had clarified what spot checks meant with the physician; -The hospital discharge order is an order to be followed; -She did not know the resident had his/her own pulse oximetry at his/her bedside; -Nurses enter the hospital discharge orders in the computer and print them off and send to the pharmacy; -Oxygen orders should include amount of liters and if the oxygen is continuous or PRN; -She would expect staff to perform spot checks at least three times a day to make sure a resident's oxygen SATS are at 95% and if they are below 95% to notify the physician; -PRN oxygen order should be on the TAR. During an interview on 02/11/25, at 3:40 P.M., the Administrator said the following: -Nurses review physician orders and enter them in the computer; -She expected nurses to clarify orders with the physician if they had any; -On admission the charge nurse inputs new orders; -Part of the admission process is clarifying new orders with the physician; -She assumed spot checks meant if a resident had issues with oxygen not at normal ranges, staff would check a resident's oxygen saturations if a resident is confused or tired; -Oxygen orders and parameters should be specific. MO00249192 51940

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to maintain complete medical records for all residents when staff failed to document full details and notifications related to one resident (Resident #1) who died at the facility. The facility census was 50. Review of the facility's policy titled Charting and Documentation, dated February 2021, showed the following: -Chart all pertinent changes in the resident's condition, reaction to treatments, medications as well as routine observations; -Be concise, accurate and complete and use objective terms. Document only the facts. Use only approved abbreviations and symbols; -For death of a resident document code status of resident and whether CPR (cardiopulmonary resuscitation - an emergency lifesaving procedure performed when the heart stops beating) was performed; pertinent information before death (example, symptoms, vital signs, treatments, etc); date and time of death; name of physician notified and when notified; time resident representative notified and by whom; name of funeral home, time notified and by whom; when and to who the resident is released;disposition of medications and personal belongings; and time of coroner notification. 1. Review of Resident #1's face sheet (a general information sheet) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), respiratory failure, unspecified with hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues), and chronic kidney disease (disease that causes progressive damage and loss of function to the kidneys). Review of resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated [DATE], showed the following: -Cognitive skills intact; -Required set up assistance with eating and oral hygiene; -Required supervision with toileting; -Required partial/moderate assistance with shower/bathing and upper and lower body dressing. Review of the resident's [DATE] Physician Order Sheet (POS) showed a physician order, dated [DATE] , for do not resuscitate (DNR - did not wish to receive CPR). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's baseline care plan, dated [DATE], showed the following: -Resident was alert and cognitively intact; -Required assistance of two staff for bed mobility, transfer, and toileting. Review of the resident's progress note dated [DATE], at 6:49 A.M., showed the Social Service Director (SSD) documented the resident's spouse and family member at the facility to say their goodbyes. The family took all the resident's items. The resident's spouse thanked the staff for all their care and assistance with his/her spouse. SSD expressed to the family if they need anything to let him/her know. Review of the resident's nursing notes showed staff did not document regarding the resident's death or physician and responsible party notifications. During an interview on [DATE], at 1:03 P.M., Registered Nurse (RN) C said the following: -The aides reported to him/her on [DATE], at 3:00 A.M., the resident had no pulse or heartbeat; -He/she messaged the physician and called the resident's family; -He/she did not realize he/she did not document a progress note on the resident's death; -He/she should have documented the resident's death. During an interview on [DATE], at 11:47 A.M., RN A said if a resident died unexpectedly, staff should document the physician notification and if the family was at the bedside During an interview on [DATE], at 1:41 P.M., the Director of Nursing (DON) said she expects staff to document in the progress note if a resident has a change in condition or when a resident passes away. Staff should document in the progress note the physician, responsible parties, DON, Administrator, and coroner notifications and how they found the resident. During interviews on [DATE], at 12:02 P.M. and 3:39 P.M., the Administrator said she did not see a summary of a progress note for when the resident died . She expected staff to document if a resident passed away which should include how staff found the resident, what happened and notifications to the physician and responsible parties. MO00249192 51940