

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/12/2025
NAME OF PROVIDER OR SUPPLIER  Big Bend Woods Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  110 Highland Avenue Valley Park, MO 63088	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</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
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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to protect a resident's right to be treated with dignity and respect when staff entered the resident's room without the resident's or resident's representative's consent and removed personal belongings (Resident #9). The sample size was 20. The census was 90. Review of the facility's Resident Rights and Dignity Protocol, reviewed January 2024, showed:-Protocol: The facility recognizes the resident right to a quality of life that supports privacy, confidentiality, dignity, independent expression, choice and decision making consistent with State law and Federal regulation. Review of the facility's New Resident Information, required for signature within 24 hours of admission, showed:-Room Search Protocol. Revised November 2023; -Purpose: To assure the safety of resident, staff and visitors without violating Resident Rights, the Room Search Policy and Procedure has been established; -Policy: A resident's room may be searched if, after investigation, evidence suggests that the resident has violated facility policy regarding the possession of contraband, prohibited items or stolen property. If recreational marijuana is legalized, you still may not have it in the facility or smoke it; -Procedure: The facility staff should not conduct searches of a resident or their personal belongings unless the resident or resident representative agrees to a voluntary search and understands the reason for the search, if they refuse then legal authorities should be notified to assist as allowed by law. Review of the resident's discharge Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/18/25, showed:-discharged to the hospital on 4/18/25;-Exhibited no behaviors;-Diagnoses included diabetes, anxiety and bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Review of the resident's progress note, showed:-4/21/25 at 3:58 P.M., showed a note by the Administrator. Informed by the Director of Nursing (DON) that resident was observed with a vaporizer in room last week. The DON accompanied this writer to resident's room. Search of resident's room resulted in finding two vape pens, two boxes of wooden matches, one lighter, one vape/electric cigarette battery and six bags of edibles. All items removed from room and locked in administrator's office. Storing any smoking supplies in residents' rooms is a violation of facility policy. Having marijuana on facility property is in violation of facility policy;-4/21/25 at 4:19 P.M., showed a note by the administrator. Will discuss smoking supplies found in room with resident and family/responsible party upon return from the hospital. Review of the resident's census report, showed he/she returned from the hospital on 5/6/25. During an interview on 9/10/25 at 1:04 P.M., the resident said he/she was in the hospital for an extended amount of time. Three days after he/she was admitted to the hospital, the Administrator searched his/her room closet without his/her consent and took six bags of marijuana infused edibles and two vape pens. The resident knew he/she could not smoke marijuana at the facility but did not realize he/she could not eat it. He/She did not have an issue with the facility saying he/she could not have the items. The resident was concerned because they searched his/her room without his/her knowledge or consent. The resident found out his/her room was searched by the Administrator and DON from staff at the facility. During an interview on 9/10/25 at 1:20 P.M., the Administrator said she was informed by staff the resident had marijuana in his/her room. She and the DON searched the resident's room and found six bags of marijuana infused edibles and two vaporizer pens. She confiscated the items and called the resident's family member to pick them up. The resident was in the hospital when the room was searched. The Administrator could not recall if she obtained permission from the resident's representative prior to searching the room but did document the occurrence. During an interview on 9/12/25 at approximately 9:30 A.M., the Administrator said she did not obtain permission from the resident or representative prior to searching his/her room. The items were returned to the family, and it was explained that the items were not permitted in the facility. She expected the policies to be followed and resident consent prior to searching a resident's room. 14541571454156</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide a safe, comfortable, homelike environment by failing to clean one resident's bathroom after a plumbing issue (Resident #77), failing to clean one resident's wheelchair (Resident #16), failing to clean one resident's room (Resident #37) and failing to keep temperature logs on five residents with personal refrigerators (Resident #11, Resident #48, Resident #17, Resident #4 and Resident #6) The sample was 20. The census is 90. Review of the facility's 100 hall housekeeping checklist, undated, showed;-Sweep/mop soiled closets wipe walls and reduce odors;-Empty trash cans;-Dust top of rooms, light fixtures, nightstands, counter tops, dresser, dispensers, and window sills;-Clean and disinfect sinks, beds. And high touch areas and items;-Sweep rooms;-Mop floor;-Clean and disinfect inside and outside of toilets, top to bottom;-Clean and disinfect shower areas and tubs; -Dust vents;-Sweep floor;-Mop floor including inside of showers. 1. Review of Resident #77's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 6/12/25, showed:-Cognitively intact;-Independent with bed to chair and chair to bed transfers and toilet transfers;-Uses a manual wheelchair;-The resident has an indwelling urinary catheter (a tube inserted into the bladder that drains urine);-Diagnoses included neurogenic bladder (inability to urinate), depression, muscle weakness, and spinal stenosis (narrowing of the spinal canal causing pain). Observation and interview on 9/10/25 at 2:37 P.M., showed the resident was self-propelling in his/her wheelchair to the shower room on 100 hall. The resident said his/her bathroom toilet was backed up bad and there was a large amount of bowel moment on the bathroom floor, and he/she was instructed by nursing staff to empty his/her urinary catheter bag in the shower room. The resident's bathroom had brown water overflowing out of the toilet and large pieces of bowel movement on the floor. Bowel movement oozed on the side of the toilet. Towels and a thin blanket lay on the floor of the bathroom, and was saturated with brown water. At 2:40 P.M. , the Assistant Director of Nursing (ADON) entered the resident's bathroom and said he would call housekeeping and maintenance to get the bathroom clean, and get the toilet fixed. Observation and interview on 9/11/25 at 9:45 A.M., showed the resident's bathroom door was open and the toilet had brown water to the top, dried bowel movement on the side of the toilet, large chunks of dried bowel movement on the floor. A pink wash basin was sitting on top of the trash can in the resident's bathroom. A plunger was located next to the toilet. A soiled towel and thin blanket were on the bathroom floor. The resident said no one came to fix his/her toilet or clean his/her bathroom. The resident said the nursing staff instructed the resident to empty his/her urine from his/her catheter bag into the wash basin, dump it in the toilet but do not flush. The resident said he/she was not going to roll his/ her wheelchair over bowel movement to empty his/her catheter. The resident said he/she used the 100-hall shower room to empty his/her catheter during the night. During an interview on 9/11/25 at 9:45 A.M., Certified Nursing Assistant (CNA) B said he/she was not aware the resident's bathroom was soiled. CNA B said he/she thought someone from maintenance locked the bathroom door so the resident and staff did not use it. The bathroom should not have been left soiled overnight. CNA B thought the bathroom was disgusting. The nursing staff can clean most of it, but the housekeeper would have to come in and disinfect the toilet and floors. CNA B would not expect the resident to use the bathroom, and it was not homelike. During an interview on 9/11/25 at 1:20 P.M., the Housekeeping Supervisor said housekeeping staff are expected to clean and disinfect bathrooms daily and as needed. During an interview on 9/12/25 at 8:20 A.M., the Maintenance Director said he was aware the building was having some plumbing issues but was not aware the resident's toilet had backed up. He expected staff to inform him verbally or fill out a work order to have it fixed. It was not homelike for the resident to have a backed-up toilet and soiled bathroom. During an interview on 9/12/25 at 9:15 A.M., the ADON and the Nurse Manager expected staff to clean the bathroom and have the housekeepers disinfect it. The bathroom should have been cleaned as soon as it happened and not have the resident have a soiled bathroom all night. 2. Review of Resident #16's quarterly MDS, dated [DATE], showed;-Cognitively intact;-Uses manual wheelchair;-Diagnoses included non-Alzheimer's dementia and anxiety. Observation and interview on 9/8/25 at 7:30 A.M., showed the resident sat in his/her wheelchair. The wheels on the wheelchair had food crumbs and dust on them. The area where the wheel connects to the wheelchair had large clumps of gray hair and dust on both sides. The resident said his/her wheelchair was disgusting and he/she would like it cleaned. The resident has never seen the facility staff clean wheelchairs. Observation on</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure residents requiring assistance with ADLs (activities of daily living) received the necessary services to maintain adequate personal hygiene in accordance with their needs and preferences (Residents #37, #48, and #71). The sample was 20. The census was 90. Review of the facility's Personal Care Needs policy, reviewed 1/2024, showed:-Protocol: The facility strives to promote a healthy environment and prevent infection by meeting the personal care needs of the residents. The facility also provides the needed support when the resident performs their ADLs. The interdisciplinary plan of care (IPOC) will address the individual needs and preferences of the resident. Personal care and ADL support will be provided according to the resident plan of care. Personal care and support include but is not limited to the following: -Assistance with meals; -Bath/shower; -Grooming/dressing; -Nail care; -Peri-care; -Shave;-Procedure includes: -Develop and implement individualized interventions; -Document on individual resident care plan; -Document in the progress notes if an exception to the established plan of care occurs, i.e., refusals. 1. Review of Resident #37's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 6/12/25, showed:-Moderate cognitive impairment;-Always incontinent of bowel and bladder;-Dependent on staff for toilet hygiene, personal hygiene, bathing and putting on and taking off footwear;-Non-Alzheimer's dementia, diabetes, hemiplegia (paralysis to one side of the body), stroke and seizures. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident experiences bowel and bladder incontinence related to dementia, cognitive impairment, impaired mobility, impaired sensation related to stroke;-Interventions: The resident uses adult incontinent briefs; Monitor for soiling on routine rounds and as needed; Assist to cleanse perineum (genitals and rectal area) and change brief as needed;-Focus: The resident has an ADL and mobility deficit related to cognitive impairment and dementia, shortness of breath, compromised respiratory status, lasting effects of stroke, weakness and limited endurance;-Interventions: Bathing and showering, check nail length and trim and clean on the resident's bathing day; The resident is dependent on staff to complete personal hygiene tasks; The resident is dependent on staff for toileting needs. Observation on 9/8/25 at 7:44 A.M., showed the resident lay in bed. On both hands, the resident's fingernails were approximately one half an inch long with dark matter underneath. The resident's feet were extremely dry with large flakes of skin on the resident's navy-blue mattress. Observation and interview on 9/9/25 at 3:12 P.M., showed Certified Nurse Aide (CNA) E entered the resident's room and explained to the resident that he/she was going to turn and clean the resident. The resident lay in bed, and CNA E checked the resident's brief and said the resident was wet. CNA E positioned the resident on his/her right side and removed the resident's brief. The resident's brief and bed pad were saturated with urine, and the resident also had a large bowel movement. CNA E finished cleaning the resident and said the resident was not on his/her assignment but was helping out another CNA. The resident had extremely dry feet with large flakes of skin on the resident's navy-blue mattress. On both hands, the resident had fingernails that were approximately one-half inch long with dark matter underneath. During an interview on 9/9/25 at 3:35 P.M., CNA F said the assignment switched about 10:30 A.M., and he/she did not know the resident was on his/her assignment. The last time the resident was checked was 10:30 A.M. CNA F said any nursing staff can change residents, but is one of the CNA's primary responsibilities to check incontinent residents every two hours. Observation on 9/10/25 at 10:24 A.M., showed the resident lay in bed. On both hands the resident had long fingernails approximately one half an inch long with dark matter underneath. The resident's feet were extremely dry with large flakes of skin on the resident's navy-blue mattress. 2. Review of Resident #48's admission MDS, dated [DATE], showed:-Moderate cognitive impairment;-Rejection of care behavior not exhibited;-Lower extremity impairment on both sides;-Substantial/maximal assistance required for showering/bathing self and lower body dressing;-Partial/moderate assistance required for personal hygiene;-Diagnoses included dementia and generalized muscle weakness. Review of the resident's care plan, in use at the time of survey, showed:-Focus: ADL/mobility deficits - Interventions listed are reflective of resident's usual performance and may fluctuate. The resident has an ADL and/or mobility deficit related to activity intolerance, chronic health conditions, cognitive impairment/dementia, weakness/limited endurance; -Interventions included: Check nail length and trim and clean on bath day and as necessary. The resident requires help from staff with bathing/showering. Resident prefers to have facial hair such as a beard. The</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview and record review, the facility failed to ensure a medication error rate less than 5%. Out of 31 opportunities observed, five errors occurred, resulting in a 16.13 % error rate. (Resident #84 and Resident #86). The census was 90. Review of the facility's Medication Administration policy, dated November 2021, showed:-To administer the following: Right medication; Right dose; Right dosage form; Right route; Right resident; and Right time;-Read the Medication Administration Record (MAR), for the ordered medication dose, dosage form, route, and time;-Verify the pharmacy prescription label on the drug and the manufacturer's identification matches the MAR;-If there is a discrepancy, check the original physician's orders and notify the pharmacy; Do not give the medication until clarified;-Verify that any further medication identifiers match the label and the medication; Identifiers may include drug size, shape and color;-Verify the correct medication, expiration date, dose, dosage form, route, and time again by comparing to the MAR before administering;-Administer oral medications with a full glass of water. Review of the Novolog (an immediate release insulin) FlexPen manufacturer's insert instructions, undated, showed: Key steps in using the FlexPen include priming the pen, dialing the dose, injecting by pressing the button for at least six seconds, removing the needle, and storing the pen without a needle. 1. Review of Resident #84's medical record showed diagnosis that included atrial fibrillation (irregular heartbeat), major depressive disorder, long term use of aspirin, long term use of anticoagulant (blood thinner), heart failure, and neuropathy (pain and numbness to the lower extremities). Review of the resident's physician order sheets (POS), dated, September 2025, showed:-An order dated, 2/5/25, escitalopram oxalate 20 milligrams (mg), give one time a day for depression;-An order dated, 9/3/24, celecoxib (pain medication) capsule 200 mg, give one capsule one time a day for inflammation;-An order dated, 6/25/22, aspirin 81 mg give one tablet, one time a day for atrial fibrillation;-An order dated, 6/25/22, Eliquis (blood thinner) 5 mg, give one tablet, every 12 hours for atrial fibrillation. Observation on 9/10/25 at 8:04 A.M. showed, Certified Medication Technician (CMT) I prepared the resident's medications at the medication cart on the 100 hall. CMT I entered the resident's room and administered the resident's medications. CMT I did not administer the resident's escitalopram oxalate 20 mg, celecoxib 200 mg, aspirin 81 mg, and Eliquis 5 mg. Review of the resident's MAR, dated 9/1 to 9/30/25, showed:-An order dated, 2/5/25, escitalopram oxalate 20 mgs, give one time a day for depression; A.M. med; documented as administered;-An order dated, 9/3/24, celecoxib capsule 200mgs, give one capsule one time a day for inflammation; A.M. med; documented as administered;-An order dated, 6/25/22, aspirin 81 mg give one tablet, one time a day for atrial fibrillation; A. M. med; documented as administered;-An order dated, 6/25/22, Eliquis 5 mgs, give one tablet, every 12 hours for atrial fibrillation; A.M. med; documented as administered. During an interview on 9/10/25 at 10:49 A. M., CMT I said he/she thought he/she gave the resident all of his/her medications. CMT I thought he/she gave the medications to the resident when the surveyor was not observing but wasn't sure. CMT I said he/she double checks the medication orders on the MAR prior to administering medications. During an interview on 9/11/25 at 10:40 Licensed Practical Nurse (LPN) K said when staff are administering medications, physician orders should be followed and medications should be given at the time the MAR shows in its entirety. If a medication was not given for any reason, it should be charted as not given. Medications should be checked twice against the MAR prior to giving the medicine to ensure accuracy. During an interview on 9/12/25 at 9:15 A.M., the Assistant Director of Nursing (ADON) and the Nurse Manager said all medications are expected to be given per the physician orders in its entirety. Staff are expected to utilize the five rights when administering medications to ensure accuracy. During an interview on 9/12/25 at 10:30 A.M., the Administrator said she expects staff to follow physician orders and accurately give residents their medications in their entirety. 2. Review of Resident #86's medical record showed diagnoses that included cognitive communication deficit and diabetes. Review of the resident's physician order sheets (POS), dated, September 2025, showed:-An order dated, 5/22/25, Novolog FlexPen subcutaneous (fatty layer of the skin) solution pen injector 100 units per milliliter (ml), inject 14 units subcutaneously with meals;-An order dated, 5/22/25, Novolog FlexPen subcutaneous solution pen injector 100 units per ml, inject per sliding scale (a measurement of blood sugar), if blood sugar is: 151-200 inject 2 units; 201-250 inject 4 units; 251-300 inject 6 units; 301-350 inject 8 units; 351-400 inject 10 units. Observation on 9/9/25 at 11:34 A. M., showed Licensed Practical Nurse (LPN) J took the resident's blood sugar and the resident's blood sugar showed 173. LPN dialed the resident's Novolog FlexPen to 16 units, entered the resident's room and</p>		