STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265367	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Point-Skilled Nursing by Americare	801 Baliff Drive Dexter, MO 63841

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision to ensure the safety of one resident (Resident #1), when staff assisted the resident to the toilet and did not check on the resident for approximately nine hours. Staff found the resident lying on the bathroom floor on top of his/her wheelchair cushion with his/her hand completely de-gloved (stripped of the skin), an open fractured wrist (bone broken and protruding through the skin), and a laceration to his/her forehead. The facility census was 60. The Administrator was notified on 03/03/25 at 1:55 P.M. of an Immediate Jeopardy (IJ) which began on 02/21/25. The IJ was removed on 03/03/25 as confirmed by surveyor onsite verification. Record review of the facility policy titled Restorative Sleep Program, dated 09/05/2018, showed: - To ensure adequate procedures have been taken to provide the appropriate opportunities and facilities to rest and sleep according to a resident's individual needs and requirements; - Residents that are assessed as needing briefs will wear overnight, superabsorbent briefs; - Residents will be assessed during the shift for incontinence and if needed, peri care will be provided; - Facility will provide quiet times from 9:00 P.M. through 7:00 A.M.; - This program is in the beginning stages of the Quality Assurance Program (QAPI) program and will be reviewed monthly and as needed to ensure the best quality of care for the residents. Record review of the facility undated Natural Wakening policy, showed: - It is the policy of this facility to be sensitive and flexible through culture change to residents' individual needs and preferences while providing standard care. The facility did not provide a policy on monitoring residents throughout the night or the expectation of the frequency of monitoring residents during any shift. 1. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 01/16/2025 showed: (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Diagnoses of coronary artery disease (a condition where the arteries that supply blood to the heart become narrowed or blocked), heart failure (occurs when the heart muscle doesn't pump blood as well as it should), chronic kidney disease, stage 3 (a moderate level of kidney damage, where the kidneys are not filtering waste effectively, resulting in mild to moderate loss of kidney function), atherosclerotic heart disease (a buildup of plaque in the arteries that can lead to heart disease), benign prostatic hyperplasia (causes your prostate to grow causing difficulty peeing and sudden urges to pee), and hypertension (high blood pressure); - Cognition intact; - Requires supervision or touch assistance of one staff with verbal cueing for transfers, bed mobility, dressing, toileting, and bathing; - Ambulatory with supervision or touch assistance of one staff; - Continent of bowel and bladder. Review of the resident's Care Plan, dated 12/11/2024, showed: - At risk for falls due to weakness and unsteady gait with interventions including staff to check on Resident #1 frequently and anticipate needs when possible. Nursing to provide supervision and set up with transfers; - Supervision set up with activities of daily living (ADLs) and transfers except dressing, limited assist of one staff; -Continent of bowel and bladder with nursing to provide supervision/set up with frequent toileting and peri care as needed; - Resident #1 received routine diuretic (medications that promote urine production by increasing the excretion of water and electrolytes) therapy for high blood pressure which may cause dizziness, postural hypotension (blood pressure dropping with position changes), fatigue, and increased risk for falls. Observe for possible side effects every shift; - No documentation of a request not to be bothered unless call light was on. Review of the resident's Progress Notes showed: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 02/21/2025 10:13 A.M., at 8:45 A.M. Licensed Practical Nurse (LPN) F was called to Resident #1's room. Upon entering the bathroom area, the resident was lying on his/her left side in front of the sink and toilet, dried blood had run down the wall. Resident #1's head was lying in a pool of blood with the right arm out in front of him/her covered with blood, visible bone and ligaments (a band of tissue that connects bones, joints or organs) exposed. LPN F placed a pressure dressing on the right wrist, wrapped with Kling dressing to stabilize the wrist. The wrist appeared broken. Resident #1 alert and oriented to person, place and time. The resident said he/she tried to get off the toilet and his/her hand slipped down the safety bar on the wall and his/her wrist got stuck and could not get loose, so he/she tried to get his/her wheelchair and fell to the floor. Informed nurse he/she did not turn on the call light in the bathroom stating he/she yelled for help instead. Staff notified emergency medical system for transport to the emergency room; - On 02/21/2025 entry made at 10:48 A.M., Resident #1 requires supervision/set up with bed mobility, and transfers. Limited assist with 1-person with dressing, ambulates as tolerated via wheelchair, able to propel self. One fall, continent of bowel and bladder, no shortness of breath noted, head of bed elevated, pressure reducing device in wheelchair. Resident plans his/her own daily activities; - On 02/21/2025 entry made at 10:48 A.M., Resident #1 stated he/she was put on the toilet and when he/she went to get off the toilet his/her hand slid down the rail and got his/her wrist stuck, was yelling for help, when no one came he/she tried to transfer self without assist. Resident sent via emergency medical services to emergency room. Resident is to be checked on frequently and encourage to use call light for assist, staff to assist resident to toilet more frequently. Review of Resident #1's hospital record, dated 02/21/2025, showed: -Arrival via emergency medical services (EMS) for fall with right arm pain and possible de-gloving of skin on right hand/arm. Resident alert and oriented to time person and place, reported he/she was in floor for around seven hours; - Examination showed very deformed wrist, significant laceration of the skin with skin edges significantly separated. No radial pulse (pulse found at the wrist) and Doppler (an instrument used to locate a pulse) does not reveal any pulse on right radial area. Right hand very cold, inability to flex and extend fingers, sensations intact (feeling). An area with a 3-centimeter (cm) laceration on the volar surface (inside of the arm) of the distal right forearm (the lower portion of the forearm, specifically the area closest to the wrist); -Resident #1 to be transferred to trauma center with open fracture of right wrist in guarded condition. Review of the trauma center record, dated 02/21/2025, showed: - Resident found to have an open distal both bone forearm fracture with soft tissue degloving - Right [NAME] (an open fractures based on the severity of the soft tissue injury, the amount of energy involved, and the extent of contamination) type II (a wound that is 1-10 cm in length and has moderate soft tissue injury) with soft tissue degloving; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident admitted to intensive care unit (ICU) in preparation for operative interventions for debridement (a surgical procedure used to clean and remove infected or dead tissue from wounds) and irrigation, will require repeat debridement and surgical stabilization of this injury at separate operative setting as well as separate operative setting needed for soft tissue coverage. Record review of the facility investigation, dated 02/21/2025, showed: - Certified Nurse Aide (CNA) A said he/she checked on Resident #1 at approximately 8:00-9:00 P.M., and the resident was on the toilet at that time. He/she did not go back and check on the resident. - Licensed Practical Nurse (LPN) B said he/she remembered Resident #1's room door was shut at approximately 10:30 P.M. to 10:45 P.M. LPN B said Resident #1 usually turns his/her call light on for assistance and does not get up unassisted. LPN B could not recall if Resident #1 used his/her call light the night of 02/21/25; - CNA E said he/she responded to Resident #1's call light at around 8:00 P.M. to 9:00 P.M. and assisted the resident to his/her wheelchair, when he/she left the resident was washing his/her hands in the bathroom; - LPN D said he/she witnessed Resident #1 on the toilet at approximately 10:00 P.M. to 10:05 P.M. LPN D did not observe the resident again. Review of the facility call light record showed: - On 02/20/2025 Resident #1's bathroom call light activated at 8:40 P.M., 8:41 P.M., and 8:42 P.M.; - On 02/21/2025 at 8:13 A.M., bathroom call light tested and worked properly. During an interview on 03/03/2025 at 10:35 A.M., LPN F said on the morning of 02/21/25, when he/she entered Resident #1's bathroom, the call light was not on, the resident was lying on the floor partially clothed in daytime clothing, with TED hose (compression socks that are specifically designed for those who are unable to walk for extended periods of time or have limited range of motion) on the lower extremities, shoes, socks still on, and the bed had not been slept in. Resident #1 was profusely bleeding, with his/her right wrist appearing as floppy. Resident #1 told LPN F that he/she had been placed on the toilet by a staff member. When he/she had finished, Resident #1 went to get up from the toilet and his/her hand slipped through the handrail. Resident #1 said the wheelchair was beside him/her, but when he/she went to reach for it he/she fell. LPN F said he/she observed imprints to the resident's left hip from lying on the wheelchair cushion. LPN F said Resident #1 is a loner and stays in his/her room, uses the call light for meals or if staff are needed for any task. Staff do not enter the resident's room unless he/she uses the call light. He/she is a very quiet spoken person. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/03/2025 at 10:50 A.M., CNA H said Resident #1 used the call light to get assistance to and from the toilet on a regular basis. The resident was not able to put pants on or take pants off independently. CNA H said the resident is very soft spoken, and it is likely if he/she did yell for help, and no one heard. CNA H said Resident #1 typically put on his/her call light at 7:30 A.M.- 8:00 A.M. every morning to get up, so when Resident #1 had not used the call light the morning of 02/21/25, he/she went in to check to see if the resident was still sleeping. CNA H said, on entering the room he/she noted the resident's wheelchair in the room, and the resident lying on his/her left side on the bathroom floor in a pool of blood. CNA H said blood was on the wall and on handrail next to the toilet, and the resident's pants were half way up. Resident #1 was responsive and said a staff member put him/her on the toilet last night. Resident #1 is very private. He/she uses the call for meals and any other needs, but at most times uses the call light for toileting. During an interview on 03/03/2025 at 12:15 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said the 10:00 P.M. to 6:00 A.M. shift works together as a group, there are no specific assignments for individual staff. The DON said on the same night of the incident, Resident #1's neighbor passed away, which created a lot of activity on the hall and near Resident #1's room. They said their investigation showed LPN B remembered seeing Resident #1 on the toilet right around 10 PM on 02/20/25, but did not see him/her again, only that his/her room door was shut. They were unable to determine how the resident got on the toilet as none of the staff admitted to assisting the resident. The DON and ADON said the resident did need assistance with ADLs and should have had assistance with toileting. The DON and ADON said the resident is a private person which should have been on his/her care plan. Their expectation is for staff to provide care based on each individual's preferences, but every resident should be checked on every shift. During an interview on 03/03/2025 at 9:55 A.M., the Administrator (ADM) said Resident #1 was a private person and used his/her call light when he/she needed assistance. The ADM said he was not aware if the resident's request for privacy was on the care plan or not. The ADM said he did watch the hall camera footage for the dates 02/20/25 and 02/21/25 and saw lots of staff activity near Resident #1's room on the night of 02/20/25, from around 9 P.M. through 11:30 P.M. The ADM said it did not appear any staff went into the resident's room but could not say for certain due to the time period when Resident #1's neighbor passed away and the things that went along with that. The ADM said staff should have checked on Resident #1 at some point during the night. MO249909 NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the G level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).