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No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265367 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/18/2025 |
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| NAME OF PROVIDER OR SUPPLIER Cypress Point-Skilled Nursing by Americare | | STREET ADDRESS, CITY, STATE, ZIP CODE 801 Baliff Drive Dexter, MO 63841 | |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. This deficient practice had the potential to affect all residents. The facility census was 65.Review of the facility's policy titled, Food Storage, dated 2011, showed:- Label all food items held for longer than 24 hours;- The label must include the name of the food and the date by which it should be sold, consumed, or discarded; - Store leftover contents of cans of prepared food in a clean, sanitized container with a proper and secure cover. The new container shall be labeled with the name of the food item and the original expiration date.The facility did not provide a policy addressing the ice machine, kitchen floor cleaning, dented cans, and use of trash cans.1. Observations on 09/15/25 at 9:34 A.M., and 2:20 P.M., 09/16/25 at 2:10 P.M., 09/17/25 at 3:24 P.M., and 09/18/25 at 9:02 A.M., of the ice machine area showed:- Visible water on the floor in front and underneath the ice machine;- Two saturated mop heads lay underneath and surrounded the air gap (amount of space that separates a water line from an ice machine drain to prevent contaminated sewer water from flowing back into the clean ice-making system) on the floor;- No wet floor signage.2. Observations on 09/15/25 at 9:44 A.M., 09/15/25 at 2:21 A.M., and 09/16/25 at 9:16 A.M., of the kitchen walk-in freezer showed:- An undated and unlabeled open ziplock bag of shredded lettuce;- An undated and unlabeled open bag of purple shredded cabbage.3. Observation on 09/15/25 at 9:47 A.M., of the stand-up freezer showed:- Two dented soda cans;- 10 undated and unlabeled small plastic cups with a white sauce.4. Observations on 09/15/25 at 9:47 A.M., and 2:25 P.M., and 09/16/25 at 2:12 P.M., of the dishwashing area showed:- Two plastic knives, a rolled-up paper napkin, a small plastic container, and debris lay on the floor beside the trash can;- A plastic container of exposed dirty hand towels with no lid;- A trash can with exposed food and debris with no lid next to the trash disposal counter;- No staff present.5. Observations on 09/15/25 at 9:52 A.M., and 2:27 P.M., of the kitchen floors showed:- A build-up of dirt, debris, and food particles underneath the steam food table and the cold food table. During an interview on 09/18/25 at 11:26 A.M., the Assistant Dietary Manager (DM) said trash cans should be covered with a lid when the area was not in use. Dirty mop heads should be removed and taken to laundry for laundering. The floors should be free of food particles and debris. Opened foods and containers should be labeled and dated. There should be nothing placed under the ice machine to soak up water. Staff should place a wet floor sign in the area where water was on the floor for safety purposes.During an interview on 09/18/25 at 11:37 A.M., the DM said trash cans should be covered with a lid when the area was not in use. Dirty mop heads should be removed and taken to laundry for laundering. The floors should be free of food particles and debris. Opened foods and containers should be labeled and dated. There should be nothing placed underneath the ice machine or the air gap to soak up water.During an interview on 09/18/25 at 2:25 P.M., the Administrator said trash cans should be covered with a lid when the area was not in use. Dirty mop heads should be removed and taken to laundry for laundering. The floors should be free of food particles and debris. Opened foods and containers should be labeled and dated. There should be nothing placed around the air gap under the ice machine to prevent contamination. |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 65. The facility did not provide a policy for a homelike environment.1. Observations on 09/15/25 at 9:34 A.M., and 2:20 P.M., 09/16/25 at 2:10 P.M., 09/17/25 at 3:24 P.M., and 09/18/25 at 9:02 A.M., of the kitchen's ice machine area showed: - A strip of baseboard trim unattached from the wall on the bottom right side near the ice machine. 2. Observations on 09/15/25 at 3:11 P.M., 09/16/25 at 2:56 P.M., and 09/17/25 at 3:06 P.M., showed:- Visible cobwebs on a sprinkler head located in the TV room near the nurses station;- Several light fixtures with insects, dirt, and debris around the nurses station;- Cobwebs on a light fixture in front of the therapy room near room [ROOM NUMBER];- Two missing light fixture protective covers near the laundry room and room [ROOM NUMBER];- An eight-foot (ft) area of missing wall trim behind the linen cart area near the nurses station;- Privacy curtains with several stains and dark scuffs in room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER].During an interview on 09/16/25 at 1:57 P.M., the resident in room [ROOM NUMBER] said he/she would like the privacy curtain at the foot of his/her bed replaced because it was dirty. During an interview on 09/16/25 at 2:15 P.M., the resident in room [ROOM NUMBER] said he/she would like the privacy curtain changed because it had two large brown stains on it. He/She lived at the facility for five years and his/her privacy curtains had never been changed.3. Observation on 09/16/25 at 3:09 P.M., of the bath/shower room next to room [ROOM NUMBER] showed:- A plastic container filled with a dark liquid lay on top of the sink;- A plastic container filled with a white liquid and a straw, a disposable razor, a wet washcloth, a black hair pick, and paper lay inside the sink basin;- Dirty gloves lay on the floor by the sink;- A shower chair and a wheelchair sat in front of the sink and toilet;- A trash can with exposed empty boxes, dirty gloves and gowns, and toilet paper with no lid:- A saturated towel and a box of medium gloves lay on the shower room floor;- A yellow tumbler, a plastic container filled with a dark liquid and a straw, a bag of cough drops, and a bag of opened chips lay on top of the shower cart next to the whirlpool;- A strong smell of urine;- The bath/shower room not in use.Review of the Maintenance Repair Log, dated 02/21/25 - 07/21/25, showed:- No areas of concern addressed.During an interview on 09/18/25 at 8:37 A.M., Shower Aide A said the shower room should always be cleaned prior to and after residents' shower had been completed. There should be no foul odors, trash, wet towels, supplies left on the floor, food, beverages, and equipment stored and/or left in the shower room. He/She locked the shower room when finished.During an interview on 09/18/25 at 8:47 A.M., Shower Aide B said the shower room should be cleaned and sanitized after giving resident showers. There should be no foul odors, trash, wet towels, supplies on the floor, food, beverages, and equipment stored and/or left in the shower room. He/She locked the shower when finished.During an interview on 09/18/25 at 10:32 A.M., Housekeeper C said if he/she saw something that needed to be fixed or repaired, he/she verbally told maintenance or would inform the housekeeping supervisor of the needed repair. During an interview on 09/18/25 at 11:37 A.M., the Dietary Manager (DM) said the Maintenance Supervisor (MS) and the Administrator were made aware of the baseboard trim coming off the wall in June 2025.During an interview on 09/18/25 at 1:48 P.M., the MS said light fixtures should have covers, be clean, and free of cobwebs, dirt, and debris on a regular basis. He/She was aware of the baseboard trim needing replaced by the ice machine but not sure how to replace the missing trim behind the linen cart area near the nurse's station. During an interview on 09/18/25 at 2:35 P.M., the Administrator said light fixtures should have covers, be clean and free of cobwebs, dirt, and debris. The wall trim should be repaired when reported in a timely manner. He was aware of the baseboard needing to be replaced by the ice machine. The MS told him verbally what he/she would be<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | doing daily but did not document daily tasks completed. Staff used the showers sometimes during shifts when showers weren't being given but should be clean and tidy. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on interview and record review, the facility failed to provide an appropriate diagnosis for the use of an antipsychotic (medication that affect a person's mental state) medication for one resident (Resident #4) and failed to monitor the drug regimen for an unnecessary medication by not ensuring an as needed (PRN) psychotropic (medication that alters the levels of chemicals in the brain that influence mood, behavior, and perception) medication order was limited to 14 days unless a specific duration and clinical rationale was provided for one resident (Resident #8) out of five sampled residents. The facility census was 65.Review of the facility's policy titled, Psychotropic Medication Use, undated, showed:- Psychotropic medications are divided into four broad categories: antipsychotic, antianxiety, antidepressant, and hypnotic medications;- CMS regulations state that each resident's drug regimen must be free from unnecessary drugs and define what it considered an unnecessary drug: in excessive dose, for excessive duration, without adequate indication, without adequate monitoring or without adequate indications for its use, or, in the presence of adverse consequences, which indicate the dosage should be reduced or discontinued;- The physician's order for a psychotropic drug will include both a qualifying diagnosis for the drug and a list of specific target behaviors which the staff will monitor during the drug administration.Review of the facility's policy titled, PRN Medications, undated, showed:- The purpose of this policy is to ensure the safe, consistent, and effective administration of PRN medications to residents in a long-term care facility, in accordance with physician orders and facility protocols;- Ensure there is a written or electronic physician's order for the PRN medication, including specific instructions on the medications, dose, route, and indications for administration (e.g. pain, anxiety, nausea);- Specific medications for anxiety (Xanax, Ativan), sleep (Restoril, Melatonin, Ambien), etc. will be a 14-day duration;- If the PRN medication is administered frequently, reassess the resident's condition and consult with the physician regarding the ongoing need for PRN versus a scheduled medication regimen.1. Review of Resident #4's September 2025 Physician Order Sheet (POS) showed:- Diagnoses of Alzheimer's disease (a progressive neurodegenerative disorder that affects memory, thinking and behavior), pneumonia, chronic obstructive pulmonary disease (COPD- a progressive group of lung diseases that block airflow to the lungs, causing breathing problems) and difficulty walking;- An order for Seroquel (an antipsychotic medication) 25 milligram (mg) by mouth at bedtime related to unspecified dementia (a group of brain disorders that cause a decline in cognitive abilities), dated 08/29/25.Review of the resident's medical record showed:- No documentation of an appropriate diagnoses for the use of the Seroquel medication;- No identified targeted behaviors;- No documentation of any behaviors;- No pharmacist recommendations for appropriate diagnoses for the use of Seroquel medication.2. Review of Resident #8's September 2025 POS showed:- Diagnoses of vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain), COPD, major depressive disorder (a serious medical illness that negatively affects how you feel, the way you think and how you act);- An order for Xanax (an antianxiety medication) 0.25 mg by mouth every 4 hours PRN for anxiety, dated 03/07/25.Review of the resident's Medication Regimen Review (MRR), dated 09/09/25, showed:- The pharmacist did not address the Xanax PRN order;- No documentation for a request for a clinical rationale to continue the PRN Xanax medication past the 14-day time frame by the pharmacist.Review of the resident's medical record showed:- No clinical rationale documented by the physician for the Xanax 0.25 mg PRN order.During an interview on 09/18/25 at 11:58 P.M., Licensed Practical Nurse (LPN) J said dementia was not an appropriate diagnosis for Seroquel. Any PRN psychotropic medication order should have a 14 day stop date. Resident #4 did not have any behaviors.During an interview on 09/18/25 at 2:55 P.M., the Assistant Director of Nursing (ADON) said PRN medication orders should have a 14-day stop date. Dementia was not an appropriate diagnosis for the use of Seroquel. During an interview on 09/18/25 at 2:57 P.M., the Director of Nursing (DON) said PRN<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medications should have a 14-day stop date. Seroquel should have an appropriate diagnosis, and dementia was not an appropriate diagnosis. During a phone interview on 09/26/25 at 1:48 P.M., the Consultant Pharmacist said dementia was not an appropriate diagnosis for the use of Seroquel. For Resident #4, the MMR was conducted on 09/13/25, and addressed the need for the physician to review the diagnosis for the Seroquel. For Resident #4's Xanax order, he/she addressed the Xanax PRN order needed a 14-day stop on the MMR. For Resident #8, he/she addressed the Xanax order needed a 14-day stop date on 04/11/25, and on 09/08/25. During an interview on 09/26/25 at 4:07 P.M., the Medical Director said a PRN psychotropic medication should have a 14-day stop date. Dementia was not an appropriate diagnosis for the use of Seroquel, unless prescribed by a psychiatric physician. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview, and record review, the facility failed to implement procedures to ensure medications were accurately reconciled for one resident (Resident #37) of out of 23 sampled residents. The facility also failed to ensure vials of tuberculin (the solution used to administer the test for tuberculosis (TB - an infectious lung disease)) were dated when opened. The facility census was 65. The facility did not provide a policy regarding the narcotic reconciliation.The facility did not provide a policy regarding dating of medications when opened. 1. Review Resident #37's medical record showed:- An admission date of 12/16/24;- An order for lorazepam (an antianxiety medication) 0.5 milliliters (ml) every 8 hours for agitation related to anxiety, dated 04/23/25.Observation on 09/18/25 at 10:14 A.M., of the locked medication refrigerator in the main medication room showed:- One opened 30 ml bottle of lorazepam 2 milligram (mg)/ml for Resident #37 and 16 ml remained. Review of the resident's lorazepam 2 mg/ml Narcotic Reconciliation Log showed:- On-coming and off-going staff documented the lorazepam was counted each shift;- Staff documented 19 ml remained of the 30 ml bottle.2. During an observation on 09/18/25 at 10:47 A.M., of the main medication room showed:- Two opened and undated vials of tuberculin.During an interview on 09/18/25 at 10:15 A.M., Licensed Practical Nurse (LPN) K said he/she was not aware there was a discrepancy between the remaining medication and what was documented in the narcotic reconciliation log for Resident #37's lorazepam. During an interview on 09/18/2025 at 10:51 A.M., the Assistant Director of Nursing (ADON) said when staff opened a new medication bottle or vial, it should be labeled with the date it was opened. Staff should count narcotic medications each shift with the on-coming and off-going staff member. During an interview on 09/18/25 at 2:33 P.M., Registered Nurse (RN) D said staff didn't always reconcile the liquid narcotic medications, such as Resident #37's lorazepam 2 mg/ml bottle, before and after each shift. During an interview on 09/18/25 at 2:55 P.M., the Director of Nursing (DON) said all narcotic medications should be counted with the on-coming and off-going staff each shift. Vials should be dated when the vials were opened. Undated vials should be discarded. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) when staff accessed and administered medications through a central venous access device (CVAD - a thin, soft, flexible tube that is placed in a vein that leads to the heart) and during personal care for one resident (Resident #33) out of one sampled resident. The facility census was 65. Review of the facility's policy, titled, Enhanced Barrier Precautions, dated 2024 showed:- An order for EBP will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident in not known to be infected or colonized with multi-drug resistant organism (MDRO);- Make gowns and gloves available immediately near or outside of the resident's room;- Personal protective equipment (PPE) for EBP is only necessary when performing high-contact care activities and may not need donned prior to entering the resident's room;- High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use such as central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and wound care (any skin opening requiring a dressing).Review of the facility's policy, titled, Administration of Intravenous (IV) Medication, not dated, showed:- Did not address aseptic (free from contamination) technique.1. Review of Resident #33's medical chart showed:- An order for ampicillin (an antibiotic) intravenously (IV - administered through a vein) every six hours for osteomyelitis (a bone infection) for 27 days, dated 08/29/25.Observation on 09/17/25 at 10:03 A.M., of the resident's medication administration showed:- Signage posted on the resident's door that instructed staff to wear gown and gloves for resident care;- Licensed Practical Nurse (LPN) E performed hand hygiene and applied gown and gloves;- LPN E entered the resident's room to administer the resident's ampicillin dose through his/her CVAD line;- LPN E removed the cap from the end of the CVAD line and cleaned the hub with an alcohol pad for three seconds;- LPN E flushed the CVAD line with 10 milliliter (ml) of saline;- LPN E released the CVAD line and the hub dangled and touched the resident's right arm;- LPN E did not clean the hub, connected the IV tubing to the CVAD hub, started infusing the ampicillin, stopped the ampicillin infusion, and disconnected the IV tubing from the CAVD line because the medications wasn't infusing correctly; - LPN E released the CVAD line and the hub rested against the resident's wheelchair, did not clean the hub, and reconnected the IV tubing to the resident's CVAD line.During an interview on 9/17/25 at 11:10 A.M., Registered Nurse (RN) F said when the CVAD line had an antiseptic cap, the cap should be removed, the hub of the CVAD line cleaned for 10 econds with an alcohol swab, attached to a saline flush and flushed, the syringe unattached, the hub cleaned for 10 seconds with an alcohol pad, and the IV tubing connected to the CVAD line.During an interview on 9/18/25 at 2:56 P.M., the Assistant Director of Nursing (ADON) said the hub should be cleaned for at least 10 seconds.Observation on 9/18/25 at 9:31 A.M., of the resident's incontinent care showed: - Signage posted on the resident's door that instructed staff to wear gown and gloves for resident care;- A cabinet with PPE outside of the resident's room;- Certified Nurse Assistant (CNA G) and Nurse Assistant (NA) I entered the resident's room, did not put on a gown, performed hand hygiene, and put on gloves;- CNA G and NA I performed incontinent care for the resident, performed hand hygiene, and exited the resident's room. During an interview on 9/18/25 at 1:39 P.M. CNA G said staff did not have to put a gown on during Resident #33's care. The EBP signage posted on the door was for Resident #33's roommate. He/She was told staff did not have to put on a gown for Resident #33.During an interview on 9/18/25 at 1:50 P.M., LPN J said staff should always put on a gown and gloves when caring for Resident #33.During an interview on 9/18/25 at 3:05 P.M., the Director of Nursing (DON) said the EBP signage should be for Resident #33 and his/her roommate. |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct inspections of all bed frames, mattresses, and side rails as a part of a regular maintenance program for three residents (Residents #8, #11, and #28) out of three sampled residents. The facility census was 65.Review of the facility's policy titled, Side Rail Inspection, undated, showed:- Side rails on resident beds must be inspected regularly to ensure safety, proper function, and compliance with regulatory standards. Faulty or unsafe side rails pose a risk of injury, entrapment, or falls and must be addressed immediately;- Routine inspection frequency: Weekly: Visual inspections by nursing staff during bed checks, Monthly: Detailed inspection by maintenance or designate safety personnel, as needed (PRN): After any incident, complaint, or reported issue with a side rail;- Each inspection must include the following checks: side rails are securely attached to the bed frame, latches and locks function properly, no broken, bent, or missing parts, no sharp edges or rust, no excessive gaps that may cause entrapment, easy to raise and lower with minimal force, proper alignment with bed height and mattress type;- Complete and sign the Side Rail Inspection Log after each check;- Record any defects, action taken, and date of repair or removal;- Minor issues: Report to maintenance, fix within 24 hours;- Major issues or safety hazards: Remove the bed from service immediately and provide an alternate for the resident;- Notify supervisor and document the action in the resident's chart and maintenance log.1. Review of Resident #8's medical record showed:- admitted on [DATE];- Diagnoses of vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain), chronic obstructive pulmonary disease (COPD - a progressive group of lung diseases that block airflow to the lungs causing breathing problems), and major depressive disorder (a serious medical illness that negatively affects how you feel, the way you think and how you act);- No maintenance inspection for the mobility rail. Observations on 09/15/25 at 9:42 A.M., 09/16/25 at 1:42 P.M., and 09/17/25 at 10:41 A.M., of the resident's bed showed:- A U-shaped mobility rail in the upright position on both sides of the resident's bed and moved with minimal effort. 2. Review of Resident #11's medical record showed:- admitted on [DATE];- Diagnoses of dysphagia (difficulty swallowing), hemiplegia (paralysis or weakness) affecting the dominant side, anxiety (intense, excessive, and persistent worry and fear about everyday situations), major depressive disorder, and history of falling;- No maintenance inspection for the mobility rail.Observations on 09/15/25 at 11:30 A.M., 09/16/25 at 10:25 A.M., and 09/18/25 at 9:45 A.M., of the resident's bed showed:- A U-shaped mobility rail in the upright position on both sides of the resident's bed and moved with minimal effort.During an interview on 09/16/25 at 10:27 A.M., the resident said he/she used both mobility rails to try and turn over in bed. 3. Review of Resident #28's medical record showed:- admitted on [DATE];- Diagnoses of diabetes mellitus (a chronic metabolic disorder where the body cannot properly regulate blood sugar levels), dementia (a group of symptoms that involve impairments in memory, thinking, and problem-solving, along with potential changes in personality and emotion), major depressive disorder, generalized weakness, and history of falls- No maintenance inspection for the mobility rail. Observations on 09/15/25 at 2:49 P.M., 09/16/25 at 10:24 A.M., and 09/18/25 at 11:37 A.M., of the resident's bed showed:- A U-shaped mobility rail in the upright position on the right side of the resident's bed and moved with minimal effort. During an interview on 09/15/25 at 2:49 P.M., the resident said he/she used the mobility rail for getting up on the side of the bed and going to the bathroom at night. During an interview on 09/18/25 at 1:55 P.M., the Maintenance Supervisor said nursing was responsible for the side rails. Maintenance had nothing to do with the mobility rails.During an interview on 09/18/25 at 1:57 P.M., Registered Nurse (RN) L said no formal inspection was completed or documented for the mobility rails. During an interview on 09/18/25 at 2:07 P.M., the Administrator said the facility did not do any inspections routinely on the mobility rails. During an interview on 09/18/25 at 2:55 P.M., the Director<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265367 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/18/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cypress Point-Skilled Nursing by Americare | 801 Baliff Drive<br>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.

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of Nursing (DON) said he wasn't aware that inspections needed to be made on the mobility rails. Staff would notify him if there was an issue with a mobility rail. |