STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265368	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Point Nursing Center	8477 North Street Birch Tree, MO 65438

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. This had the potential to affect all residents. The facility census was 71.The facility did not provide a policy regarding dietary. 1. Observation on 03/17/26 at 9:50 A.M., 03/18/26 at 10:23 A.M., and 03/19/26 at 6:16 P.M., of the kitchen showed: - One compartment and three compartment sinks with the hot side water temperature at 106 degrees Fahrenheit after one minute;- One large metal cookie sheet with dark brown carbon build-up in the corners and one small cookie sheet with carbon build-up in the corners; - The commercial gas range oven with excessive black grime build-up on all interior surfaces and on the floor beneath; - One dented 3-quart can of spinach, dated received on 03/03/26;- One dented 50-ounce can of cream of mushroom condensed soup, dated received on 03/03/26;- The commercial dishwasher interior and exterior with flaky white grime (dirt ingrained on the surface of something) build-up and scattered debris on the floor beneath;- An approximate 2-inch (in.) x 4 in. uncovered hole in the wall near the dishwasher plumbing accessories;- An approximate 4 in. x 6 in. hole in the wall near the disposal area with a pink substance;- The floor, the plumbing pipes, and the electrical switch box below the corner dishwashing area counters with scattered debris, oily film, and brown grime build-up;- An approximate 2 in. x 6 in. non-intact wall section without a vinyl cove base near the dining room entrance;- An approximate 2 in. diameter non-intact wall section above the vinyl cove base near the closet door;- An approximate 8-foot (ft.) x 8 ft. section of the ceiling tiles and four plastic light fixture covers over the food preparation area counter and one-compartment sink with dust build up and a dark brown substance;- An approximate 3 ft. x 6 ft. and a 24 in. diameter ceiling diffuser (one of the few visible parts of an air conditioning system) with dust buildup and a brown substance on the front exterior surface and in between the ventilation louvers over the food preparation area counter and one-compartment sink;- A 6 in. diameter ceiling diffuser in the dry storage area with dust buildup and a brown substance on the front exterior surface and in between the ventilation louvers. During an interview on 03/19/26 at 6:16 P.M., the Dietary Manager said he/she expected there not to be dented cans left on the racks and normally she kept them from going on the metal storage rack. The kitchen should be clean and without food debris under appliances, shelves, and food counters. The ceiling tiles and vents should be clean; some of the staff attempted to clean the ceiling, but the tiles started to come apart. The water temperatures should be higher on the three-compartment sink and the middle sink, but they might be connected to a separate water heater. The dishwasher should be clean inside and out, the plumbing pipes below each counter should be clean, and the walls should be intact and easy to wipe with cleaner. During an interview on 03/19/26 at 7:18 P.M., the Administrator said the kitchen walls should be intact and easy to clean, the ceiling and vents should be clean, but there was an issue with the large vent. The oven and dishwasher should be clean. The floor should not have food crumbs or debris and there should not be grime or build up on the tiles or the plumbing pipes. She said the door had been replaced to the dining area and a baseboard was left off. There should not be dented cans in storage.

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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refund resident funds within 30 days of when a resident expired for three residents (Residents #80, #81 and #82) out of three sampled residents. The facility census was 71.Review of the facility's policy titled, Accounting and Records of Resident Funds, revised [DATE], showed:- The facility maintains accounting records of resident funds on deposit with the facility;- Individual accounting ledgers are maintained in accordance with generally accepted accounting principles;- Inquiries concerning a resident's personal funds account record are referred to the Administrator or to the business office. 1. Review of Resident #80's closed medical record showed:- The resident expired on [DATE]. Review of the facility maintained Resident Trust Fund Ledger, dated [DATE], showed:- Resident #80 had $93.13 held in the resident trust fund account as of [DATE] (121 days late). 2. Review of Resident #81's closed medical record showed:- The resident expired on [DATE]. Review of the facility maintained Resident Trust Fund Ledger, dated [DATE], showed:- Resident #81 had $1,683.73 held in the resident trust fund account as of [DATE] (168 days late). 3. Review of Resident #82's closed medical record showed:- The resident expired on [DATE]. Review of the facility maintained Resident Trust Fund Ledger, dated [DATE], showed:- Resident #82 had $483.52 held in the resident trust fund account as of [DATE] (142 days late). During an interview on [DATE] at 3:32 P.M., the Business Office Manager (BOM) said he/she reviewed the resident trust ledger individual balances to make sure they were within the limit. If a resident expired, he/she was normally sent a notice from the funeral home about the expenses. Residents should have a final accounting of their personal funds. During an interview on [DATE] at 5:12 P.M., the Administrator said the resident trust ledger should be audited regularly to make sure no funds were left in the account for residents that expired in the facility. She said the facility should have submitted a Third-Party Liability (TPL - a form which is sent to Missouri (MO) Health Net which gives an accounting of the remaining balance of a resident's funds in the resident trust account for the expired residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to ensure a homelike environment was provided for the residents residing on the Men's Locked Behavior Unit which affected 12 residents with the potential to affect all 15 residents on the unit. The facility also failed to provide a safe, clean, and comfortable homelike environment which could have the potential to affect all residents in the facility. The facility census was 71. Review of the facility's policy titled, Homelike Environment, revised February 2021, showed:- Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible;- Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences;- The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting including a clean, sanitary and orderly environment. 1. Observation on 03/17/26 at 12:05 P.M., of the Men's Locked Behavior Unit showed:- Staff wheeled a metal cart with the resident lunch trays into the dining area;- Staff removed the individual plastic food trays from the cart, placed the plastic food tray on the table in front of the 12 residents seated family style around the dining room table. 2. Observation on 03/18/26 at 7:21 A.M., of the Men's Locked Behavior Unit showed:- 10 residents were seated family style around the dining room table;- Each resident had a food tray with a plate, bowl, drinks, and silverware that sat on a plastic food tray in front of them;- Staff supervised while the residents fed themselves. During an interview on 03/19/26 at 2:43 P.M., Licensed Practical Nurse (LPN) A said he/she did not know for sure why the residents' food dishes were not removed from the plastic trays when the meals were served. He/She said this is just how things were done at the facility. During an interview on 03/19/26 at 2:05 PM, Certified Medication Technician (CMT) B said it was easier for the staff to serve food on the trays than to take the dishes off the trays. It helped keep the residents from trying to get someone else's food. During an interview on 03/19/26 at 2:07 P.M., LPN C said staff had always served food on the trays to the residents on the unit. The residents were territorial, and it helped define their boundaries. During an interview on 03/19/26 at 5:43 P.M., the Administrator said meals were served on trays on the Men's Locked Behavior Unit because it had been done like that for a while. She did believe that it minimized other residents from trying to take someone else's food that was on the table and some residents liked to use the tray to serve or remove their trays themselves. She said serving meals on trays did not create a homelike environment in the general population but would have to work with the unit since it was part of their structure. 3. Observations on 03/19/26 at 9:00 A.M., and 7:18 P.M., showed:- The A Hall assisted bathroom with a 4-foot (ft.) x 4 ft. ceiling diffuser (one of the few visible parts of an air conditioning system) hung unevenly with a 1-inch (in.) diameter corner section with a brown substance. 4. Observations on 03/19/26 at 9:00 A.M., and 7:18 P.M., showed:- The E Hall assisted bathroom toilet with a non-intact caulking seal near the base and floor joint;- A portable shower chair with an approximate 2 in. smeared brown substance. 5. Observations on 03/19/26 at 9:00 A.M., and 7:18 P.M., of Room A1 showed:- A 1 ft. x 2 ft. section of floor tiles with a dark grime build up;- Two pieces of approximately 2 ft. x 4 ft. ceiling tiles with a 1 ft. diameter brown substance above the resident bed and near the hall door;- The utility closet door with a non-intact surface near the floor gap approximately 3 ft. x 6 in. 6. Observations on 03/19/26 at 9:05 A.M., and 7:23 P.M., of Room A3 showed:- An unlocked utility closet with non-draining yellow water pooled about 6 in. deep above a 4 in. floor drain with miscellaneous facility supplies stored upon the shelving. During an interview on 03/19/26 at 7:18 P.M., the Administrator said there was a leak in the roof above Rooms A1 and A3 and the roofer would have to be called. Maintenance tried to fix the leak with a sealant, but it did not work. A dehumidifier was used to help dry out the closet in Room A1. She said the ceiling tiles should not be stained, and the door would be replaced. There should not be water standing in the closet of Room A3. The caulk should be around the toilet in the shower rooms, and the shower chairs should be cleaned. The tiles should be clean and not stained.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the failed to provide an appropriate diagnosis for the use of an antipsychotic (medication to treat psychosis, a mental health condition characterized by delusions, hallucinations, and disorganized thinking) medication for two residents (Residents #9 and #16) and failed to attempt a gradual dose reduction (GDR) for an antipsychotic medication for one resident (Resident #16) out of five sampled residents. The facility census was 71. Review of the facility's policy Psychotropic Medication Use, revised 02/2025, showed:- An adequate indication for use refers to the identified, documented clinical rationale for administering medication that is based on: a. an assessment of the resident's condition and therapeutic goals;b. a determination that non-pharmacological interventions are clinically contraindicated;- Psychotropic (any medication that affects brain activity associated with mental processes and behavior) medication may be considered appropriate when: a. a resident's behavioral symptoms present a danger to the resident or others; b. a resident is exhibiting indications of distress that are significant to the resident;c. non-pharmacological approaches (if not clinically contraindicated) have been attempted, but did not relieve the medical symptoms which are presenting a danger or significant distress; and/ord. gradual dose reduction was attempted, but clinical symptoms returned;- The clinical rationale for the use of psychotropic medication, or a change from one type of psychotropic to another, is documented in the medical record;- Diagnosis alone does not necessarily warrant the use of psychotropic medication;- Residents on psychotropic medication receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated to determine whether the continued use of the medication is benefitting the resident, to find an optimal dose, or in an effort to discontinue the medication. 1. Review of Resident #9's medical record showed:- An admission date of 04/11/19;- Diagnoses of major depressive disorder (persistent sadness, loss of interest and low energy lasting at least two weeks) without psychotic features, unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with unspecified severity with other behavioral disturbance, unspecified dementia moderate with other behavioral disturbance;- An order for Zyprexa (an antipsychotic medication) 5 milligrams (mg) by mouth at bedtime for unspecified dementia unspecified severity with other behavioral disturbance, dated 12/01/25;- No documentation the consultant pharmacist or physician addressed the need for appropriate diagnoses for the Zyprexa. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/11/25, showed:- Severe cognitive impairment;- No hallucinations, delusions, behaviors, and rejection of care;- Received antipsychotic medication on a routine basis. Review of resident's comprehensive care plan, dated 03/13/26, showed:- Did not address specific problems, interventions, or goals for dementia care. Observations of the resident showed:- On 03/17/26 at 11:50 A.M., and 1:55 P.M., the resident lay in bed with his/her eyes closed; - On 03/18/26 at 3:00 P.M., the resident sat in his/her wheelchair in the common area near the nurse's station and leaned to the right side with his/her eyes closed. 2. Review of Resident #16's medical record showed:- An admission date of 07/23/25;- Diagnoses of unspecified dementia with unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; anxiety disorder; and sleep disorder;- An order for quetiapine (an antipsychotic medication) 25 mg by mouth at bedtime related to anxiety disorder and unspecified sleep disorder, dated 07/23/25;- No documentation the consultant pharmacist or physician addressed the need for appropriate diagnoses for the quetiapine;- No documentation of an attempted GDR. Review of the resident's quarterly MDS, dated [DATE], showed:- Severe cognitive impairment;- No hallucinations, delusions, behaviors, and rejection of care;- Received antipsychotic medication on a routine basis;- GDR not attempted and not documented (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as contraindicated. Review of the resident's comprehensive care plan, dated 02/03/26, showed:- Use of medication quetiapine related to anxiety and sleep disorder. Observations of the resident showed:- On 03/17/26 at 11:50 A.M., and 1:55 P.M., the resident lay in bed, with his/her eyes closed. During an interview on 03/19/26 at 6:10 P.M., the Director of Nursing (DON) and the Administrator said they would expect residents to have the correct diagnosis and attempted GDRs when appropriate for antipsychotic medications.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the amount a bed would be held for on the bed hold policy upon transfer to the hospital and failed to include the statement of appeal rights or the name, address, or the telephone number of the Office of the State Long Term Care Ombudsmen (advocate for the resident in nursing facilities), the mailing and email address for the agency for protection and advocacy for residents with intellectual disabilities, and the mailing, email address, and telephone number for the agency for protection and advocacy for residents with mental illness, within the transfer and discharge notices for four residents (Residents #1,#3, #24, and #41) out of four sampled residents. The facility census was 71.Review of the facility's policy titled, Bed-Holds and Returns, revised October 2022, showed:- All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave);- Residents, regardless of payer source, are provided written notice about these policies at least twice, notice 1: well in advance of any transfer (e.g., in the admission packet); and notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours);- The written bed-hold notices provided to the residents/representatives explain in detail the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; the reserve bed payment policy as indicated by the state plan (for Medicaid residents), the facility policy regarding bed-hold periods; the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and the facility return policy. Review of the facility's policy titled, Transfer or Discharge, revised March 2025, showed:- Once admitted to the facility, residents have the right to remain in the facility, transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record;- When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider, the basis for the transfer or discharge, that an appropriate notice was provided to the resident and/or legal representative, the date and time of the transfer or discharge, the new location of the resident, the mode of transportation, a summary of the resident's overall medical, physical, and mental condition, disposition of personal effects, disposition of medications, others as appropriate or as necessary, and the signature of the person recording the data in the medical record;- If the basis for the transfer or discharge is that the transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility, the resident's physician (or provider) documents the specific resident needs that cannot be met, the facility's attempt to meet those needs, and the receiving facility's service(s) that are available to meet those needs;- Residents have the right to appeal a transfer or discharge through the state agency that handles appeals;- Upon notice of transfer or discharge, the resident is provided with a statement of his/her right to appeal the transfer or discharge, including the name, address, email, and telephone number of the entity which receives such requests, information about how to obtain, complete, and submit an appeal form, how to get assistance completing the appeal process; and the facility bed-hold policy. 1. Review of Resident #1's medical record showed:- admitted on [DATE];- Transferred to the hospital on [DATE] and returned on 11/06/25;- Transferred to the hospital on [DATE] and returned on 11/26/25;- Transferred to the hospital on [DATE] and returned on 12/17/25;- Transferred to the hospital on [DATE] and returned on 12/28/25. Review of the resident's Notice of Resident Transfer/Discharge and Bed Hold and Return Notification forms, dated 11/03/25 and 12/08/25, showed:- No documentation of the daily bed-hold rate;- No documentation of the appeal agency contact information, the Ombudsmen contact (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information, the agency contact information responsible for protection and advocacy of individuals with developmental disabilities, and the contact information for the agency for protection and advocacy of individuals with a mental disorder. Review of the resident's Notice of Resident Transfer/Discharge and Bed Hold and Return Notification forms, dated 11/16/25 and 12/28/25, showed:- No selected bed-hold preference;- No documentation of the daily bed-hold rate;- No documentation of the appeal agency contact information, the Ombudsmen contact information, the agency contact information responsible for protection and advocacy of individuals with developmental disabilities, and the contact information for the agency for protection and advocacy of individuals with a mental disorder. 2. Review of Resident #3's medical record showed:- admitted on [DATE];- Transferred to the hospital on 1/22/26 and returned to the facility on [DATE]. Review of the resident's Transfer/Discharge and Bed Hold forms, dated 01/22/26, showed:- No selected bed-hold preference;- No documentation of the daily bed-hold rate;- No documentation of the appeal information, the Ombudsmen contact information, the agency contact information responsible for protection and advocacy of individuals with developmental disabilities, and the contact information for the agency for protection and advocacy of individuals with a mental disorder. 3. Review of Resident #24's medical record showed:- admitted on [DATE];- Transferred to the hospital on [DATE] and returned to the facility on [DATE]. Review of the resident's Transfer/Discharge and Bed Hold forms, dated 12/22/26, showed:- No documentation of the daily bed-hold rate;- No documentation of the appeal information, the Ombudsmen contact information, the agency contact information responsible for protection and advocacy of individuals with developmental disabilities, and the contact information for the agency for protection and advocacy of individuals with a mental disorder. 4. Review of Resident #41's medical record showed:- admitted on [DATE];- Transferred to the hospital on [DATE] and returned to the facility on [DATE];- Transferred to the hospital on [DATE] and returned to the facility on [DATE];- Transferred to the hospital on [DATE] and returned to the facility on [DATE]. Review of the resident's Transfer/Discharge and Bed Hold forms, dated 01/10/26, 03/05/26, and 03/11/26, showed:- No documentation of the daily bed-hold rate;- No documentation of appeal information, the Ombudsmen contact information, the agency contact information responsible for protection and advocacy of individuals with developmental disabilities, and the contact information for the agency for protection and advocacy of individuals with a mental disorder. During an interview on 03/19/26 at 2:43 P.M., Licensed Practical Nurse (LPN) A said they did the bed hold and transfer/discharge paperwork when a resident left the facility. The nurse sending out the resident was responsible to complete it. If it couldn't go out for some reason, then the Social Service Designee or the Administrator should be notified and they would assist. During an interview on 03/19/26 at 5:50 P.M., the Administrator said the facility staff should fill out all blanks on the bed hold and transfer/discharge paperwork to include the bed hold amount, the appeal information, the Ombudsmen contact information, the agency contact information responsible for protection and advocacy of individuals with developmental disability, and the contact information for the agency for protection and advocacy of individuals with a mental disorder.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for one resident (Resident #43) out of one sampled resident that included the instructions needed to provide effective and person-centered care to meet professional standards of quality care. The facility census was 73.Review of the facility's policy titled, Care Plans - Baseline, revised March 2022, showed:- A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission;- The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meets professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, discussion with the resident/representative, and physician orders;- The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed;- Provision of the summary to the resident and/or resident representative is documented in the medical record. 1. Review of Resident #43's medical record showed:- admission date of 03/02/26:- No documentation of a baseline care plan;- The facility did not complete the resident's baseline care plan within 48 hours after admission to the facility and did not provide a summary to the resident and/or the resident representative. During an interview on 03/18/26 at 9:05 A.M., Licensed Practical Nurse (LPN) A said the nurse was responsible for completing the baseline care plan for new admissions. He/She did not complete a baseline care plan for Resident #43 upon his/her admission. During an interview on 03/18/26 at 12:15 P.M., the Minimum Data Set (MDS - part of a federally mandated process for clinical assessment of all residents in certified nursing homes) Coordinator said the charge nurse was responsible for completing the baseline care plan on admission and for Resident #43 it would have been LPN A. The baseline care plan should be in the front of the resident's hard chart; if it's not there, it should be under assessments in the electronic medical record. During an interview on 03/19/26 at 7:25 P.M., the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) said they would expect a resident to have a baseline care plan completed upon admission and within 48 hours with care areas addressed. The admitting nurse should complete the baseline care plan when the resident comes in as part of the admission packet and then the baseline care plan should be placed in the resident's hard chart upon completion.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure placement of the urinary indwelling catheter (a tube inserted into the bladder to drain urine) drainage bag and tubing was maintained for two residents (Residents #1and #5) out of two sampled residents. The facility census was 71. Review of the facility's policy titled, Urinary Catheter Care, dated August 2022, showed:- The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections;- Be sure the catheter tubing and drainage bag are kept off the floor;- Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. 1. Review of Resident #1's medical record showed:- admitted on [DATE];- Diagnoses of neurogenic bladder (the bladder does not empty properly due to a neurological condition) and urinary tract infection. Review of the resident's Physician Order Sheet (POS), dated March 2026, showed:- An order to flush the suprapubic catheter (a sterile tube inserted into the bladder through the abdominal wall to drain urine) with 60 milliliters (ml) normal saline (salt water) as needed to prevent clots and for patency (open), dated 03/09/26;- An order to change the 16 French (Fr. - size of the catheter) with 10 ml balloon suprapubic catheter and bedside drainage bag every day shift starting on the 28th and ending on the 28th every month related to pressure ulcer (injury to the skin and/or the underlying tissue usually over a bony prominence, as a result of pressure or friction) of the right buttock, unstageable and pressure ulcer of sacral (triangular bone located above the tail bone) region, stage 4 (full thickness tissue loss with exposed bone, tendon or muscle; slough or eschar may be present on some parts of the wound bed. Often includes undermining or tunneling), dated 03/28/26;- An order for suprapubic catheter care every shift for prevention, dated 02/07/26. Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/24/25, showed:- Used an indwelling catheter. Review of the resident's Care Plan, dated 03/17/26, showed:- Resident with an indwelling catheter;- Position the catheter bag and tubing below the level of the bladder, in a dignity bag;- Catheter care every shift. Observations of the resident showed:- On 03/18/26 at 6:33 A.M., and 12:35 P.M., and 03/19/26 at 7:40 A.M., the resident lay in a low bed and the catheter drainage bag hung on the bed frame where the bottom of the catheter drainage bag rested on the floor;- On 03/18/26 at 10:30 A.M., during wound care, the Assistant Director of Nursing (ADON) placed the catheter drainage bag on top of the mattress near the resident's right leg, turned the resident to the side, hung the catheter drainage bag on the bed frame, retrieved the catheter drainage bag, placed on top of the mattress and the urine flowed up towards the resident's bladder in the tubing, repositioned the resident, and returned the catheter drainage bag to the bed frame. 2.Review of Resident #5's medical record showed:- admitted on [DATE];- Diagnosis of neuromuscular dysfunction of the bladder (nerve damage from diseases or injuries that interrupts signals between the brain, spinal cord, and the bladder). Review of resident's POS, dated March 2026, showed:- An order to change the urinary catheter 18 Fr. 10 ml balloon and bag monthly on the 15th using sterile technique, dated 12/15/25;- An order to irrigate the urinary catheter with 30 ml normal saline as needed, dated 10/24/25;- An order for urinary catheter care every shift, dated 10/24/25. Review of the resident's quarterly MDS, dated [DATE], showed:- Used an indwelling catheter. Review of the resident's care plan, revised on 01/06/26, showed:- Resident with an indwelling catheter;- Position the catheter bag and tubing below the level of the bladder and away from the entrance room door. Observation of the resident showed:- On 03/18/26 at 9:30 A.M., the resident lay in bed with the catheter drainage bag covered with a dignity drape hung on the bed frame and the bottom of the catheter drainage bag rested on the floor;- On 03/18/26 at 9:40 A.M., the resident lay in bed. Certified Nursing Assistant (CNA) D and Nursing Assistant (NA) E picked up the catheter drainage bag covered with a dignity drape, raised it waist high above the resident's bladder, urine drained toward the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Point Nursing Center	8477 North Street Birch Tree, MO 65438

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insertion site, placed the catheter drainage bag on the foot of the bed, and rolled the resident side to side to put a Hoyer (a mechanical lift used to transfer residents from one position to another) sling under him/her. CNA D raised the resident up with the Hoyer lift and placed the catheter drainage bag into the resident's lap above the level of the bladder. NA E lowered the resident into his/her wheelchair. CNA D removed the catheter bag from the resident's lap and hooked it to the wheelchair below the resident's bladder. During an interview on 03/19/26 at 2:43 P.M., Licensed Practical Nurse (LPN) A said the catheter placement should be below a resident's bladder. The catheter drainage bag should be secured under the wheelchair or on the bed frame. The catheter drainage bag and tubing should not touch the floor and should never be above the waist or the bladder. The catheter drainage bag should not be placed directly on top of the mattress. During an interview 03/19/26 at 3:07 P.M., CNA B said catheter drainage bags should not be raised above the bladder because the urine would backflow towards the bladder. The catheter drainage bags shouldn't touch the floor although it was hard sometimes when the beds were in a low position. Cather drainage bags shouldn't be placed on the bed, but it was done with some because otherwise it would tug the catheter while moving the resident. During an interview on 03/19/26 at 3:15 P.M., Nursing Assistant (NA) C said catheter drainage bags shouldn't touch the floor or go above the resident's bladder. Catheter drainage bags shouldn't be placed on the beds but sometimes it had to be done. During an interview on 03/19/26 at 3:24 P.M., CNA D said catheter drainage bags shouldn't touch the floor or go above the resident's bladder. The catheter drainage bags should always be at a downward angle and hung in a dignity bag. During an interview on 03/19/26 at 3:32 P.M., CNA E said catheter bags shouldn't touch the floor and should always be below the bladder so the urine could flow away from the bladder. During an interview on 03/19/26 at 5:09 P.M., the Director of Nursing (DON) and the ADON said catheter drainage bag placement should be below the bladder and not touch the floor. The catheter bag should also be in a dignity bag. The DON said the catheter drainage bag shouldn't be placed in bed with the resident. The ADON said the bag should be moved from one side to another as the resident was being turned. During an interview on 03/19/26 at 5:43 P.M., the Administrator said she would expect staff to follow policy and procedure for catheter placement ensuring it didn't touch the floor or was above the resident's bladder.

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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** Based on observation, interview, and record review, the facility failed to ensure training was provided, competence was assessed, and a physician's order was received for laryngectomy tube ([NAME] tube - a flexible silicone tube inserted into the stoma (neck opening) to maintain the airway opening) care to be completed independently, and the type and size of the [NAME] tube supplies, and to have all of the needed [NAME] tube supplies easily accessible for one resident (Resident #5) out of one sampled resident with a [NAME] tube. The facility also failed to follow the physician's order for supplemental oxygen therapy and to change, date, and store the oxygen tubing (flexible tubing that delivers supplemental oxygen through the nostrils) and the nebulizer (a medical device that converts liquid medication into a mist to be inhaled directly into the lungs) tubing for one resident (Resident #43) out of two sampled residents. The facility census was 71.The facility did not provide a policy regarding oxygen tubing and humidification. Review of the facility's procedure titled, Laryngectomy Tube Care, dated 09/2013, showed:- Good hand washing habits are important;- Clean the stoma before changing the straps;- You may use water soluble lubricant around the stoma to moisten the crusting. If there are crusted areas inside the stoma, you may spray two squirts of normal saline (salt water) into the stoma to moisten, cough and expel the plugs. Always wash hands before and after doing stoma and [NAME] tube care;- To clean the [NAME] tube, do it regularly and is usually done two or three times a day. Do not use hydrogen peroxide, rubbing alcohol, or chemical to clean the tube;- Changing the strap should be done when it becomes dirty. Remove the tube to replace the straps;- Suctioning (the use of a catheter attached to a machine to suction airway) the trachea: Before suctioning, check to make sure the airway isn't blocked with mucus. Wash hands, and fill a bowl with water, turn the machine on (setting no higher than 120 millimeters of mercury (mm Hg), remove the suction catheter from the wrapper and attach to the suction catheter, dip loose tip into the water, put a thumb on the port and suck up some water, release the thumb from the port, put saline mist in stoma, take a few deep breaths and gently insert moist catheter five to eight inches into trachea until resistance, cover and uncover catheter suction port with thumb and slowly take catheter out of trachea, no longer than 10 seconds, put catheter tip in water to clean suction, turn off machine and disconnect tubing, throw disposable catheter away, if using reusable sterilize;- Did not address the facility would ensure a resident providing self-[NAME] tube care, including suctioning, was trained and competent according to professional standards of practice. 1. Review of Resident #5's medical record showed:- admission date of 10/16/25;- Diagnoses of tracheostomy (trach - an incision in the windpipe to relieve an obstruction for breathing) status, malignant neoplasm (cancer) of the supraglottis (the upper portion of the larynx (voice box) located above the true vocal cords), and paraplegia (impairment or loss of motor and/or sensory function in the lower half of the body, usually caused by damage to the spinal cord below the neck). Review of the resident's Physician Order Sheet (POS), dated March 2026, showed:- An order for [NAME] tube site care: clean with normal saline, change the dressing every day shift, dated 10/27/25;- An order to remove the [NAME] tube, rinse with water, clean with soap, rinse with water, disinfect with 70% rubbing alcohol, allow to dry completely before replacing every day shift, dated 10/28/25;- An order for oxygen tubing, mask, and humidifier to be changed weekly every night shift on Sunday, dated 11/02/25;- An order for oxygen at 4 liters per minute (LPM) via a trach mask every shift, dated 10/24/26;- An order to change the collar for the [NAME] tube weekly on Wednesday every day shift for prevention, dated 10/29/25;- No order for the suctioning and the size and type of the airway tube used by the resident;- No physician order for the resident to perform the [NAME] tube care and suctioning independently. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/16/26, showed:- Resident with a tracheostomy;- Received oxygen. Review of the resident's care plan, dated 11/13/25, showed:- Difficulty breathing and the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	need for monitoring related to the [NAME] tube. Administer oxygen as ordered at 4 LPM via a trach mask, clean or change the filter at least weekly and as needed, and change the tubing weekly and as needed;- Resident with a [NAME] tube and the resident to change the collar for the [NAME] tube weekly on Wednesday. Give oxygen at 4 LPM via a trach mask. Change the oxygen tubing, mask, and humidifier weekly on Sunday evening. Monitor for restlessness, agitation, confusion, increased heart rate, bradycardia (a below normal heart rate), level of consciousness, mental status, lethargy, and the respiratory rate, depth, and quality check every shift. Provide good oral care daily. Provide means of communication and procedural information. Reassure that help is available immediately. Suction as necessary. The resident will suction him/herself and does not want staff to do it. The resident will remove the [NAME] tube, rinse with water, clean with soap, rinse with water, disinfect with 70% rubbing alcohol, and allow to dry completely before replacing every day shift; - Did not address the type and size of the [NAME] tube airway. Review of the resident's medical record showed:- No documentation the resident was provided [NAME] tube care education;- No documentation the resident's competency for the [NAME] tube care was assessed and the resident was competent to provide his/her own [NAME] tube care. During an interview on 03/17/26 at 11:00 A.M., Resident #5 said he/she did his/her own airway care. He/She preferred to do it him/herself to ensure it was done correctly. Staff would help if he/she needed it, but the resident didn't want help. 2. Review of Resident #43's medical record showed:- admission date of 03/02/26;- Diagnoses of dependence on supplemental oxygen, dyspnea (shortness of breath), chronic obstructive pulmonary disease (COPD - lung disease). Review of the resident's POS, dated March 2026, showed:- An order for oxygen tubing to be changed every Sunday night shift for prevention, dated 03/08/26;- May have oxygen at 2 LPM per nasal cannula as needed, dated 03/02/26. Review of the resident's care plan, dated 03/02/26, showed:- Difficulty breathing/short of breath related to COPD and uses oxygen at night as needed;- Administer oxygen as per the physician order. Observation of the resident showed:- On 03/17/26 at 10:01 A.M., the resident was taken to the shower by staff. The oxygen concentrator was not in use, the resident's undated nasal cannula (oxygen tubing inserted into the nostrils to deliver supplemental oxygen) lay on the floor at the bedside, the humidifier was undated, and no storage container for the nasal cannula when not in use. The undated nebulizer mask lay on the recliner seat with no storage container for it;- On 03/18/26 at 5:40 A.M., the resident lay in bed with oxygen on at 3 LPM. The nasal cannula and humidifier were undated. The undated nebulizer mask sat on the recliner seat in a plastic resealable bag;- On 03/18/26 at 10:30 A.M., and 03/19/26 at 9:05 A.M., the resident lay in bed with oxygen via a nasal cannula, dated 03/18/26, on at 3 LPM. During an interview on 03/18/26 at 10:30 A.M., Resident #43 said he/she wore oxygen at night but wasn't sure what the setting was supposed to be. During an interview on 03/19/26 at 3:07 P.M., Certified Nursing Assistant (CNA) B said usually there was a plastic bag that had the date on it to store the oxygen tubing in while not in use. The nurses usually dated the oxygen tubing and humidifier when they changed them. If the nasal cannula was on the floor, he/she would replace it. During an interview on 03/19/26 at 2:43 P.M., Licensed Practical Nurse (LPN) A said oxygen tubing and the humidifiers on the oxygen concentrators should be dated. There should be a plastic bag on the concentrator for storing the oxygen tubing, and the nebulizer mask should be rinsed and sprayed with disinfectant spray and left to air dry. If the nasal cannula was on the floor, then it should be replaced with a new one and it should not be placed on the resident. The oxygen setting should be set at what was ordered. Resident #43's oxygen order was for 2 LPM as needed, so that was what he/she should receive. Resident #5 did his/her own airway care. The extra [NAME] tube was stored in the Assistant Director of Nursing (ADON)'s office. During an interview on 03/19/26 at 5:09 P.M., the ADON and Director of Nursing (DON) said there should be an order for oxygen and if it had a set rate, they would expect the order to be followed. The nurse who changed the oxygen tubing and humidifier water was responsible for dating them. The oxygen tubing and mask should be stored in a plastic resealable bag and attached to the concentrator or the nebulizer machine. The nasal cannula should be thrown away and staff should get a new one if it was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	found on the floor. The ADON and DON said the extra [NAME] tube was kept in their office. The DON said she lived just a few minutes away and could run up to get it if needed. Resident #5 was able to keep his/her airway open without the [NAME] tube in place. The care plan showed Resident #5 would do his/her own care but no assessment to show the resident was competent in the care had been completed and there was not a policy regarding that. During an interview on 03/19/26 at 5:43 P.M., the Administrator said oxygen tubing should be dated and in a bag for storage. If a nasal cannula was on the floor, it should be thrown away, replaced with a new one, dated, and put in a bag. She would expect staff to follow the regulations.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents diagnosed with dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) had a personalized plan of care to ensure appropriate services to promote the resident's highest level of functioning and psychosocial needs were provided for three residents (Residents #9, #13, and #16) out of three sampled residents. The facility census was 71.Review of the facility's policy titled Dementia - Clinical Protocol, dated November 2018, showed:- The interdisciplinary team (IDT) will evaluate individuals with new or progressive cognitive impairment and help identify symptoms and findings that differentiate dementia from other causes;- For the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life;- Direct care staff will support the resident in initiating and completing activities and tasks of daily living. Bathing, dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed. 1. Review of Resident #9's medical record showed:- admission date of 04/11/19; - Diagnoses of unspecified dementia with unspecified severity and behavioral disturbance, and unspecified dementia, moderate, with other behavioral disturbance. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/11/25, showed:- Severe cognitive impairment;- Diagnosis of non-Alzheimer's dementia;- Able to understand others and to be understood. Review of the resident's Care Plan, dated 03/13/26, showed:- Did not address specific problems, interventions, or goals for dementia care;- Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia. Observations of the resident showed:- On 03/17/26 at 11:50 A.M., and 1:55 P.M., the resident lay in bed with his/her eyes closed; - On 03/18/26 at 3:00 P.M., the resident sat in his/her wheelchair in the common area near the nurse's station and leaned to the right side with his/her eyes closed. 2. Review of Resident #13's medical record showed:- admission date of 11/13/25;- Diagnosis of dementia in other diseases classified elsewhere, mild, with anxiety (persistent worry and fear about everyday situations), and Alzheimer's disease (progressive mental deterioration) with late onset. Review of the resident's quarterly MDS, dated [DATE], showed:- Cognition intact;- Diagnoses of Alzheimer's with late onset, Alzheimer's disease, and non-Alzheimer's dementia;- Able to understand others and to be understood. Review of the resident's Care Plan, dated 02/16/26, showed:- Did not address specific problems, interventions, or goals for dementia care;- Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia. Observation of the resident showed:- On 03/17/26 at 9:45 A.M., the resident lay in bed with his/her eyes closed;- On 03/17/26 at 10:30 A.M., the resident lay in bed with his/her eyes open;- On 03/18/26 at 2:30 P.M., the resident sat in the chair next to the bed with his/her eyes open, the television off, and the door to the room closed. 3. Review of Resident #16's medical record showed:- admission date of 07/23/25;- Diagnoses of unspecified dementia with unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the resident's quarterly MDS, dated [DATE], showed:- Severe cognitive impairment;- Diagnosis of non-Alzheimer's dementia;- Able to understand others and to be understood. Review of the resident's Care Plan, dated 02/23/26, showed:- Did not address dementia;- Did not address specific problems, interventions, or goals for dementia care;- Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia. Observations of the resident showed:- On 03/17/26 at 11:50 A.M., the resident lay in bed, with his/her eyes closed;- On 03/18/26 at 3:00 P.M., the resident sat in his/her wheelchair in his/her room with the television on, not watching it, and looking around the room. During an interview on 03/19/26 at 6:05 P.M., the Director of Nursing (DON) and the Administrator said they would expect dementia care to be care planned individually and to address the resident's diagnosis and needs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow appropriate infection control practices with hand hygiene and glove changes during wound care, and suprapubic catheter (a sterile tube inserted into the bladder through the abdominal wall to drain urine) care for one resident (Resident #1) and incontinent care for three residents (Residents #5, #38, and #75) out of three sampled residents. The facility failed to follow appropriate infection control practices when inserting a nasal cannula (a device used to deliver oxygen with two small tubes that fit into the nostrils) into the nares of one resident (Resident #38) after it lay on the floor. The facility census was 71. Review of the facility's policy, Handwashing/Hand Hygiene, dated October 2023, showed:- This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections;- All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infection;- Hand hygiene is indicated immediately before touching a resident, before performing aseptic tasks, after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching the resident's environment, before moving from work on a soiled body site to a clean, and immediately after glove removal;- Single use disposable gloves should be used before aseptic procedures, when anticipating contact with blood or body fluids, and when in contact with a resident or equipment or environment of a resident, who is on contact precautions;- To apply and remove gloves: perform hand hygiene before applying non-sterile gloves, when applying only touch top of the cuff; when removing gloves, pinch at wrist and peel away turning glove inside out, perform hand hygiene. Review of the facility's policy, Perineal Care, dated February 2018, showed:- The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition;- For a catheter, gently wash the juncture of the tubing from the urethra down the catheter about three inches. Review of the facility policy, Urinary Catheter Care, dated August 2022, showed:- The purpose of this procedure is to prevent urinary catheter-associated complications, including infections;- Use aseptic technique when handling or manipulating the drainage system;- To clean, cleanse around the catheter insertion site, use a clean washcloth to cleanse and rinse the catheter from the insertion site to approximately four inches outward, remove gloves and wash hands. The facility did not provide a policy for wound care. 1. Observation of Resident #38's incontinent care on 03/17/26 at 1:24 P.M., showed:- Certified Nursing Assistant (CNA) E and Nursing Assistant (NA) F entered the room, put on gloves, and did not perform hand hygiene;- CNA E unfastened the urine saturated brief, wiped fecal matter off of the resident's buttocks with the back of the brief, and removed the soiled brief;- NA F removed gloves, did not perform hand hygiene, exited the room, retrieved a clean incontinent pad from the clean utility room, entered the room, performed hand hygiene, and put on gloves;- CNA E used a wipe to clean fecal matter from the resident's buttocks with fecal matter on his/her left glove, did not change gloves, did not perform hand hygiene, used a clean wipe to wipe the buttock again, changed the left glove, did not perform hand hygiene, touched the resident's shirt, rolled and placed a clean incontinent pad under the resident, changed gloves, did not perform hand hygiene, and placed a clean brief under the resident;- NA F removed the incontinent pad soiled with urine and fecal matter from the bed, did not change gloves, did not perform hand hygiene, removed two wipes from the package, and handed them to CNA E;- CNA E cleaned part of the upper area of the groin, did not clean all of the upper area and the lower area of the groin, did not change gloves, did not perform hand hygiene, and fastened the clean brief into place;- CNA E and NA F removed gloves and did not perform hand hygiene;- NA F picked up the resident's nasal cannula from the floor and placed it into the resident's nostrils;- CNA E covered the resident with linens, performed hand hygiene, and exited the room. 2. Observation of Resident #75's incontinent care on 03/18/26 at 5:32 A.M., showed:- CNA B and NA C performed hand hygiene and put on gloves;- CNA B unfastened brief, placed new brief on bed beside resident;- CNA B cleaned the groin area, did not clean the perineal area, did not perform hand hygiene, and changed gloves;- CNA B wiped (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's buttocks and perineal area with same area of the wipe going over the same area in a circular motion multiple times, did not perform hand hygiene, and changed gloves;- CNA B put a clean brief under the resident and fastened the brief, did not perform hand hygiene, changed gloves, and pulled the blankets up over the resident;- CNA B performed hand hygiene and did not put on gloves;- NA C removed gloves, did not perform hand hygiene, and tied up the bags of dirty laundry and trash;- CNA B and NA C pulled the resident up in bed with the incontinent pad with their bare hands;- CNA B did not perform hand hygiene, exited the room, took the bag of dirty trash and laundry to the dirty utility room, and performed hand hygiene;- NA C performed hand hygiene and exited the room. 3. Observation of Resident #1's wound care on 03/18/26 at 7:45 A.M., showed:- EBP signage on the door;- Licensed Practical Nurse (LPN) A performed hand hygiene, put on a gown and gloves, and entered the resident's room;- LPN A removed the dressing from the resident's left gluteal fold (the skin crease under the buttock that separates the buttock from the upper thigh), did not change gloves, and did not perform hand hygiene;- LPN A cleaned the wound bed with gauze saturated with normal saline (salt water), changed gloves, and did not perform hand hygiene;- LPN A packed the wound with gauze wet with Dakins solution (an antiseptic wound cleanser), did not perform hand hygiene, did not change gloves, applied skin prep (a protective barrier wipe) around the outside of the wound, changed gloves, and did not perform hand hygiene;- LPN A removed the gauze dressing around the suprapubic catheter with a brown substance on the gauze and the catheter tubing site, changed gloves, and did not perform hand hygiene;- LPN A cleaned down the catheter tubing towards the insertion site with a gauze wet with normal saline from the top to bottom three times with the same area of the wet gauze, did not perform hand hygiene, did not change gloves, placed a clean split gauze to the catheter insertion site, changed gloves, and did not perform hand hygiene;- LPN A applied tape to secure the split gauze in place, used a marker off the bedside table to write the date on the tape, did not change gloves, and did not perform hand hygiene;- LPN A detached the catheter tubing from the catheter drainage bag, did not change gloves, did not perform hand hygiene, used a syringe to flush the suprapubic catheter as ordered, reattached the catheter tubing to the catheter drainage bag, did not perform hand hygiene, and changed gloves;- LPN A applied skin prep wipe around the wound vacuum (vacuum-assisted closure used to conduct negative pressure wound therapy to promote healing) dressing to the right thigh, did not perform hand hygiene, did not change gloves, assisted the resident to roll to the right side, sprayed the left side of the resident's back with skin prep spray, removed gown and gloves, performed hand hygiene, and exited the room. 4. Observation of Resident #5's incontinent care, catheter care, and transfer on 03/18/26 at 9:40 A.M., showed: - EBP signage on door;- CNA B and NA C put on gowns, entered the room, performed hand hygiene, and put on gloves;- CNA B cleaned the groin area, did not perform hand hygiene, changed gloves, cleaned the genital area with the same area of the wipe, did not perform hand hygiene, changed gloves, dabbed with a wipe around the insertion point of the catheter, performed hand hygiene, changed gloves, and emptied the urine from the catheter bag into a clean canister;- CNA B performed hand hygiene, changed gloves, rolled the resident to the right and NA C cleaned the resident's buttocks;- NA C did not change gloves and did not perform hand hygiene;- CNA B and NA C rolled the resident from side to side and placed a Hoyer lift (a mechanical lift used to transfer residents from one position to another) sling under the resident and transferred the resident into the wheelchair with the Hoyer lift;- NA C removed gloves and gown, performed hand hygiene, and exited the room;- CNA B removed gown and gloves, picked up the trash, exited the room, took the trash to the dirty utility room, and performed hand hygiene. During an interview on 03/19/26 at 2:43 P.M., LPN A said glove changes should occur at the start, end, and anytime the gloves might have been contaminated when doing care. Hands should be washed at the start, end, and when visibly soiled, or sanitized if not visibly soiled. A nasal cannula should never be placed in the nares of a resident if it had touched the floor. A catheter should be cleaned from the insertion point down, using one wipe each time. During an interview on 03/19/26 at 3:07 P.M., CNA B said sanitize hands before care, when entering a resident room, should change gloves a lot, and wash (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265368	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Point Nursing Center	8477 North Street Birch Tree, MO 65438

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands at the end. Should wash hands if used sanitizer three times. If a nasal cannula was found on the floor, it should be replaced and not placed on a resident. During an interview on 03/19/26 at 3:15 P.M., NA C said hands should be washed before putting gloves on at the start and end of care. Soiled gloves should be changed during care. If a nasal cannula was found on the floor, it should be replaced with a new one. During an interview on 03/19/26 at 3:24 P.M., CNA D said hands should be washed when you go into a room, touch anything dirty, and leave the room. Gloves should be changed when dirty or as many times as needed. A nasal cannula found on the floor should be thrown away. During an interview on 03/19/26 at 3:32 P.M., CNA E said gloves should be changed as needed when going from dirty to clean care, hands should be sanitized at the start, when you walk out, and as needed. A nasal cannula should not be placed on a resident if found on the floor but should be replaced. During an interview on 03/19/23 at 5:09 P.M., the Assistant Director of Nursing (ADON) and Director of Nursing (DON) said hand washing should occur before and after care. Hands should be sanitized with glove changes, and gloves changed when going from dirty to clean care and use one wipe per swipe. If a nasal cannula was found on the floor it should be thrown away and a new one obtained. During an interview on 03/19/23 at 5:43 P.M., the Administrator said she would expect staff to follow policy and procedure for hand hygiene and glove changes and follow infection control standards. A nasal cannula that was found on the floor should never be placed back on a resident, instead a new one should be obtained.