STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265638	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Homes, Tri-County	601 North Galloway Road Vandalia, MO 63382

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 35615 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #2), who staff identified as incontinent and required staff assistance with toileting and incontinence care, in a review of nine residents, was provided incontinence care timely and maintained good personal hygiene. The facility census was 54. Review of the facility policy, Urinary Continence and Incontinence, Assessment and Management, dated 8/2022 showed the following: -As part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary continence; -Staff will check the resident for incontinence and change the resident at regular intervals using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin. 1. Review of Resident #2's admission Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 9/27/24 showed the following: -Severely impaired cognition; -Frequently incontinent of urine; -Always incontinent of bowel; -Required substantial/maximum staff assistance (helper does more than half the effort) with toileting, dressing lower body and personal hygiene; -Dependent on staff for transfers to and from the toilet. Review of the resident's Care Plan dated 10/20/24 showed the following: -Diagnoses of dementia, urinary incontinence, abnormal gait and mobility, unsteadiness on feet, kidney disease, stroke and urinary tract infection; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Impaired physical mobility and risk for self-care deficit. Staff should determine the level of assistance needed, provide assistance with Activities of Daily Living (ADL) as needed; -ADL self-care performance deficit related to stroke. Staff should provide assistance with ADLs, transfers, dressing and personal hygiene and total assistance with toileting. Observation of the resident on 1/22/25 showed the following: -At 10:05 A.M. the resident sat in a wheelchair in his/her room, facing the television. A strong urine odor was noted in the room; -At 11:00 A.M. the resident remained in the wheelchair with no change in position. A strong urine odor was noted coming from the resident; -At 11:45 A.M. Certified Nurse Assistant (CNA) B pushed the resident's wheelchair to the dining room for lunch. During an interview on 1/22/25 at 11:46 A.M. CNA B said he/she toileted the resident and changed the resident's clothing before lunch. The resident was soiled and wet. Observation on 1/23/25 showed the following: -At 8:30 A.M. the resident sat in a wheelchair in his/her room facing the television, dressed in black pants and a gray shirt; -At 9:50 A.M. the resident sat in a wheelchair in his/her room facing the television, dressed in the same black pants and gray shirt, in the same position; -From 11:30 A.M. through 12:45 P.M. the resident sat in a wheelchair in the dining room eating lunch, dressed in the same black pants and gray shirt. A strong urine odor was noted coming from the resident. CNA G said the resident was last toileted at about 9:00 A.M.; -At 12:45 P.M. staff pushed the resident in his/her wheelchair from the dining room to his/her room and positioned the resident's wheelchair facing the television and did not offer to assist the resident with toileting or check the resident for incontinence. The resident had a strong urine and feces odor. During an interview on 1/23/25 at 12:48 P.M. the resident said staff got him/her up about 9:00 A.M. Staff had not taken him/her to the toilet or changed his/her incontinence brief since 9:00 A.M. The resident needed to go to the bathroom and needed his/her soiled incontinence brief changed. Observation of the resident 1/23/25 at 1:00 P.M. showed the following: -CNA H and Nurse Assistant (NA) E transferred the resident to the toilet and removed the resident's urine and feces saturated incontinence brief. Feces was noted on the inside of the resident's pants; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA H repeatedly wiped the resident's buttocks and perineal area removing firm feces stuck to the resident's skin from the resident's buttock and perineal areas. CNA H said the feces had been there awhile as it was dried and was hard to clean. During an interview on 1/23/25 at 1:15 P.M. Nurse Aide (NA) E said he/she worked the resident's hall and last toileted and changed the resident at 9:00 A.M. that day. During an interview on 1/23/25 at 1:20 P.M. CNA H said staff should check the resident at least every two hours change the resident if the resident was incontinent. Staff should not let the resident sit in feces and urine. During an interview on 1/24/25 at 11:45 A.M. the Director of Nursing said staff should keep residents clean and dry, check and change residents every two hours and should not leave residents wet and soiled for extended periods of time. During an interview on 1/24/25 at 11:15 A.M. the Administrator said staff should check incontinent residents every one hour and provide incontinence care as needed. Staff should make sure residents were clean and dry and not left soiled. MO242963 MO245840 MO246518

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 35615 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #2) in a review of nine residents, was provided treatment and care in accordance with professional standards of practice when staff failed to assess the resident's clinical condition, failed to ensure a heart monitor was in place and functioning as ordered by the physician, failed to ensure the resident received therapy services following a hospitalization , and failed to ensure the resident's Care Plan was up to date and reflected the resident's current condition and care needs. The facility census was 54. Review of the facility policy Admission Notes, dated 9/2012, showed the following: -Preliminary resident information shall be documented upon a resident's admission to the facility; -When a resident is admitted to the nursing unit, the admitting nurse must document the following information in the nurses' notes, admission form, or other appropriate place, as designated by facility protocol; -The date and time of admission, from where the resident was admitted , reason for the admission and admitting diagnoses, the general condition of the resident upon admission, the presence of a urinary catheter (a sterile tube inserted into the bladder), dressings and any other medical equipment, a brief description of any disabilities, a statement indicating the nursing history and preliminary assessment is completed or has been started, notation of any signs or symptoms of an infectious or communicable disease; -This initial information-gathering precedes the complete history and physical assessment that also accompanies the resident admission process; -Should a resident be discharged from and readmitted to the facility, new admission data must be recorded. Review of the facility Admission Chart Audit, dated 2/7/24, showed the following: -The audit was to be completed every admission and re-admission; -The audit included the admission nurses note completed by the charge nurse; -Admission vital signs. 1. Review of Resident #2's admission Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 9/27/24, showed the following: -Severely impaired cognition; -Required substantial/maximum staff assistance (helper does more than half the effort) with toileting, dressing lower body and personal hygiene; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dependent on staff for transfers to and from the toilet, to and from the chair. Review of the resident's Care Plan, dated 10/20/24, showed the following: -Diagnoses of dementia, anxiety, urinary incontinence, abnormal gait and mobility, unsteadiness on feet, kidney disease, and stroke; -Impaired physical mobility and risk for self-care deficit. Staff should determine the level of assistance needed, provide assistance with Activities of Daily Living (ADL) as needed, determine residents ability to transfer, educate resident on exercise and safe transfer techniques, encourage resident to increase activity as indicated, evaluate skin for areas of redness, evaluate functional abilities; -Risk for disturbed sensory perception. Staff should consult occupational and physical therapy per orders; -ADL self-care performance deficit related to stroke. Staff should provide assistance with ADLs, transfers, dressing and personal hygiene and total assistance with toileting. Review of the resident's Nurses Note, dated 12/29/24, showed staff documented the following: -At 12:48 P.M. the resident was not acting right. The resident sat in the wheelchair with head tilted back, no response to verbal stimuli and slight response to sternal rub (act of forcefully rubbing the sternum) Blood pressure 186/116 (normal 120/80), heart rate 128 (normal 60-80) beats per minute and bounding, respirations 16 (normal 12-18) breaths per minute and slow. COVID-19 (an infectious disease caused by severe acute respiratory syndrome Coronavirus 2(SARS-CoV-2) test was positive. Staff called the ambulance and transferred resident to the emergency room for evaluation and treatment; -At 4:20 P.M. the resident was admitted to the hospital with acute CVA (cardiovascular accident or stroke). Review of the resident's Hospital Discharge Physician Orders dated 12/31/24 showed the following: -Hospital admission diagnosis of acute stroke; -Physical therapy, occupational therapy and speech therapy evaluation and treat; -Check weights and record; -Check vital signs and record; -COVID-19 precautions; -Follow up with cardiology physician in 30 days related to Zio heart monitor (a heart monitor patch applied to the skin that records the heart rhythm for up to two weeks). Review of the resident's Physician Order Sheet (POS), dated 12/31/24, showed speech therapy evaluate and treat. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's POS showed no physician orders for readmission, physical therapy, occupational therapy, check weights and vital signs and record or the Zio heart monitor. Review of the resident's Nurses Note, dated 12/31/24 at 6:33 P.M., showed staff documented the resident returned to the facility by medical transport. The resident was on isolation precautions due to positive COVID-19 status. Review of the resident's medical record showed no documentation staff completed an admission clinical assessment or assessed the resident's vital signs (blood pressure, heart rate, respirations, temperature and oxygen saturation level) upon readmission on 12/31/24. Review of the resident's Speech Therapy Evaluation and Plan of Treatment, dated 1/1/25, showed the following: -Diagnoses of stroke, dysphagia (difficulty swallowing), cognitive communication deficit; -Evaluation of speech sound production and language assessment; -Treatment of swallowing dysfunction and/or oral function for feeding; -Evaluation of oral and pharyngeal (pharynx, commonly referred to as the throat) swallow function; -Frequency 14 times/period for 30 days; -Resident referred to Speech Therapy due to recent hospitalization following acute stroke indicating the need for Speech Therapy to analyze oral/pharyngeal function and analyze speech, language and cognitive skills; -Recommendations for any/all solid intake and any liquid intake with supervision for oral intake. To facilitate safety and efficiency, alternate liquid and solids, decrease environmental distractions, be seated at a table with assist for verbal cues as needed. Review of the resident's Vital Signs Record, dated 1/1/25, showed staff documented the resident's heart rate was 91 beats per minute. Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's vital signs, other than heart rate, (blood pressure, respirations, temperature, oxygen saturation level) on 1/1/25. Review of the resident's POS dated 1/2/25 showed the following: -Admit to the facility, the resident needed continuous care due to inability to live independently and the need for 24 hour assistance, observation and planning; -Physical Therapy and Occupational Therapy evaluate and treat; -Check vital signs and weigh monthly. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Vital Signs Record, dated 1/2/25, showed staff documented the resident's heart rate was 83 beats per minute. Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's vital signs, other than heart rate, (blood pressure, respirations, temperature, oxygen saturation level) on 1/2/25 and no documentation staff updated the resident's Care Plan regarding the recent hospitalization for stroke and the presence of a heart monitor. Review of the resident's Nurses' Note, dated 1/3/25, showed staff documented the following: -At 1:21 A.M. the resident was readmitted and was positive for COVID-19. The resident was isolated in his/her room and monitored for any worsening of symptoms; -At 12:05 P.M. the resident remained COVID-19 positive and in isolation. The resident was up in the wheelchair in room for meals, no complaints noted. Vital signs within normal limits, medications administered. Review of the resident's Vital Signs Record, dated 1/3/25, showed staff documented the resident's heart rate was 77 beats per minute and oxygen saturation level was 94 percent (normal greater than 92 percent). Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's blood pressure, respirations or temperature) on 1/3/25. Review of the resident's Nurses' Note, dated 1/4/25, showed staff documented the following: -At 1:47 A.M. the resident continued isolation due to positive COVID-19. No cough noted and no adverse reactions; -At 5:18 P.M. the resident continued isolation due to positive COVID-19. No cough noted. The resident ate well for meals while staff set up food and offered limited assistance. Review of the resident's Vital Signs Record, dated 1/4/25, showed staff documented the resident's blood pressure was 144/86, heart rate was 79 beats per minute, respirations 20 breaths per minute, and temperature was 98.7 degrees (normal 98.6 degrees). Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's oxygen saturation on 1/4/25. Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's vital signs on 1/5/25, 1/6/25 or 1/7/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Nurses Note, dated 1/7/25 at 2:16 P.M., showed staff documented hospital staff called and said cardiology did not receive any recording of the resident's heart monitor that was on the resident when he/she returned from the hospital on 12/31/24. The hospital staff member said the transmitter should be within ten feet of the resident to allow recording. Facility staff were not aware of any transmitter, but the resident had a heart monitor still in place. Staff searched the resident's room but were unable to locate the transmitter. The hospital will send another heart monitor and transmitter to be placed on the resident 1/14/25 for 14 days and then remove the monitor and send back to the hospital. Review of the resident's Occupational Therapy Evaluation and Plan of Treatment, dated 1/8/25, showed the following: -Diagnoses of stroke, need for assistance with personal care, muscle weakness, unsteadiness on feet and lack of coordination; -Therapeutic exercises; -Neuromuscular reeducation; -Self-care management training, -Wheelchair management training; -Three times per week for 30 days; -Referred to Occupational therapy after hospitalization , dementia and repeated falls; -Resident presented with impaired cognition, right sided weakness, decreased participation in self-care and functional mobility; -Required skilled Occupational Therapy to assess safety and independence with self-care and functional tasks of choice in order to enhance the resident's quality of life by improving ability to facilitate increased participation with functional daily activities; -Due to documented physical impairment and associated functional deficits, the resident was at risk for further decline in function and increased dependency upon caregivers. Review of the resident's Physical Therapy Evaluation and Plan of Treatment, dated 1/8/25, showed the following: -Diagnoses of stroke and muscle weakness; -Therapeutic exercises; -Neuromuscular re-education; -Gait training therapy; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Referred to Physical Therapy due to new onset of decrease in transfers and decrease in strength; -Will benefit from skilled therapy to progress with strength and mobility to return to prior level of function and reduce need for assistance; -Increase range of motion and strength, increase functional activity tolerance and evaluate need for assistive device in order to enhance the resident's quality of life by improving ability to facilitate increased functional mobility throughout the facility; -At Risk for falls and further decline in function and immobility. Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's vital signs on 1/8/25, 1/9/25 or 1/10/25. Review of the resident's Nurses Note, dated 1/10/25 at 4:26 P.M., showed staff documented the heart monitor box was found with the transmitter at the nurses desk behind some papers. Staff attached the transmitter to the resident's wheelchair. Review of the resident's POS, dated 1/10/25, showed check for the heart monitor on the resident and check transmitter attached to the wheelchair. Change the heart monitor and transmitter to a new one on 1/14/25. Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's vital signs on 1/11/25, 1/12/25, 1/13/25 or 1/14/25. Review of the resident's POS, dated 1/14/25, showed place Zio heart monitor, keep transmitter within ten feet of the resident. Take the heart monitor off on 1/28/25. Review of the resident's Nurses Note, dated 1/14/25 at 12:25 P.M., showed staff documented the new heart monitor did not arrive to replace the original heart monitor. Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's vital signs on 1/15/25 or 1/16/25. Review of the resident's Nurses Note, dated 1/16/25 at 8:10 A.M., showed staff documented the cardiology hospital nurse was notified the new heart monitor was not received. Cardiology hospital staff said the new monitor was sent to the resident's home address. Family notified and will bring in the hew heart monitor. Review of the resident's POS, dated 1/17/25, showed check heart monitor daily, remove on 1/28/25. Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's vital signs on 1/17/25 or 1/18/25. Review of the resident's Nurses Note, dated 1/19/25, showed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 12:41 P.M. staff documented around breakfast time the cardiology physician's staff requested the nurse press on the heart monitor to obtain a reading. At 11:00 A.M. the cardiology physician's staff instructed the facility to send the resident to the emergency room due to abnormal readings obtained from the heart monitor. Staff transferred the resident to the emergency room by ambulance. Vital signs at the time of transfer were blood pressure 102/64, heart rate 62 beats per minute, respirations 18 breaths per minute, temperature 98.2 degrees, oxygen saturation 98 percent; -At 8:46 P.M. the resident was admitted to the hospital with bradycardia (abnormal slow heart rate). Review of the resident's Hospital Discharge Physician Orders, dated 1/20/25, showed the following: -Diagnoses of heart pause lasting seven seconds per cardiac monitor, recent stroke, bradycardia; -Zio heart monitor patch remained in place; -Check and record weights; -Check and record vital signs. Review of the resident's Nurses Note, dated 1/20/25 at 5:29 P.M., showed the resident returned to the facility. Alert and responded verbally to questions. Blood pressure 130/90, heart rate 96 beats per minute, respirations 18 breaths per minute, temperature 98.7 degrees, oxygen saturation 98 percent. Review of the resident's medical record showed no documentation staff completed a clinical assessment on 1/20/25 or updated the resident's care plan regarding the recent hospitalization for bradycardia and heart pause or the presence of a heart monitor. Observation of the resident on 1/22/25 showed the following: -At 10:05 A.M. the resident sat in a wheelchair, a heart monitor was noted attached to the resident's left chest wall just below the collar bone. Four, square foam dressings, dated 1/19/25, covered both the resident's inside and outside ankle areas; -At 4:45 P.M. the resident sat in a wheelchair, the square foam dressings dated 1/19/25 remained covering the resident's inside and outside ankle areas. Observation on 1/23/25 at 10:00 A.M. showed RN A removed the foam dressings from both of the resident's ankle areas. The skin was intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/25 at 2:40 P.M. Certified Occupational Therapy Assistant (COTA) J said the resident had an acute stroke and returned from the hospital on 12/31/24. Physician orders for therapy services was received with evaluation and treatment provided until discharge back to the hospital on 1/19/25. The resident should continue therapy following discharge from the hospital on 1/20/25. He/She was not aware of any continuation of the therapy services. The resident would benefit from continued therapy services. The charge nurse or nursing administration obtained the discharge physician orders and communicated with therapy either by a written form or verbal notification. Therapy had no documentation to indicate when therapy services should resume for the resident. Therapy services discharged the resident on 1/19/25 due to the hospitalization . The last occupational therapy session was 1/15/25, the last physical therapy session was 1/17/25 and the last speech therapy session was 1/17/25. Observation on 1/23/25 at 8:30 A.M. showed the resident sat in a wheelchair, the square foam dressing dated 1/19/25 remained covering the resident's inside and outside ankle areas. During an interview on 1/23/25 at 9:50 A.M. Registered Nurse (RN) A said the following: -The charge nurse was responsible to complete a head-to-toe assessment and document the findings in the medical record on admission and readmission. Staff did not assess the resident following the two hospitalization s and readmissions on 12/31/24 and 1/20/25. The electronic medical record system triggered the assessments required at the time of admission and readmission. Staff had not completed the nursing admission assessment and had not documented a head-to-toe assessment, including skin condition following either re-admission as required; -The resident's heart monitor was not implemented as ordered on 12/31/24. Staff lost the heart monitor transmitter and had to get a new transmitter. After the new transmitter was obtained and put into place, the resident ended up in the hospital with bradycardia; -Staff should have assessed the resident's skin and removed the 1/19/25 foam dressings from the resident's ankles. Staff did not know if the resident had a wound under the dressings or not. There was no documented skin assessments in the resident's medical record since the resident's re-admission on 12/31/24. During an interview on 1/23/25 at 1:45 P.M. the MDS coordinator said the following: -The charge nurse was responsible for obtaining orders and completing admission assessments at the time of a resident's admission or readmission; -He/She was responsible for updating the resident's Care Plan. The resident's care plans should be up to date and reflect the resident 's current status; -He/She was not aware therapy services were not resumed following the 1/20/25 hospital discharge. Therapy services should have resumed. The physician should be notified of the resident's return to the facility and orders reviewed including therapy services; -Staff did not place the resident's heart monitor on correctly and the resident went two weeks without the monitor working correctly; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Charge nurses should utilize the admission check list to make sure all assessments, orders and procedures were implemented following admission or readmission. Currently, the charge nurses were not completing the check list as intended and there was no process to ensure the admission process was completed accurately. During an interview on 1/23/25 at 2:30 P.M. Licensed Practical Nurse (LPN) C said the charge nurse was responsible for completing a resident's admission or readmission. Currently there was no check or balance to ensure accuracy. During an interview on 1/23/25 at 9:00 P.M. LPN I said he/she was the charge nurse on 12/31/24 evening/night shift. He/She did not know the resident had a heart monitor and did not see the heart monitor attached to the resident's chest. The resident was COVID-19 positive and in isolation. He/She did not complete an admission assessment. He/She should have completed a head-to-toe assessment on his/her shift and documented the assessment in the resident's medical record. During an interview on 1/24/25 at 11:45 A.M. the Director of Nursing (DON) said the following: -The charge nurse should complete the admission or readmission process and assess the resident on admission. The admission check list should be completed to ensure accuracy of the admission and all assessments were completed timely. The assessments and check list were not done 99 percent of the time and admission assessments were not completed. Staff were not completing a head-to-toe assessment on admission or readmission; -The resident did not currently have therapy following the 1/20/25 readmission. The charge nurse should have contacted the physician and reviewed the hospital discharge orders and obtained orders for continued therapy following the resident's stroke; -Staff did not implement the resident's heart monitor correctly. The DON was not working at the facility on 12/31/24 and she did not know the circumstances. Staff should review the hospital admission orders and implement the orders on facility admission. The charge nurse should contact the primary care physician and review the hospital discharge orders; -The care plan should be updated with any new changes to the resident's care following hospitalization or a change in condition. During an interview on 1/24/25 at 11:15 A.M. the Administrator said the following: -On admission or readmission, the electronic medical record triggered all the assessments staff should complete and all the assessments should be completed timely. The charge nurse should complete a head-to-toe assessment and document the findings in the medical record including skin condition; -Staff should follow the physician orders and ensure medical devices were attached and functioning. Staff should have assessed the resident's cardiac status and should have monitored the resident's vital signs. Staff should have ensured the resident's therapy services resumed and contacted the primary care physician regarding continuation of the therapy and any new orders or changes following hospitalization ; -Care Plans should be up to date and reflect the residents' current status. (continued on next page)

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	265638	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Homes, Tri-County	601 North Galloway Road Vandalia, MO 63382

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO242963 MO244306

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35615 Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to meet the needs of two residents (Resident #2 and #8) in a review of nine residents when staff failed to provide incontinence care timely and maintain good personal hygiene and failed to ensure resident clinical assessments were completed and documented for Resident #2. The facility failed to provide sufficient staff on the memory care unit to ensure supervision of Resident #8. The facility also and failed to consistently have Certified Nurse Assistant (CNA) staff as identified in the facility assessment. The facility census was 54. Review of the facility policy Staffing, Sufficient and Competent Nursing, dated 8/2022 showed the following: -The facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment; -Licensed nurses and certified nurse assistants are available 24 hours a day, seven days a week to provide competent resident care services including assuring resident safety, attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident, assessing, evaluating, planning and implementing resident care plans, and responding to resident needs; -Licensed nurses are required to supervise nurse assistants and are scheduled in such a way that permits adequate time to do so; -Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment; -Factors considered in determining appropriate staffing ratios and skills include an evaluation of the disease, conditions, physical or cognitive limitations of the resident population and acuity. 1 Review of the facility Assessment Tool, revised 8/5/24, showed the following: -Use of the facility assessment will demonstrate a good faith effort by the facility to evaluate necessary resources to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies; -Based on our resident population and their needs for care and support, the facility had made a good faith effort and approach to ensure sufficient staff to meet the needs of the resident at any given time; -Average daily census was 55 residents; -Average 20 residents with behavioral health needs; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nursing services hours per day listed by shift (day and night); -Registered Nurse eight hours per day; -Licensed Practical Nurse (LPN) 24 hours per day shift and 24 hours per night shift; -Certified Nurse Assistant (CNA) 72 hours per day shift and 60 hours per night shift; -Certified Medication Technician (CMT) 24 hours per day shift. Review of the facility December 2024 daily nursing assignment sheets showed the following CNA hours documented as worked per day shift (6:00 A.M. to 6:00 P.M.) and night shift (6:00 P.M. to 6:00 A.M.): -On 12/1/24 day shift 52 hours and night shift 36 hours, 20 CNA hours less on day shift and 24 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/3/24 day shift 37 hours, 23 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/4/24 day shift 39 hours, 33 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/5/24 day shift 35 hours, 37 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/6/24 day shift 67 hours and night shift 42 hours, five CNA hours less on day shift and 18 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/7/24 day shift 48 hours, 24 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/9/24 day shift 64 hours and night shift 32 hours, eight CNA hours less on day shift and 28 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/10/24 day shift 47 hours and night shift 51 hours, 25 CNA hours less on day shift and six CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/11/24 day shift 52 hours, 20 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/13/24 night shift 44 hours, 16 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/14/24 day shift 55 hours and night shift 51 hours, 17 CNA hours less on day shift and nine CNA hours less on night shift than indicated as needed on the facility assessment; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/15/24 day shift 64 hours, 18 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/16/24 day shift 60 hours, 12 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/17/24 night shift 39 hours, 21 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/18/24 day shift 29 hours, 43 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/19/24 day shift 32 hours, 40 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/20/24 day shift 52 hours and night shift 34 hours, 20 CNA hours less on day shift and 26 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/21/24 day shift 58 hours, 24 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/23/24 day shift 48 hours and night shift 32 hours, 24 CNA hours less on day shift and 28 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/24/24 day shift 63 hours, nine CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/25/24 day shift 43 hours, 29 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/26/24 day shift 66 hours and night shift 48 hours, 16 CNA hours less on day shift and 12 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/27/24 day shift 52 hours and night shift 48 hours, 20 CNA hours less on day shift and 12 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/28/24 day shift 36 hours, 35 CNA hours less on day shift than indicated as needed on the facility assessment; -On 12/29/24 day shift 60 hours and night shift 48 hours, 12 CNA hours less on day shift and 12 CNA hours less on night shift than indicated as needed on the facility assessment; -On 12/31/24 day shift 44 hours and night shift 44 hours, 28 CNA hours less on day shift and 16 CNA hours less on night shift than indicated as needed on the facility assessment. Review of the facility January 2025 daily nursing assignment sheets showed the following CNA hours scheduled per day shift and night shift: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 1/1/25 day shift 58 hours, 14 CNA hours less on day shift than indicated as needed on the facility assessment; -On 1/2/25 day shift 56 hours and night shift 36 hours, 16 CNA hours less on day shift and 24 CNA hours less on night shift than indicated as needed on the facility assessment; -On 1/3/25 day shift 60 hours, 12 CNA hours less on day shift than indicated as needed on the facility assessment; -On 1/5/25 day shift 48 hours and night shift 24 hours, 24 CNA hours less on day shift and 36 CNA hours less on night shift than indicated as needed on the facility assessment; -On 1/6/25 day shift 40 hours and night shift 36 hours, 32 CNA hours less on day shift and 24 CNA hours less on night shift than indicated as needed on the facility assessment; -On 1/7/25 day shift 42 hours, 30 CNA hours less on day shift than indicated as needed on the facility assessment; -On 1/10/25 day shift 45 hours, 27 CNA hours less on day shift than indicated as needed on the facility assessment; -On 1/11/25 day shift 60 hours and night shift 42 hours, 12 CNA hours less on day shift and 18 CNA hours less on night shift than indicated as needed on the facility assessment; -On 1/12/25 day shift 60 hours and night shift 36 hours, 12 CNA hours less on day shift and 24 CNA hours less on night shift than indicated as needed on the facility assessment; -On 1/13/25 day shift 60 hours, 12 CNA hours less on day shift than indicated as needed on the facility assessment; -On 1/14/25 day shift 60 hours, 12 CNA hours less on day shift than indicated as needed on the facility assessment; -On 1/16/25 day shift 48 hours and night shift 42 hours, 24 CNA hours less on day shift and 18 CNA hours less on night shift than indicated as needed on the facility assessment; -On 1/17/25 night shift 24 hours, 36 CNA hours less on night shift than indicated as needed on the facility assessment; -On 1/18/25 night shift 48 hours, 12 CNA hours less on night shift than indicated as needed on the facility assessment. 2. Review of Resident #2's admission Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 9/27/24, showed the following: -Severely impaired cognition; -Frequently incontinent of urine; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Always incontinent of bowel; -Required substantial/maximum staff assistance (helper does more than half the effort) with toileting, dressing lower body and personal hygiene; -Dependent on staff for transfers to and from the toilet. Review of the resident's Care Plan, dated 10/20/24, showed the following: -Diagnoses of dementia, anxiety, urinary incontinence, abnormal gait and mobility, unsteadiness on feet, kidney disease, stroke and urinary tract infection; -Impaired physical mobility and risk for self-care deficit. Staff should determine the level of assistance needed, provide assistance with Activities of Daily Living (ADL) as needed, determine residents ability to transfer, educate resident on exercise and safe transfer techniques, encourage resident to increase activity as indicated, evaluate skin for areas of redness, evaluate functional abilities; -ADL self-care performance deficit related to stroke. Staff should provide assistance with ADLs, transfers, dressing and personal hygiene and total assistance with toileting. Review of the resident's Nurses Note, dated 12/29/24, showed staff documented the following: -At 12:48 P.M. the resident was not acting right. The resident sat in the wheelchair with head tilted back, no response to verbal stimuli and slight response to sternal rub (act of forcefully rubbing the sternum) Blood pressure 186/116 (normal 120/80), heart rate 128 (normal 60-80) beats per minute and bounding, respirations 16 (normal 12-18) breaths per minute and slow. Covid-19 (an infectious disease caused by severe acute respiratory syndrome Coronavirus 2(SARS-CoV-2) test was positive. Staff called the ambulance and transferred the resident to the emergency room for evaluation and treatment; -At 4:20 P.M. the resident was admitted to the hospital with acute CVA (cardiovascular accident or stroke). Review of the resident's Hospital Discharge Physician Orders, dated 12/31/24, showed the following: -Hospital admission diagnosis of acute stroke; -Physical therapy, occupational therapy and speech therapy evaluation and treat; -Check weights and record; -Check vital signs and record; -COVID-19 precautions; -Follow up with cardiology physician in 30 days related to Zio heart monitor (a heart monitor patch applied to the skin that records the heart rhythm for up to two weeks). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Nurses Note, dated 12/31/24 at 6:33 P.M., showed staff documented the resident returned to the facility by medical transport. The resident was on isolation precautions due to positive COVID-19 status. Review of the resident's medical record showed no documentation staff completed an admission clinical assessment or assessed the resident's vital signs (blood pressure, heart rate, respirations, temperature and oxygen saturation level) on 12/31/24. Review of the resident's medical record showed no updated and current MDS assessment since the admission MDS assessment completed on 9/27/24. Review of the resident's vital signs record dated 1/1/25 showed staff documented the resident's heart rate was 91 beats per minute. Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's vital signs other than heart rate (blood pressure, respirations, temperature, oxygen saturation level) on 1/1/25. Review of the resident's Physician Order Sheet (POS), dated 1/2/25, showed the following: -Admit to the facility, the resident needed continuous care due to inability to live independently and the need for 24-hour assistance, observation and planning; -Vital signs and weigh monthly. Review of the resident's medical record dated 1/2/25 showed staff documented heart rate 83 beats per minute. No documentation staff completed a clinical assessment or updated the resident's care plan regarding recent hospitalization for stroke and presence of a heart monitor or assessed the resident vital signs other than heart rate. Review of the resident's Nurses' Note, dated 1/3/25, showed staff documented the following: -At 1:21 A.M. the resident was readmitted and was positive for COVID-19. The resident was isolated in his/her room and monitored for any worsening of symptoms; -At 12:05 P.M. the resident remained COVID-19 positive and in isolation. The resident was up in the wheelchair in room for meals, no complaints noted. Vital signs within normal limits, medications administered. Review of the resident's medical record dated 1/3/25 showed staff documented heart rate 77 beats per minute and oxygen saturation level of 94 percent (normal greater than 92 percent). No documentation staff completed a clinical assessment or assessed the resident vital signs other than heart rate and oxygen saturation level. Review of the resident's Nurses' Note, dated 1/4/25, showed staff documented the following: -At 1:47 A.M. the resident continued isolation due to positive COVID-19. No cough noted and no adverse reactions; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 5:18 P.M. the resident continued isolation due to positive COVID-19. No cough noted. The resident ate well for meals while staff set up food and offered limited assistance. Review of the resident's medical record dated 1/4/25 showed staff documented blood pressure was 144/86, heart rate was 79 beats per minute, respirations 20 breaths per minute, and temperature was 98.7 degrees (normal 98.6 degrees).and oxygen saturation level of 94 percent (normal greater than 92 percent). No documentation staff completed a clinical assessment or assessed the resident's oxygen saturation level. Review of the resident's medical record showed no documentation staff completed a clinical assessment or assessed the resident's vital signs from 1/5/25 through 1/18/25. Review of the resident's Nurses Note, dated 1/19/25, showed the following: -At 12:41 P.M. staff documented around breakfast time the cardiology physician's staff requested the nurse press on the heart monitor to obtain a reading. At 11:00 A.M. the cardiology physician's staff instructed the facility to send the resident to the emergency room due to abnormal readings obtained from the heart monitor. Staff transferred the resident to the emergency room by ambulance. Vital signs at the time of transfer were blood pressure 102/64, heart rate 62 beats per minute, respirations 18 breaths per minute, temperature 98.2 degrees, oxygen saturation 98 percent; -At 8:46 P.M. the resident was admitted to the hospital with bradycardia (abnormal slow heart rate). Review of the resident's Hospital Discharge Physician Orders, dated 1/20/25, showed the following: -Diagnoses of heart pause lasting seven seconds per cardiac monitor, recent stroke, bradycardia; -Zio heart monitor patch remained in place; -Check and record weights; -Check and record vital signs. Review of the resident's Nurses' Note, dated 1/20/25 at 5:29 P.M., showed the resident returned to the facility, alert and responded verbally to questions. Blood pressure 130/90, heart rate 96 beats per minute, respirations 18 breaths per minute, temperature 98.7 degrees, oxygen saturation 98 percent. Review of the resident's medical record dated 1/20/25 showed no documentation staff completed a clinical assessment or updated the resident's care plan regarding the recent hospitalization for bradycardia and heart pause or the present of the a heart monitor and no updated MDS assessment since the admission MDS assessment completed on 9/27/24. Observation on 1/22/25 showed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 10:05 A.M. the resident sat in a wheelchair, a heart monitor was noted attached to the resident's left chest wall just below the collar bone. Four square foam dressings dated 1/19/25 covered the resident's inside and outside ankle areas. A strong urine odor was noted coming from the resident; -At 11:00 A.M. the resident remained in the wheelchair with no change in position. A strong urine odor was noted coming from the resident; -At 11:45 A.M. Certified Nurse Assistant (CNA) B pushed the resident's wheelchair to the dining room for lunch. During an interview on 1/22/25 at 11:15 A.M. Licensed Practical Nurse (LPN) K said he/she was a charge nurse. The facility needed additional CNA staff especially for the East side (200 hall) and memory care unit. Two CNA staff were not enough for the East Hall, the residents required a lot of assistance with care, and many required mechanical lift transfers. During an interview on 1/22/25 at 11:46 A.M. CNA B said he/she toileted the resident and changed the resident's clothing before lunch. The resident was soiled and wet. The East Hall (200 hall) had many two person transfers and the residents required staff assistance to meet care needs. The East Hall needed additional CNA staff. Observation on 1/23/25 showed the following: -At 8:30 A.M. the resident sat in a wheelchair in his/her room, dressed in black pants and gray shirt. The square foam dressing dated 1/19/25 remained covering the resident's inside and outside ankle areas; -At 9:50 A.M. the resident sat in a wheelchair in his/her room, dressed in the same black pants and gray shirt; -From 11:30 A.M. through 12:45 P.M. the resident sat in a wheelchair in the dining room eating lunch, dressed in the same black pants and gray shirt. A strong urine odor was noted coming from the resident. CNA G said the resident was last toileted at about 9:00 A.M.; -At 12:45 P.M. staff pushed the resident in his/her wheelchair from the dining room to his/her room and parked the resident's wheelchair facing the television and did not offer to assist the resident with toileting or check the resident for incontinence. The resident had a strong urine and feces odor. During an interview on 1/23/25 at 12:48 A.M. the resident said staff got him/her up about 9:00 A.M. Staff had not taken him/her to the toilet or changed his/her incontinence brief since 9:00 A.M. The resident needed to go to the bathroom and change his/her soiled incontinence brief. Observation 1/23/25 at 1:00 P.M. showed the following: -CNA H and Nurse Assistant (NA) E transferred the resident to the toilet and removed the resident's urine and feces saturated incontinence brief. Feces was noted on the inside of the resident's pants; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA H repeatedly wiped the resident's buttocks and perineal area removing feces stuck to the resident's skin from the resident's buttock and perineal areas. CNA H said the feces had been there awhile as it was dried and was hard to clean. During an interview on 1/23/25 at 1:15 P.M. NA E said he/she worked the resident's hall and last toileted and changed the resident at 9:00 A.M. The East Hall needed three CNA staff to provide adequate care for the residents. The East Hall had multiple residents who required two-person total assistance with mechanical lift transfers and total care including showers and incontinence care. Staff was not able to keep the residents clean and dry. During an interview on 1/23/25 at 1:20 P.M. CNA H said staff should check the resident every two hours at least and change the resident if the resident was incontinent. Staff should not let the resident sit in feces and urine. The East Hall (Resident #2's hall) needed additional staff. The East Hall was usually staffed with two CNAs on the day shift, and they were not able to provide the resident cares, showers and two person transfers to meet the resident needs. Residents were left soiled and wet for extended periods of time and were not toileted as frequently as they should be. Review of the East Hall resident roster on 1/23/25 at 1:30 P.M., with LPN C and CNA H, showed 12 of the 19 residents who lived on the East Hall required a two-person mechanical lift transfer. During an interview on 1/23/25 at 1:45 P.M. the MDS Coordinator said the following: -He/She was responsible for completing the resident's MDS assessments. He/She should have completed a significant change MDS assessment for Resident #2 following the 12/31/24 hospital discharge and updated the resident's Care Plan at that time. He/She should also have updated the resident's care plan following the 1/20/25 hospital discharge. The resident's assessments and Care Plan updates were behind. He/She was currently working on December MDS assessments and was about three weeks behind. He/She was usually pulled to the floor to work as a charge nurse two days per week and could not keep up with the MDSs and Care Plan updates. 3. Review of the resident roster provided 1/22/25 showed eight residents resided on the memory care unit. Observation of the Memory Care Unit (a locked unit located adjacent to the 200 hall and the 200 hall nurses' desk) on 1/22/25 at 11:05 A.M. showed eight residents and one staff member. Multiple residents sat in wheelchairs at the core area table with the television on, drink cups sat on the table. CNA D came out of a resident's room. During an interview on 1/22/25 at 11:10 A.M. CNA D said he/she was the only staff assigned to the memory care unit. The memory care unit was usually staffed with one CNA. The CNA provided the residents' meals, incontinence care and toileting needs, showers, safety monitoring and activities. While the CNA provided resident cares and showers there was no staff to monitor the other residents. If behaviors occurred while he/she was providing a resident's care there was no other staff to ensure safety. (continued on next page)

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Baptist Homes, Tri-County	601 North Galloway Road Vandalia, MO 63382

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the Memory Care Unit on 1/22/25 at 2:30 P.M., showed Resident #8 yelled for help multiple times from the bathroom. No staff was in the resident's room or bathroom. The resident shuffled out of the bathroom with pants down to his/her ankles, a shirt on and no shoes or socks. The resident shuffled towards his/her bed yelling for help. CNA B rushed into the resident's room, pulled up the resident's pants and sat the resident in a chair. CNA B returned to the core dining area where three residents sat in wheelchairs. Resident #9 hollered and attempted to stand. Two other residents' wheelchair wheels were tangled and the residents attempted to reach for the table and each other. CNA B attempted to redirect the residents. During an interview on 1/22/25 at 2:40 P.M. CNA B said he/she did not know what was wrong with Resident #9, the resident was new to the memory care unit. One staff member on the memory care unit was not enough to meet the residents' needs and provide supervision. During an interview on 1/23/25 at 8:55 A.M. Certified Medication Technician (CMT) F said the memory care unit staff provided all the residents care needs and supervision. One staff member was not enough to provide cares, showers and supervision. 4. During an interview on 1/23/25 at 9:50 A.M. Registered Nurse (RN) A said the following: -The charge nurse was responsible to complete a head-to-toe clinical assessment and document the findings in the medical record on admission and readmission. Staff did not assess Resident #2 following the two hospitalization s and readmissions and did not complete and document clinical assessments and assess vital signs as clinically indicated. The electronic medical record system triggered the assessments required at the time of admission and readmission. Staff had not completed the nursing admission assessment and had not documented a head-to-toe assessment including skin condition following either re-admission as required. The charge nurses filled in the CNA staff and floated to the memory care unit to meet the resident care needs. Additional CNA staff on the East Hall and memory care unit would allow the charge nurses additional time for clinical assessments and follow ups; -The charge nurse should have assessed the resident's skin and removed the 1/19/25 foam dressings from the resident's ankles. Staff did not know if the resident had a wound under the dressings or not. There was no documented skin assessments in the resident's medical record since the resident's re-admission on 12/31/24. The charge nurse should complete a weekly skin assessment for every resident and document the findings. -The facility did not have enough staff to meet the resident's needs. Additional CNA staff was needed on the East Hall and the memory care unit. One CNA staff was not enough on the memory care unit to meet the resident's needs and provide supervision. Staff from the East Hall had to float over to the memory care unit and left the East Hall understaffed. The East Hall had heavy care and many residents required two person transfer assistance with mechanical lifts. During an interview on 1/23/25 at 10:30 A.M. the Human Resources Director said he/she made the nursing schedule. The facility did not have enough staff currently to meet the residents' needs. The facility was trying to hire additional staff. During an interview on 1/24/25 at 11:45 A.M. the Director of Nursing said the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff should keep residents clean and dry, check and change residents every two hours and should not leave residents wet and soiled for extended periods of time; -The charge nurse should complete the admission or readmission process and assess the resident on admission. The admission check list should be completed to ensure accuracy of the admission and all assessments were completed timely. The assessments and check list were not done 99 percent of the time and admission assessments were not completed. Staff were not completing a head-to-toe assessment on admission or readmission and not completing and documenting daily clinical assessments as should be done. The charge nurses were helping the CNA staff complete cares and floating to the memory care unit when needed preventing the charge nurses from completing the assessments and clinical care; -The Care Plan should be updated with any new changes to the resident's care following hospitalization or a change in condition. -It was difficult to get all things done as they should be. The facility needed additional staff. The memory care unit needed two CNA staff on each shift to provide the residents' needs and safety, currently one CNA staff was generally scheduled for the memory care unit and a staff member from the East Hall floated to the memory care unit at times. The CMT or chare nurse should not be pulled to the memory care unit unless it was emergent. The East Hall needed an additional CNA staff on the day shift to meet the residents' needs. The MDS coordinator was pulled to work the floor and was three weeks behind on MDS assessments and Care Plan updates. The MDS coordinator should not be pulled to the floor to work as a charge nurse. During an interview on 1/24/25 at 11:15 A.M. the Administrator said the following: -On admission or readmission, the electronic medical record triggered all the assessments staff should complete and all the assessments should be completed timely. The charge nurse should complete a head-to-toe assessment and document the findings in the medical record including skin condition. He did not know why charge nurses were not completing the assessments; -Staff should follow the physician orders and ensure medical devices were attached and functioning. Staff should have assessed Resident #2's cardiac status and should have monitored the resident's vital signs. -Care Plans should be up to date and reflect the residents' current status; -Staff should check incontinent residents every one hour and provide incontinence care as needed. Staff should make sure residents were clean and dry and not left soiled; -The facility assessment reflected the current staffing needs of the facility. The facility was not meeting the staffing needs; -The MDS coordinator was pulled to fill in as a charge nurse and MDSs and Care Plans were not up to date; -Currently the staff was pulled from one area to help another. Two CNA staff assigned to the memory care unit would help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO244306 MO246518

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35615 Based on observation, interview and record review, the facility failed to ensure infection control measures were followed when staff failed to utilize proper handwashing and gloving techniques while providing wound care and failed to utilize Enhanced Barrier Precautions (EBP, an infection control intervention that utilizes personal protective equipment to reduce the spread of multi drug-resistant organisms) during wound care for two residents (Resident #3 and #7) in a review of nine residents. The facility census was 54. Review of the facility policy, Handwashing/Hand hygiene, dated 8/2019, showed the following: -The facility considered hand hygiene the primary means to prevent the spread of infections; -All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections; -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors; -Wash hands with soap and water when hands are visibly soiled and after contact with a resident with infectious diarrhea; -Use an alcohol based hand rub or alternatively soap and water before and after direct contact with resident, before performing any non-surgical invasive procedure, before donning gloves, before handling used dressings, contaminated equipment, after contact with objects such as medical equipment in the immediate vicinity of the resident, after removing gloves; -Hand hygiene is the final step after removing and disposing of personal protective equipment; -The use of glove does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections; -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 the equipment or environment of a resident who is on contact precautions; -Perform hand hygiene before applying non-sterile gloves. Review of the facility policy, Personal Protective Equipment - gloves, dated 7/2009, showed the following: -Gloves must be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed; -Wash your hands after removing gloves. Review of the facility policy, Enhanced Barrier Precautions, dated 8/2022, showed the following: -Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents; -EBPs are used as an infection prevention and control intervention to reduce the spread of MDROs; -EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply; -Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room); -Personal protective equipment (PPE) is changed before caring for another resident; -Face protection may be sued if there is also a risk of splash or spray; -Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care (any skin opening requiring a dressing); -EBPs are indicated when contact precautions do not otherwise apply for residents with wounds and/or indwelling medical devices regardless of MDRO colonization; -EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk; -Staff are trained prior to caring for residents on EBP; -Signs are posted in the door or wall outside the resident room indicating the type of precautions and personal protective equipment (PPE) required; -PPE is available outside of the resident rooms. 1. Review of Resident #3's Care Plan, dated 10/12/24, showed the following: -Diagnoses of mild cognitive impairment, chronic pain, stroke, muscle weakness, unsteadiness on feet, difficulty in walking; -Impaired mobility. Staff should assist the resident in performing movements, ensure proper positioning and evaluate skin for areas of redness; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Risk for impaired skin integrity. Staff should monitor for moisture, provide skin care as needed; -Activities of Daily Living (ADLs) self-care performance deficit related to activity intolerance and chronic pain. Staff should provide total assistance with ADLs. Review of the resident's annual Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 10/16/24, showed the following: -Severe cognitive impairment; -Dependent on staff for toileting, showers, transfers, bed mobility, wheelchair mobility; -Always incontinent of bladder; -Frequently incontinent of bowel; -No pressure ulcers (a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and /or friction). Review of the resident's Physician Order Sheet (POS) showed the following: -On 1/13/25 cleanse back of left foot/ankle Stage II pressure ulcer (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister) pressure ulcer with wound cleanser (spray solution used to cleanse an open wound) and apply Medihoney (ointment applied to wound base to promote healing) daily and as needed, apply non-adherent pad and wrap with gauze until healed; -On 1/22/25 cleanse skin tears to left wrist/lower thumb area with wound cleanser, apply steri-strips (thin strips of tape used to secure torn skin), monitor every shift until healed; -On 1/22/25 cleanse skin tears to right forearm with wound cleanser, apply steri-strips, monitor every shift until healed. Apply gauze and wrap if needed. Observation on 1/22/25 at 1:10 P.M. showed the following: -No EBP signage on the resident's room door and no PPE stocked on the resident's room door; -Licensed Practical Nurse (LPN) C cleaned his/her hands with hand sanitizer, applied gloves and without applying EBP, removed the soiled wound dressings from the back of the resident's left lower leg below the knee. LPN C, without washing hands or changing gloves, removed a soiled wound dressing from the resident's left heel area; -LPN C, without washing hands or changing gloves, cleansed both open wounds with wound cleanser and the same gauze pad using the exact same surface of the gauze pad on both wounds; -LPN C, without washing hands or changing gloves, applied Medi-honey on a clean gauze pad and placed the new dressing on the resident's left heel open wound and secured with gauze wrap; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN C said the left posterior upper calf wound had no wound care orders and left the moist open wound uncovered. LPN C applied the resident's pressure relieving boot directly over the left posterior upper calf open wound; -LPN C changed gloves and washed hands, obtained a stack of gauze pads and sprayed two skin tears on the resident's left arm with wound cleanser and wiped the open skin tears with the same surface of the same gauze pad; -LPN C did not apply a dressing over the skin tears. 2. Review of Resident #7's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Impaired mobility of both upper extremities and one lower extremity; -Dependent on staff for toileting, bathing, dressing upper and lower body, personal hygiene; -Dependent on staff for bed mobility, transfers, wheelchair mobility; -At risk for pressure ulcers and had one, unhealed stage II pressure ulcer. Review of the resident's Care Plan, dated 10/20/24, showed the following: -Diagnoses of stroke, contractures (immobility and stiffness of the joints preventing movement), paralysis of the left side, muscle weakness, open wound of the foot; -ADL self-care performance deficit related to impaired balance and paralysis of the left side. Staff should apply a brace to the resident's left leg when out of bed and elevate legs when in bed, assist and provide all ADLs as needed. The resident had contractures of the left arm and leg, provide skin care every shift to keep clean and prevent skin breakdown; -Impaired skin integrity. Staff should administer treatments as ordered, follow facility protocol for treatment of injury, keep skin clean and dry, monitor skin for changes, monitor and document location, size and treatment of skin injury; Review of the resident's POS, dated 1/15/25, showed cleanse left ball of foot wound and right heel wound with wound cleanser daily. Apply calcium alginate (wound dressing used to promote healing) cut to fit inside the wound. Cover with foam dressing daily until healed. Observation on 1/22/24 at 1:45 P.M. showed the following: -EBP signage hung on the resident's room door and PPE was stocked on the resident's room door; -LPN C washed his/her hands, applied a gown and gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN C removed a soiled wound dressing from the bottom of the resident's left foot. A quarter size amount of brownish drainage was noted on the soiled dressing. LPN C, without changing gloves or washing hands, touched the resident's bed controller and elevated the bed. LPN C changed gloves without washing his/her hands; -LPN C cut a quarter size piece of calcium alginate wound dressing and with the same soiled hands placed the calcium alginate on the base of the resident's left foot wound and covered with a foam dressing. LPN C removed the gloves and gown and washed his/her hands; -LPN C obtained additional dressing supplies from the wound cart in the hallway and without applying EBP and without washing hands, applied gloves and removed a wound dressing from the resident's right foot. LPN C with the same soiled gloves, cleansed the open wound with wound cleanser and a gauze pad. LPN C changed gloves and without washing his/her hands applied a calcium alginate wound dressing in the base of the right foot wound and covered it with a foam dressing. 3. During an interview on 1/22/24 at 2:00 P.M. LPN C said he/she should have washed his/her hands and apply gloves before providing wound care and should use EBP for all wound care. He/She should change gloves and wash hands every time his/her hands were soiled, after removing soiled wound dressings and before cleansing the resident's wounds. He/She should use a clean gauze pad with each wound and not use the same soiled gauze pad on more than one wound. PPE was available on multiple resident doors, he/she should have followed the facility infection control procedures and EBP procedures. During an interview on 1/23/25 at 9:50 A.M. Registered Nurse (RN) A said he/she was the facility Infection Preventionist. Staff should utilize EBP when providing wound care and follow the facility infection control policy regarding handwashing and gloving. Staff should use clean technique during wound care for each wound individually and not use the same gauze pad to clean more than one wound. Staff should wash their hands before putting on gloves and wash hands between each glove change. During an interview on 1/23/25 at 4:00 P.M. the Director of Nursing said staff should follow the facility EBP policy and the instructions posted on the doors of resident rooms. All residents with an invasive device or wound care required EBP during care. Staff should provide wound care utilizing clean technique and prevent cross contamination. Staff should not use the same gauze pad to clean more than one wound and should not wear the same soiled gloves and provide wound care to more than one wound. During an interview on 1/24/25 at 11:15 A.M. the Administrator said staff should always follow the EBP when providing care, including wound care. Staff should follow the facility handwashing and gloving policy while providing wound care and personal care. MO244306