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	03/05/2026

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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(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, interview, and record review, the facility failed to ensure food service equipment/surfaces were appropriately cleaned under sanitary conditions in accordance with professional standards for food service safety. The facility census was 58.Review of the facility policy, Sanitization, revised November 2022, showed the following:-The food service area is maintained in a clean and sanitary manner;-All kitchens, kitchen areas and dining areas are kept clean;-All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. 1. Observations in the kitchen on 3/2/26 between 10:45 A.M. and 3:30 P.M., and on 3/3/26 between 8:30 A.M. and 3:40 A.M., showed the following:-A ceiling-mounted air unit, located above the coffee machine and clean cups, had a heavy buildup of oily substance, dust and debris on the bottom vent area;-A ceiling-mounted air vent, located between the clean coffee cup area and clean side of dishwasher area, had a moderate buildup of dust and debris;-A ceiling-mounted air vent, located above the dishwasher, had a heavy buildup of dust and debris;-A ceiling-mounted air unit, located above a preparation table, food processor, and blender, had a moderate buildup of oily substance, dust and debris on the bottom vent area;-A ceiling-mounted air unit in the preparation sink area, had a heavy buildup of oily substance, dust and debris on the bottom vent area;-A ceiling-mounted air unit to the left side of the K-fire extinguisher, had a heavy buildup of oily substance, dust and debris on the bottom vent area;-The sprinkler system drain piping, located next to the coffee maker, had a moderate buildup of dust and debris;-The electrical box, located behind the coffee maker, had a heavy buildup of oily substance, dust and debris;-The wall-mounted exhaust fan, located between the tea dispenser and coffee maker, had a moderate buildup of dust and debris;-The steamer oven, positioned between the white upright freezer and meat slicer, had a moderate buildup of oily substance, dust and debris on the top surface;-The top surface of the white upright freezer had a moderate buildup of dust and debris;-Two wall-mounted fire suppression control boxes and piping systems, located above a food preparation table containing clean Styrofoam plates, foil wrap box and floor mixer, had a moderate to heavy buildup of oily substance, dust and debris;-The front and the left side of the deep fryer had a heavy buildup of oily substance, brown and yellow crusted material, and liquid runs;-The front and sides of the four-burner stovetop/oven had a moderate buildup of an oily substance, food runs and debris;-The top and sides of the four-door upright oven had a moderate to heavy buildup of oily substance, dust and debris;-The top of the two-door upright refrigerator had a moderate to heavy buildup of dust and debris. During an interview on 3/2/26 at 2:20 P.M., Dietary Aide I said dietary staff did not have any specific daily, weekly, or cleaning duties. Everyone was supposed to clean as they go. If staff are using something or an area, they should clean it. Everyone should work as a team. A sheet was kept on the preparation table of things evening staff were to complete before the shift ended. Some examples of things to complete were sweeping and mopping the kitchen, wipe down the counters, change the steam table water, and sweet and mop both dining rooms. During an interview on 3/3/26 at 10:30 A.M., the Dietary Manager said the following:-She was not aware of the condition of the identified areas. She expected the identified areas to be in a clean and sanitized condition;-Staff cleaned these areas at least once a month; -When staff used an item, they should (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	clean it or take care of the situation;-Staff completed general cleaning daily and between meals;-When staff noticed unclean items, they should clean the item and notify her. -The dietary department had no set daily, weekly and monthly cleaning lists or logs.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund petty cash account and by not reconciling each month. The facility managed funds for 37 residents. The facility census was 58. Review of the facility's monthly bank statements and resident trust fund records for December 2025, January 2026 and February 2026, showed no documentation the facility reconciled the monthly bank statements with the month ending resident trust fund records, to include outstanding checks and petty cash, to ensure an accurate accounting of all resident finds. During an interview on 3/5/26 at 1:00 P.M., the Business Office Manager (BOM), said the following: -She was responsible for managing the resident trust fund account and the resident petty cash; -The resident petty cash account was maintained from money withdrawn monthly from the resident trust account; -She typically kept $400.00 from the resident trust account in the resident petty cash account; -She issued a voucher to each resident who withdrew cash from the resident petty cash account when the withdrawal occurred and filed these monthly; -She counted the resident petty cash each month, then withdrew from the resident trust account what was needed to ensure there was $400.00 in the resident petty cash account for the next month; -She did not maintain a written record of the monthly reconciliation of the resident petty cash but would just figure it in my head and use some sticky notes to determine how much she would need to withdraw from the resident trust account to put in the resident petty cash account. During an interview on 03/16/26 at 12:35 P.M., the administrator said he would expect the BOM to reconcile the residents' petty cash fund to the resident trust fund statements monthly.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review the facility failed to ensure residents received mail on regular mail delivery days as identified by the United States Postal Service (USPS), including Saturdays. The facility census was 58. Review of the facility's undated admission Packet showed a Patient [NAME] of Rights (page 33), which included the right of each resident to send and receive unopened mail. Review of the facility policy, Mail and Electronic Communication, revised May 2017, showed the following: -Residents are allowed to communicate privately with individuals of their choice and may send and receive personal mail, email, and other electronic forms of communication confidentially; -Mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries). 1. During a group interview on 03/04/26 at 10:00 A.M., Resident #3, Resident #32, and Resident #39 said residents did not receive mail on Saturdays. 2. During an interview on 03/05/26 at 2:50 P.M., Licensed Practical Nurse (LPN) A said the following: -Occasionally the (United States Postal Service) mail carrier delivered mail on Saturdays, but facility staff did not pass out the mail to the residents and were never told to do so; -He/She placed any delivered mail on Saturday in the medication room and the mail, which could include resident mail, stayed there until Monday. During an interview on 03/05/26 at 3:00 P.M., the Assistant Director of Nurses (ADON) said the following: -About a year ago the facility stopped the post office from delivering mail to the facility because the mail carrier would leave the mail at the nurses' station unattended; -The mail was no longer delivered to the facility on Saturdays, it was held at the post office and no facility staff went to the post office to check for mail and deliver it. During an interview on 03/05/26 at 5:47 P.M., the Director of Nurses (DON) said the following: -Per facility request, the post office held residents' mail on Saturdays because the facility did not have administrative staff available to pick it up and deliver it to the residents; -The Saturday mail was picked up on Monday and delivered to the residents at that time. During an interview on 03/05/26 at 3:14 P.M., the administrator said he would expect that mail should come to the facility on Saturdays, and that he had no idea that mail was not being delivered to the residents on Saturdays.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to ensure residents knew how to file a grievance, where grievance forms were located, or how to complete a grievance form. The facility census was 58. Review of the facility's undated admission packet, Resident Rights, showed the following: -Each resident shall be encouraged and assisted throughout his/her stay to exercise their rights as a resident and citizen and may voice grievances and recommend changes in policies and services to the facility staff or outside representatives of his/her choice; -A staff person shall be designated to receive grievances and residents may voice their complaints and recommendations to staff designee, an ombudsman, or any person outside the facility; -Residents shall be informed of and provided with a viable format for recommending changes in policy and services. Review of the facility policy, Grievances/Complaint, Filing, revised April 2017, showed the following: -Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman); -The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative; -All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response;-Upon admission, residents are provided with written information on how to file a grievance or complaint. A copy of our grievance/complaint procedure is posted on the resident bulletin board;-Grievances and/or complaints may be submitted orally or in writing, and may be filed anonymously;-The administrator has delegated the responsibility of grievance and/or complaint investigation to the grievance officer who is the Social Services Designees through the grievance form or in person; -Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within five (5) working days of receiving the grievance and/or complaint; -The grievance officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law; -The grievance officer, administrator and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated;-The administrator will review the findings with grievance officer to determine what corrective actions, if any, need to be taken; -The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems; -The administrator, or his or her designee, will make such reports orally within 5 working days of the filing of the grievance or complaint with the facility'-A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office; -If the grievance was filed anonymously, the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance(s) and report the findings. The grievance officer will reiterate to the resident that it is against facility policy and federal regulations to discriminate or sanction a resident who has filed or verbalized a complaint against the facility, and that his or her rights to be free of discrimination or reprisal will be protected; -The results of all grievances files, investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision; -This policy will be provided to the resident or the resident's representative upon request;The policy did not address where forms were located or available to file a written grievance. 1. During the resident council group interview on 03/04/26 at 10:00 A.M., Resident #3, Resident #32, and Resident #39 said the following: -They did not know how to file a grievance, and they were not sure if there were (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grievance forms available to residents; -If they had a problem or a complaint, they would just tell the nursing staff;-Resident #3 said if he/she had a concern, he/she would just verbally have to tell the Social Service Designee (SSD);-They do not receive a quick response from staff regarding their concerns. -They do not receive in writing a rationale for the response of their verbal grievance. 2. Observation on 03/05/26 at 11:21 A.M. of the resident bulletin board, just inside the facility entrance showed no evidence of a copy of the facility grievance/complaint procedure posted and no forms were available for anyone to complete a written grievance. 3. During an interview on 3/03/26 at 12:22 P.M., the Activity Director (AD) said the following:-She takes concerns from resident council to the Administrator and the individual departments to be addressed;-She does not fill out a grievance form and was not aware of any specific grievance form. During an interview on 03/12/26 at 2:01 P.M., the SSD said the following:-She has been the facility's Grievance Official since August 2024;-She has had no training regarding how to handle a grievance or that there should be a paper grievance form or log of grievances;-She does not have a grievance log;-The AD reports concerns from resident council and takes those concerns to the individual departments to be addressed. During an interview on 03/05/26 at 3:00 P.M. the Assistant Director of Nurses (ADON) said the following: -She was not aware if there were grievance forms available to the residents in the facility, unless the SSD had them; -When made aware of resident concerns from the resident council meetings, she followed up with the residents and reported the resolutions to the group. During an interview on 03/05/26 at 5:47 P.M., the Director of Nurses (DON) said the following: -The facility did not have grievance forms that she was aware of;-The SSD would be responsible for keeping and handling grievances, a paper trail would be the SSD responsibility as well. During an interview on 03/04/26 at 3:05 P.M. and 03/16/26 at 12:35 P.M. the Administrator said the SSD was responsible for grievances. The SSD does not have a grievance log. Prior to the survey, there was no process in place for residents to file grievances anonymously.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide services that met professional standards of practice for two residents (Resident #10 and #56), in a review of 19 sampled residents. The facility failed to administer bolus tube feedings according to physician orders and per manufacturer guidelines and failed to properly administer medications via a feeding tube for Resident #10. The facility failed to obtain a lithium level (a laboratory test to monitor the concentration of lithium in the blood - a mood stabilizing medication to treat mental illness) for Resident #56. The facility census was 58. Review of the facility policy, Enteral Feedings (nutrition delivered directly into the gastrointestinal tract) - Safety Precautions, revised November 2018, showed the following:-All personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities;-All personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities;-The facility will remain current in and follow accepted best practices in enteral nutrition;-Use only sterile or purified water for formula reconstitution, medication dilution and flushed before and after medication administration;-Administer only full-strength formulas, do not add water or dilute liquid or reconstituted enteral nutrition formulas;-Check enteral tube placement every shift and prior to feeding or administration of medication;-Check gastric residual volume as ordered;-Elevated the head of the bed at least 30 degrees during tube feeding and at least one hour after feeding. Review of the [NAME] Nutrition Osmolite 1.5 Cal manufacturer guide, updated 2025, showed the following:-Follow physician's instructions;-Additional fluid requirements should be met by giving water. Review of the American Society of Parenteral and Enteral Nutrition (ASPEN) Safe Practices of Enteral Nutrition Therapy, dated January 2017, showed the following:-The administration of enteral therapy is a step in the process with significant potential for error;-Feeding tubes are prone to clogging for a variety of reasons, including insufficient water flushes and incorrect medication preparation and administration;-Flush feeding tubes immediately before and after feeding with intermittent feedings;-Flush feeding tubes before and after medication administration and follow appropriate medication administration practices;-In adult patient, flush feeding tubes with a minimum volume of 30 milliliters (mL) of water before and after intermittent feedings;-Administer each medication separately;-Avoid mixing different medications intended for administration through the feeding tube given the risks for incompatibilities and altered therapeutic drug responses;-Provide appropriate tube irrigation around the timing of drug administration: -Prior to administering medication, flush the tube with at least 15 mL of water; -Administer the medication using a clean enteral syringe; -Flush the tube again with at least 15 mL of water; -Repeat with each medication; -Flush the tube one final time with at least 15 mL of water. 1. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/23/26, showed the following:-Had a feeding tube;-Received 51 percent or more of his/her total calories through tube feeding;-Received 501 milliliters (mL) or more of his/her average fluid intake per day by tube feeding. Review of the resident's Care Plan, updated 3/3/26, showed the following:-Nutritional status general NPO (nothing by mouth) tube feeding;-Feedings will be given as ordered;-Give fluids as ordered via G-tube;-The resident had dehydration or potential fluid deficit related to poor intake and G-tube use;-The resident requires tube feeding related to dysphagia (swallowing disorder);-The resident needed the head of his/her bed elevated 45 degrees during and 30 minutes after tube feeding;-Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold if greater than 200 mL aspirate. Review of the resident's Physician Orders, dated 3/4/26, showed the following:-Nothing by mouth (NPO) diet;-May crush medications: tablets may be crushed, capsules may be opened, unless contraindicated, to be administered individually with water and administered via G-tube due to NPO status, every day and night shift;-Osmolite 1.5 Cal oral liquid (nutritional (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplement), give 120 mL via G-tube two times a day for nutritional supplement with 125 mL water flush before and after bolus feeding. Observation on 3/4/26 at 10:26 A.M. showed the following:-The MDS/Care Plan Coordinator filled a water graduate with 150 mL of tap water. (He/She did not use sterile or purified water as directed by facility policy); -He/She drew up 60 mL of Osmolite 1.5 Cal into a syringe and added it to the graduate of water;-He/She drew up another 60 mL of Osmolite 1.5 Cal into the syringe and added it to the graduate of water; -The MDS/Care Plan Coordinator did not check the positioning of the resident's G-tube;-He/She flushed the tube with 20 mL of the water and Osmolite 1.5 Cal mixture;-He/She removed the plunger from the syringe and administered the remainder of the water and Osmolite 1.5 Cal mixture (230 ml) via gravity. (He/She diluted the Osmolite formula with water and did not follow facility policy to not dilute the formula);-He/She flushed the tube with 30 mL of water after the gravity feeding was completed.(The MDS/Care Plan Coordinator administered 180 ml of water, not 250 ml of water as ordered.) During an interview on 3/4/26 at 10:45 A.M., the MDS/Care Plan Coordinator said the following:-The order was for 120 mL of Osmolite and a total of 125 mL water flush;-He/She mixed the water and Osmolite to help thin the Osmolite and prevent clogging;-He/She flushed a small amount of the mixture first to ensure the G-tube was not clogged;-He/She flushed with water after the feeding to ensure no mixture was left in the tube to decrease the risk of clogging. Observation on 3/5/26 at 10:05 A.M. showed the following:-Licensed Practical Nurse (LPN) A entered the resident's room to administer the resident's scheduled Osmolite 1.5 Cal;-He/She poured the Osmolite 1.5 Cal formula into a disposable cup. (The cup did not contain any measurements to identify the amount of formula in the cup); -He/She filled a graduate with approximately 200 mL of tap water. (He/She did not use sterile or purified water as directed by facility policy);-He/She checked the placement of the G-tube by pushing approximately 10 mL of air and water through the G-tube and listened to the abdomen by the G-tube;-He/She administered a 60 mL water flush via gravity. (He/She did not flush the G-tube with 125 ml of water as ordered); -He/She added approximately 50 mL of the Osmolite 1.5 Cal to the syringe when the water flush had approximately 10 mL left, filling the 60 mL syringe;-He/She added approximately 40 mL of Osmolite 1.5 Cal to the syringe when the feeding was at approximately 20 mL, filling the 60 mL syringe;-He/She added more water, approximately 30 mL, to the syringe when the feeding was at approximately 30 mL, filling the 60 mL syringe;-He/She added the remaining Osmolite 1.5 Cal, approximately 30 mL, when the feeding was at approximately 20 mL, not quite filling the 60 mL syringe;-He/She added 60 mL of water to the syringe after the feeding was complete; -The graduate of water still contained approximately 50 mL;(LPN A flushed the G-tube with approximately 150 ml of water. He/She did not follow orders to flush with 125 mL of water before and after the bolus feeding.) During an interview on 3/5/26 at 10:47 A.M., LPN A said the following:-The resident should receive a total of 175 mL of water with each bolus feed; -He/She used the disposable cup to measure the Osmolite 1.5 Cal formula because the cup was 120 mL; -He/She always flushed before giving the bolus feeding to ensure there wasn't any blockage of the G-tube;-He/She added a little water to the Osmolite 1.5 Cal to help the feeding go a little quicker and to lessen the chance of clogging;-When administering medications via G-tube, he/she crushed and mixed all the medications together with water;-When administering crushed medications, he/she flushed the G-tube first, then administered the crushed medication solution, added water as needed to clear the syringe, and finished with a final flush. During an interview on 03/05/26 at 5:47 P.M., the Director of Nursing (DON) said staff were to follow physician orders for administering medications and tube feedings. During an interview on 03/18/26 at 3:01 P.M., the resident's physician said the following:-Staff should always check placement of the feeding tube prior to administering a feeding; -If the physician order specified to give a specific amount of water with a flush, staff should follow the order;-It is important for staff to flush the G-tube with the ordered amount of water as the hydration status of the resident requiring tube feedings was very important;-Staff should be administer medications per G-tube individually unless the facility had it approved/confirmed by the pharmacy then received his approval and an order to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	combine the medications for administration through the tube. 2. Review of the undated facility policy, Obtaining Lab Orders, showed the facility will accept and act on lab orders signed or electronically authenticated by physicians (MD/DO), physician assistants, nurse practitioners, or clinical nurse specialists acting within Missouri scope of practice. Review of Resident #56's diagnosis list showed the resident had diagnosis of multiple sclerosis (a nervous system disease that affects the brain and spinal cord), major depressive disorder, stroke and dysphagia (difficulty swallowing). Review of the resident's November 2025 physician's orders showed the following:-Lithium level every three months;-Lithium Carbonate 150 mg, give two capsules by mouth once daily;-Lithium Carbonate 150 mg, give four capsules once daily. Review of the resident's EHR, dated 11/03/25, showed staff obtained the resident's lithium level as ordered and it resulted 0.5 mmol/L (below normal range). (Review showed no documentation staff notified the resident's physician of the resident's lab results Review of the resident's December 2025 physician's orders showed the following:-Lithium level every three months;-Lithium Carbonate 150 mg, give two capsules by mouth once daily;-Lithium Carbonate 150 mg, give four capsules once daily. Review of the resident's January 2026 physician's orders showed the following:-Lithium level every three months;-Lithium Carbonate 150 mg, give two capsules by mouth once daily;-Lithium Carbonate 150 mg, give four capsules once daily. Review of the resident's February 2026 physician's orders showed the following:-Lithium level every three months;-Lithium Carbonate 150 mg, give two capsules by mouth once daily (end 02/19/26);-Lithium Carbonate 150 mg, give four capsules once daily (end 02/19/26). Review of the resident's EHR, dated 02/19/26, showed the resident admitted to hospice. Review of the resident's progress notes, dated 02/20/26 at 2:11 P.M., showed the following:-The resident admitted last night to hospice;-Hospice nurse here and gave new orders to start Lithium Carbonate 300 mg twice daily per tube. Review of the resident's February 2026 physician's orders showed the following:-Lithium level every three months;-Lithium Carbonate 300 mg one capsule per tube twice daily (start 02/20/26). Review of the resident's February 2026 EHR showed no documentation staff obtained a lithium level due since the last level was drawn 11/03/25. Review of the resident's March 2026 EHR showed no documentation a lithium level was obtained through the review date of 03/03/26. 3. During an interview on 03/04/26 at 11:30 A.M., the DON said the resident's lithium level should have been obtained in February but was not. The nurse who took the order for the lithium level was new and did not fill out a lab requisition for the level to be drawn. During an interview on 03/18/26 at 3:01 P.M., the resident's physician said the following:-He would expect staff to obtain labs as ordered or notify him if there were issues or a delay and why;-It is important to obtain lithium levels; -He may not adjust the lithium dosage, but he won't know to adjust the dosage if the lithium levels are not monitored;-If he placed the order to monitor lithium levels, it was not a suggestion, it must be done.

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	265638	A. Building B. Wing	03/05/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent (%), when staff made two medications errors out of a total of 30 opportunities for error, resulting in a 6.67% error rate. Staff did not ensure Resident #2 received the full dose of ordered insulin and did not administer the ordered dose of Tramadol (a narcotic pain medication) to Resident #44. The facility census was 58. Review of the facility policy, Administering Medications, revised April 2019, showed the following:-Medications are administered in a safe and timely manner, and as prescribed;-The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Review of the facility policy, Insulin Pens, showed the following:-Priming an insulin pen (an air shot) is essential before each injection to remove air bubbles from the cartridge and needle, ensuring the resident receive the full, accurate dose of insulin. It also confirms the pen is working correctly, checks for blockages in the needle, and prevents under-dosing;-Release air out of the insulin pen, turn the dial to 2 units, with the needle pointing up, push the plunger of the pen all the way in, until you see a drop of insulin;-Inject the insulin by slowly pushing in the plunger all the way, leave the needle in and slowly count to five, this will keep insulin from leaking out of the injection site. 1. Review of Resident #2's Physician Orders, dated March 2026, showed an order for NovoLog FlexPen subcutaneous solution pen-injector (a rapid-acting, injectable insulin used to manage high blood sugar)100 unit/milliliter (mL), inject as per sliding scale: if 150-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-500=10 units, subcutaneously with meals. Review of the NovoLog FlexPen manufacturer instructions for use, revised February 2023, showed the following:-Before each injection small amounts of air may collect in the cartridge during normal use, to avoid injections air and to ensure proper dosing:-Turn the dose selector to select 2 units;-Hold your NovoLog FlexPen with the needle pointing up, tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; -Keep the needle pointing upwards, press the push-button all the way in and the dose selector returns to 0;-A drop of insulin should appear at the needle tip;-NovoLog can be injected under the skin (subcutaneously);-Insert the needle into your skin, inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer;-Keep the needle in the skin for at least six seconds and keep the push-button pressed all the way in until the needle has been pulled out from the skin, this will make sure that the full dose has been given. Observation on 3/4/26 at 10:54 A.M. showed the following:-Certified Medication Technician (CMT) H checked the resident's blood glucose;-The resident's blood glucose was 218;-CMT H applied a needle into the insulin pen;-He/She did not prime the insulin pen; -He/She dialed up 4 units of NovoLog insulin in the pen as ordered;-He/She injected the insulin into the resident's right upper arm and held for three seconds;-He/She removed the needle from the resident's arm. During an interview on 3/4/26 at 11:04 A.M., CMT H said the following:-He/She had never primed an insulin pen before he/she administered insulin to residents; -He/She usually held the insulin pen against a resident's skin for a couple seconds after he/she administered the insulin; -He/She had not received any additional education or training regarding insulin administration, including priming the insulin pen needle and holding the needle in the skin when administering. 2. Review of Resident #44's Physician Order Sheet (POS), dated March 2026, showed an order for Tramadol 50 milligrams (mg), two tablets daily at bedtime. Observation on 03/03/26 at 8:32 P.M. showed the following: -CMT M pulled the prefilled packet of Tramadol 50 mg tabs from the narcotic lock box on the medication cart and pushed one tablet into a medication cup to administer to the resident; -CMT M returned the prefilled packet of Tramadol 50 mg into the narcotic lock box on the medication cart; -CMT M documented he/she administered Tramadol 50 mg, two tablets at bedtime, on the resident's electronic medical record (EMR); -CMT M took the medication to the resident and prepared to give the resident one tablet of Tramadol 50 mg.-The survey agency asked CMT M to (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verify the medication with the resident's medication order. During an interview on 93/03/26 at 8:45 P.M., CMT M said he/she did not read the resident's medication order correctly when he/she started to administer one Tramadol 50 mg tablet to the resident. 3. During an interview on 3/5/26 at 5:47 P.M., the Director of Nursing (DON) said the following:-She expected staff to follow physician's orders and to give medications as ordered;-When administering insulin, she expected staff to follow the manufacturer recommendations, including priming the insulin pen needle and holding pressure for the appropriate amount of time. During an interview on 03/16/26 at 12:35 P.M., the Administrator said he expected staff to follow physician's orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure stock medications (a limited supply of non-prescription, over-the-counter [OTC] or emergency drugs stored on-site for immediate use) were labeled with the date they were opened and removed and/or replaced when expired. This had the potential to affect all residents. The facility census was 58. Review of the facility policy, Storage of Medications, last revised November 2020, showed the following: -The facility stores all drugs and biologicals (specialized medications used to treat specific conditions) in a safe, secure, and orderly manner; -Discontinued, outdated, or deteriorated drugs or biologicals are destroyed; -OTC medication will be available for use until the manufacturer expiration date unless there are signs of deterioration; -OTC will have an open date label when the container is opened; -OTCs that have been opened will be stored from a separate area from those that are unopened. 1. Observation on 03/05/26 at 9:45 A.M. of the 200-hall medication cart showed the following: -A previously opened stock bottle of acetaminophen (a non-narcotic pain reliever) 500 milligram (mg) tablets in the first drawer with no open date; -A previously opened stock bottle of ibuprofen (a non-narcotic pain reliever) 200 mg tablets in the first drawer with no open date; -A previously opened stock bottle of cetirizine (an OTC allergy medication) 10 mg tablets in the first drawer with no open date; -A previously opened stock bottle of vitamin B1 (a supplement) 250 mg tablets in the first drawer with no open date. Observation on 03/05/26 at 10:20 A.M. of the facility's east medication room showed the following: -A previously opened bottle of Refresh Tears (an OTC eye drop used for dry eyes) sat on the countertop, did not have an open date and had expired 07/2025; -A previously opened stock bottle of Azo Urinary Pain Relief tabs sat in the overhead cabinet above the countertop, did not have an open date and had expired on 12/2025; -A previously opened stock bottle of Benadryl (an allergy medication) 25 mg sat in the overhead cabinet above the countertop, did not have an open date and expired on 02/2026; -A previously opened 16-ounce (oz) stock bottle of Geri-Tussin (a non-narcotic cough suppressant syrup) sat in the cabinet below the countertop, opened on 05/13/25, and expired on 11/2025; -A previously opened card of stock Compazine Suppositories (a rectal suppository used for nausea and vomiting) 10 mg was in the refrigerator, did not have an open date and expired on 01/2026. 3. During an interview on 03/05/26 at 10:30 A.M., Certified Medication Technician (CMT) H said the following:-All stock medications should be labeled when they are opened, and any expired medications should be removed and/or replaced; -He/She was not sure who the Refresh Tears eye drops belonged to or how long the bottle had been on the counter, it should have been labeled with an open date and resident's name;-All the medications in the east medication room were in-use medications and not medications that were to be destroyed. During an interview on 03/05/26 at 5:47 P.M., the Director of Nurses (DON) said the following: -The facility used to have a system in place for checking medications for labeling and expiration dates and this was done every Monday and Tuesday by the charge nurse; -This had not been done.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff served food that was palatable and served at a safe and appetizing temperature. The facility census was 58.Review of the facility policy, Food Preparation and Services, revised November 2022, showed the following:-Proper hot and cold temperatures are maintained during food distribution and service; -Food and nutrition services staff are to monitor the temperatures of foods held in the steam tables throughout the meal service. 1. Review of the Resident Council Minutes, dated 01/08/26, showed the following:-The vegetables were cooked too long;-The food on the west hall was cold. Staff explained to the residents the plate warmer broke, and they were working on getting a new one. During an interview on 03/02/26 at 2:33 P.M., Resident #3 said the following:-Saturday night there was some kind of casserole on his/her plate that was unrecognizable. It didn't look appetizing, and he/she couldn't eat it;-The food was horrid and didn't taste good;-The meat was tough and hard to chew;-The residents complained to the facility about the food and nothing was done. The food was still bad. During an interview on 03/02/26 at 1:25 P.M., Resident #32 said the following: -He/She ate all meals in the dining room; -The food was often served cold;-He/She reported this during resident council meetings, but nothing was ever done. During a resident council meeting on 03/04/26 at 10:00 A.M., several residents in attendance reported the food was often served cold. 2. Review of lunch menu for 03/03/26 showed the lunch meal included meatloaf, mashed potatoes, and mixed vegetables. Observation on 3/3/26 at 11:17 A.M., showed staff took serving temperatures of the following food items at the steam serving table prior to beginning the meal service: -Meatloaf, 190 degrees Fahrenheit;-Mashed potatoes, 185 degrees Fahrenheit;-Mixed vegetables, 190 degrees Fahrenheit. Observation on 3/3/26 at 11:19 A.M., showed the following:-Dietary staff began serving the lunch meal from the steam table;-Staff placed the prepared plates on trays in the electric temperature-controlled, insulated food cart;-The temperature in the food cart was 153 degrees Fahrenheit. Observation on 3/3/26 at 11:41 A.M. showed dietary staff prepared the final lunch plate (test tray), placed it in the food cart, and transported the cart to the west dining room. Observation on 3/3/26 at 11:45 A.M., showed dietary staff arrived at the west dining room with the food cart. Staff plugged in the cart. The temperature in the cart was 137 degrees Fahrenheit. Observation on 3/3/26 at 11:47 A.M., showed staff began serving lunch trays to the residents in the west dining room. Staff served the last tray in the dining room at 11:58 A.M. The temperature in the cart was 116 degrees Fahrenheit. Observation on 3/3/26 at 12:04 P.M., showed the temperature in the cart was 130 degrees Fahrenheit. Staff unplugged the cart and began serving room trays beginning with room [ROOM NUMBER] and ending with room [ROOM NUMBER] (eight trays). Observation of the test tray on 3/3/26 at 12:18 P.M., after staff served the last resident, showed the following: -The meatloaf was cool to the taste, and the temperature was 111.7 degrees Fahrenheit;-The mashed potatoes and gravy were cool to the taste, and the temperature was 107.4 degrees Fahrenheit;-The mixed vegetables were cool to the taste, and the temperature was 112.2 degrees Fahrenheit. 3. Observation on 03/04/26 at 12:15 P.M. of a test tray at the lunch meal showed the following:-The turkey crunch was very salty, and the turkey pieces were hard to chew;-The stuffing was dry and had minimal flavor;-The chocolate cake was dry. During an interview on 03/04/26 at 12:02 P.M., Resident #37 said the following:-He/She didn't eat all his/her lunch;-The turkey was too hard to chew, so he/she didn't eat it. During an interview on 03/02/26 at 2:29 P.M. and 03/04/26 at 12:08 P.M., Resident #41 said the following:-The food was awful;-The turkey crunch tasted awful, so he/she only ate a bite of it;-The food was bland and had no taste;-The meat was too tough to chew. 4. During an interview on 3/4/26 at 3:40 P.M., the Dietary Manager said the following:-She was not aware the food temperatures for the 03/03/26 lunch meal was below 120 degrees Fahrenheit;-The cooks took the temperature of the food before moving the food items to the steam table and before meal service began; -The residents (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	occasionally reported the food was cool and had concerns with the texture of foods;-The dietary department received a heated hall cart a few weeks ago, and she had only received a couple concerns with the food temperatures since implementing the new cart;-Dietary staff should prepare meals by methods that conserve nutritive value, flavor, and appearance. However, if a resident had a concern during a meal service with the temperature or texture of the food, staff was to prepare a new plate if the resident wanted one;-She expected the meals to be palatable and served at safe and appetizing temperatures. Hot foods should be served hot, and cold foods should be cold.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview and record review, the facility failed to ensure staff offered suitable, nourishing evening snacks for two residents (Resident #01 and Resident #03), in a review of 18 sampled residents, and for two additional residents, (Resident #32 and Resident #39), who participated in a group interview and reported bedtime snacks were not offered on a routine basis at the facility. The facility census was 58. Review of the facility policy Frequency of Meals, dated July 2017, showed the following:-Nourishing snacks will be available for residents who need or desire additional food between meals;-Evening snacks will be offered routinely to all residents;-Residents will also be offered nourishing snacks if the time span between the evening meal and the next day's breakfast excessed 14 hours. Nourishing snacks are items from the basic food groups, offered either separately or with each other;-A substantial evening meal is an offering of two or more menu items at one time, one of which includes a high-quality protein such as meat, fish, eggs or cheese. The meal represents no less than 20% of the day's total nutritional requirements;-The facility will choose the snacks that are served at bedtime. However, the dietitian and food services manager will solicit input from the residents and/or the resident council. 1.During a resident council meeting on 03/04/26 at 10:04 A.M., four of nine residents (Resident #01, Resident #03, Resident #32, and Resident #39) said staff did not pass bedtime snacks and they would take a bedtime snack if offered. 2. Review of Resident #01's annual Minimum Data Set (MDS), a federally mandated assessment to be completed by facility staff, dated 12/19/25, showed the following: -He/She was cognitively intact; -He/She considered it very important to have snacks available between meals; -Diagnosis of diabetes mellitus (DM, a group of diseases that affect how the body uses blood sugar). 3. Review of Resident #03's annual MDS, completed by facility staff, dated 01/15/26, showed the following: -He/She was cognitively intact;-He/She considered it very important to have snacks available between meals; -Diagnosis of diabetes mellitus. 4. Review of Resident #32's annual MDS, completed by facility staff on 02/19/26, showed the following: -He/She was cognitively intact; -He/She considered it very important to have snacks available between meals. 5. Review of Resident #39's quarterly MDS, completed by facility staff on 02/02/26, showed the following: -He/She was cognitively intact; -He/She considered it very important to have snacks available between meals; -Diagnosis of diabetes mellitus. 6. Observation on 03/03/26 at 8:20 P.M., in the [NAME] Dining Room, showed the following:-Bags of chips and cookies on the counter;-Boxes of snack cakes in the cabinet;-Pudding cups and juices in the refrigerator. 7. During an interview on 03/03/26 at 8:20 P.M., Certified Nurse Aide (CNA) C said the following:-Staff pass bedtime snacks to residents only if the residents ask for a snack;-They have cookies, pudding, chips and drinks available if a resident wants a snack;-There were no fruit or nutritious snacks available. During an interview on 03/05/26 at 3:40 P.M., the Dietary Manager said the following:-Dietary staff prepare and leave a snack cart in the kitchen for nursing staff to have available for the residents' evening/bedtime snacks before leaving at 6:30 P.M. to 7:00 P.M.;-Available items are snack cakes, vanilla and chocolate pudding (sweetened and unsweetened), peanut butter and crackers and unsweetened apple sauce;-The kitchen is left unlocked, and nursing staff can go in and get the cart. The walk-in cooler and freezer are also unlocked;-Sandwich meats, cheeses and bread are available. Ice cream and gelato for thickened resident orders. Flavors include butter pecan, chocolate, and vanilla; -Approximately six months ago, sandwiches were made available for the cart. However, residents were not taking them, and the sandwiches were wasted and were discontinued. During an interview on 03/05/25 at 5:47 P.M., the Director of Nursing (DON) said the following:-She thought staff brought out a bedtime snack cart, but she did not know if staff offered bedtime snacks to all residents;-Ideally she wanted staff to offer bedtime snacks to all residents, and there should be something of some substance, not just sweets, available. During an interview on (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/16/26 at 12:35 P.M., the Administrator said the following:-He would expect staff to offer bedtime snacks to all residents;-Nutritious options should be available for bedtime snacks if desired. During an interview on 03/18/26 at 3:01 P.M., the Medical Director said he would expect staff to offer residents nutritious bedtime snacks, especially a diabetic resident, if awake, should be offered a snack.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) the Infection Preventionist attended QAPI meetings as required. The facility census was 58. Review of the facility policy, Quality Assurance and Performance Improvement (QAPI) Plan, dated 06/23/25, showed the following:-QAPI Committee Members:-Administrator;-Medical Director;-Director of Nursing;-Pharmacy Consultant;-Infection Preventionist (IP);-MDS Coordinator;-Social Services Director;-The QAPI Committee meets quarterly. 1. Review of the Quarterly QAPI Meeting Attendance, dated 04/29/25, showed documentation the IP was absent. Review of the Quarterly QAPI Meeting Attendance, dated 07/24/25, showed documentation the IP was absent. Review of the Quarterly QAPI Meeting Attendance, dated 10/27/25, showed documentation the IP was absent. The facility did not provide evidence of a fourth quarter QAPI meeting in 2025. 2. During an interview on 03/18/26 at 8:51 A.M., the IP said the following:-She works six shifts per month, all on the weekends;-She was a part of the QAPI team;-She does not attend the meetings in person because they are during the week;-She creates a three-month report of all infections, antibiotics, and culture results as well as any interventions, like training, that occurred during those three-months;-The Director of Nursing presents the report to the QAPI team. 3. During an interview on 03/05/26 at 5:47 P.M., the Director of Nursing said the IP has not attended the QAPI meetings. The IP sends information to the meeting for the committee to review. During an interview on 03/05/26 at 7:00 P.M. and 03/16/26 at 12:30 P.M. the Administrator said the IP had not attended the QAPI meetings. The IP was part-time and sends information to the meeting. Prior to the survey, he was not aware the IP was required to attend the QAPI meetings. He felt like the IP had always provided a comprehensive report. The facility did not have a fourth quarter QAPI meeting in 2025 due to a COVID-19 (an infectious disease caused by the SARS-CoV-2 virus) outbreak in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate infection control practices for six residents (Resident #59, #47, #1, #2, #9 and #36), in a review of 19 sampled residents, and for four additional residents (Residents #46, #60, #48 and #44). Facility staff failed to change gloves or perform appropriate hand hygiene during personal care and assistance with eating for Residents #59, #46, #47 and #60, failed to properly clean a multi-use glucometer (device used to obtain a blood sugar reading after obtaining a drop of blood from the resident that is then placed on a test strip and placed in the device), failed to maintain infection control when a barrier was not used during blood glucose checks for Residents #1, #2, #48 and #44, failed to maintain catheter bags and tubing to prevent infection for Resident #9, and failed to properly clean and store a nebulizer mask for Resident #36. The facility failed to develop written policies and procedures as required to outline the facility's infection prevention and control program to prevent the development and transmission of communicable diseases and infections and failed to maintain a system to consistently track infections to prevent transmission. The facility census was 58. Review of the facility policy, Handwashing/Hand Hygiene, revised August 2019, showed the following: -The facility considers 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; -Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies;-Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations:-When hands are visibly soiled, and:-Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:-Before and after direct contact with residents; -Before moving from a contaminated body site to a clean body site during resident care; -After contact with a resident's intact skin; -After contact with blood or bodily fluids; -After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; -After removing gloves; -Before and after eating or handling food; -Before and after assisting a resident with meals; -Hand hygiene is the final step after removing and disposing of personal protective equipment; -The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 1. Review of Resident #59's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff), dated 11/20/25, showed the following:-Dependent on staff for dressing, toileting hygiene and personal hygiene;-Always incontinent of bladder and bowel. Review of the resident's Care Plan, revised 12/01/25, showed the following:-The resident was totally dependent on one staff for repositioning, turning in bed and personal hygiene;-The resident has bladder incontinence related to impaired mobility and physical limitations;-The resident has bowel incontinence related to immobility;-Provide pericare after each incontinent episode. Observation on 3/3/26 at 7:27 P.M. showed the following:-Certified Nurse Assistant (CNA) C used alcohol-based hand rub (ABHR) and put on gloves;-CNA C transferred the resident from his/her Broda chair (specialized wheelchair) to bed;-CNA C removed the resident's pants; -The resident's incontinence brief was saturated with urine and feces;-CNA C performed front peri care and rolled the resident to his/her right side;-CNA C performed rectal peri care and removed the soiled incontinence brief from under the resident;-Without changing gloves or washing his/her hands, CNA C placed a clean incontinence brief under the resident's hips, rolled the resident back in forth in bed, fastened the clean incontinence brief, pulled the resident's gown down, and covered the resident with a blanket;-CNA C removed his/her gloves, and without performing hand hygiene, placed (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his/her hands under the resident's head, straightened the resident's pillow, picked up the bed control and lowered the resident's bed. 2. Review of Resident #46's quarterly MDS, dated [DATE], showed the following: -Dependent on staff for toileting; -Always incontinent of bladder and bowel. Observation on 03/04/26 at 1:10 P.M. showed the following: -The resident lay on his/her bed; -Nurse Aide (NA) D and CNA L wore gloves and stood on either side of the resident's bed and prepared to perform peri-care; -NA D and CNA L pulled down the resident's pants; -NA D and CNA L unfastened the resident's incontinence brief and pushed the urine-soiled incontinence brief down and in between the resident's upper thighs; -NA D and CNA L did not remove their gloves after touching the soiled incontinence brief; -CNA L cleaned the resident's perineum from front to back with disposable wipes;-CNA L did not remove his/her gloves; -CNA L rolled the resident to his/her left side by touching the resident's right shoulder and right hip with his/her soiled gloved hands; -NA D supported the resident on his/her left side by touching the resident's right shoulder and right hip; -CNA L cleaned the resident's rectal area with disposable wipes;-The resident was soiled with a small amount of feces; -CNA L removed his/her gloves, did not wash his/her hands or use a hand sanitizer, and donned new gloves; -Both CNA L and NA D repositioned the resident to his/her right side, and CNA L supported the resident by touching his/her left shoulder and left hip; -NA D pulled the wet incontinence brief from under the resident and placed it in the bag on the bed; -NA D cleaned feces from the resident's bottom with disposable wipes; -NA D did not remove his/her gloves, wash his/her hands, or use a hand sanitizer; -NA D placed a clean incontinence brief under the resident; -NA D and CNA L repositioned the resident onto his/her back; -NA D and CNA L pulled the clean incontinence brief up and around the resident, fastened it, and then pulled up the resident's pants; -CNA L removed his/her gloves but did not use hand sanitizer or wash his/her hands; -NA D, without removing his/her gloves, pulled up the resident's blankets and placed the resident's call light across the resident's lap; -NA D removed his/her gloves, gathered the trash bag, tied it shut, and left the room; -NA D did not use a hand sanitizer or wash his/her hands after removing his/her gloves. During an interview on 03/04/26 at 1:20 P.M., NA D said the following:-He/She should change gloves and wash hands or use ABHR if his/her gloves were soiled, after pericare and prior to touching clean items in the room;-He/She did not think his/her gloves were soiled when he/she changed the resident. During an interview on 03/05/26 at 5:57 P.M., the Director of Nursing (DON) said staff should change their gloves when they moved from a dirty area to a clean area when providing incontinence care. 3. Review of the facility policy, Glucometer Maintenance and Calibrating Glucometer, dated 7/6/25, showed the following:-To ensure that all glucometers are clean and disinfected prior to each use;-All staff who perform glucometer checks on our residents will follow the guidelines put forth in this policy to ensure that glucometers are calibrated and to prevent cross contamination from one resident to another;-Each glucometer is to be disinfected prior to and after each use, using an approved disinfectant;-Cleaning and disinfecting are to be completed by using a commercially available Environmental Protection Agency (EPA) registered disinfectant detergent or germicidal wipe;-Remove the wipe from the container and follow product label instructions to disinfect the glucometer. Review of the Arkray Technical Brief for Cleaning and Disinfecting the Assure Platinum Blood Glucose Monitoring System (BGMS), updated September 2024, showed the following;-To minimize the risk of transmitting bloodborne pathogens, the cleaning and disinfecting procedures should be performed as recommended in the instructions below;-The Assure Platinum BGMS may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed;-The meter should be cleaned and disinfected after use on each patient;-The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure;-The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens;-Option 1: -Obtain a commercially available EPA-registered disinfectant detergent or germicide wipe; -Carefully review the manufacturer's instructions; -Remove wipe from the container and squeeze out any excess liquid; -Clean and disinfect the meter following (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	step-by-step instructions in the reference manual;-Option 2: -Clean the outside of the blood glucose meter with a lint-free cloth dampened with soapy water or isopropyl alcohol (70-80%); -Disinfect the meter by diluting 1 milliliter (mL) of household bleach (5-6% sodium hypochlorite solution) in 9 mL water to achieve a 1:10 dilution; -Use a lint-free cloth dampened with the solution to thoroughly wipe down the meter. Review of [NAME] Germicidal Surface Wipes Brochure, revised March 2026, showed the following:-[NAME] disposable germicidal surface wipes are an ideal cleaning and disinfection solution for hard, non-porous surfaces;-Wipes: hospital and general disinfection or bactericidal. This product kills the following bacteria in two minutes on pre-cleaned hard, non-porous surfaces at room temperature when used as directed: Acinetobacter baumannii, Escherichia coli, Enterobacter aerogenes, carbapenem-resistant klebsiella pneumoniae, listeria monocytogenes, methicillin-resistant staphylococcus aureus, mycobacterium bovis, pseudomonas aeruginosa, salmonella enterica, serratia marcescens, staphylococcus aureus, and vancomycin-resistant enterococcus faecium;-Wipes: virucidal. This product kills the following viruses in two minutes on pre-cleaned hard, non-porous surfaces at room temperature when used as directed: SARS-related coronavirus, avian influenza A reassortant virus, rotavirus, hepatitis B virus (HBV), Hepatitis C virus (HCV), Herpes simplex II virus, human immunodeficiency virus (HIV), influenza A virus-H1N1, influenza A virus-strain A2/[NAME] kong, and rhinovirus;-This product kills HIV, HBV and HCV pre-cleaned hard, non-porous surfaces/objections previously soiled with blood/body fluids in health care or other setting in which there is an expected likelihood of soiling of hard, non-porous surfaces/objects with blood/body fluids, and in which the surfaces/objects can be associated with the potential for transmission of HIV, HBV and HCV;-Special instructions for cleaning against HIV, HBV, and HCV on surfaces/objects soiled with blood/body fluids: blood and other body fluids must be thoroughly cleaned from surfaces/objects before disinfection, allow hard, non-porous surfaces to remain wet for 2 minutes to kill HIV, HBV, and HCV. Review of the Centers for Disease Control and Prevention (CDC) website, showed the following:-Proper Protocol: For cleaning blood or other potentially infectious materials, the CDC recommend using an EPA-registered tuberculocidal disinfectant or a 1:10 to 1:100 dilution of bleach and water;-If you are dealing with blood in a professional or healthcare setting, it is recommended to use specialized germicidal wipes (such as Sani-Cloth) or a bleach solution rather than standard consumer disinfecting wipes. Review of the undated American Health Care Association, Tips for Meeting the Cleaning and Disinfection of Blood Glucose Meters Requirements in Skilled Nursing Facilities, showed the following: -Place barrier under blood glucose meter when in resident's room or placed on top of medication cart to avoid spread of microorganisms and contamination of surfaces and other equipment or supplies;-Tip: Place clean and dry paper towel(s) under blood glucose meter before placing on resident table or on top of medication cart. 4. Observation on 03/04/26 at 10:48 A.M. showed the following:-Certified Medication Technician (CMT) H obtained a blood sample from Resident #1's finger and collected a drop of blood onto a test strip in the glucometer (a portable medical device that measure the concentration of sugar in the blood) to check the resident's blood glucose level; -CMT H removed the test strip from the glucometer and placed the glucometer directly on the medication cart without a barrier;-CMT H did not clean or sanitize the glucometer and proceeded to Resident #2's room. Observation on 03/04/26 at 10:54 A.M. showed the following:-CMT H gathered blood glucose testing supplies and the glucometer he/she used to obtain Resident #1's blood glucose level and sat them on a barrier on Resident #2's lap. CMT H did not clean or sanitize the glucometer before he/she used it to check Resident #2's blood glucose level; -CMT H obtained a blood sample from Resident 2's finger. He/She collected a drop of blood onto a test strip in the glucometer to check the resident's blood glucose level;-He/She sat the glucometer directly onto the medication cart without a barrier.-CMT H did not clean or sanitize the glucometer and proceeded to Resident #48's room. During an interview on 03/04/26 at 11:04 A.M., CMT H said the following:-Each resident did not have their own glucometer; -He/She forgot to clean the glucometer between residents;-He/She typically cleaned the surface of the medication cart with the germicidal surface (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wipes after each resident;-He/She typically cleaned the glucometer quickly with germicidal surface wipes after every use and ensured the glucometer was dry before using it on the next resident;-He/She was not aware the glucometer needed to stay wet for two minutes, according to the wipe manufacturer directions. Observation on 03/04/26 at 11:13 A.M. showed the following:-CMT H retrieved the glucometer, he/she used to obtain Resident #2's blood glucose level, from the medication cart drawer and put it on a barrier on the medication cart. He/She did not clean or sanitize the glucometer prior to taking it into Resident #48's room;-He/She placed blood glucose testing supplies and the glucometer on a barrier on Resident #48's bedside table;-He/She obtained a blood sample from Resident #48's finger. He/She collected a drop of blood onto a test strip in the glucometer to check the resident's blood glucose level;-He/She sat the glucometer on the medication cart on the same barrier he/she used in the resident's room;-He/She wiped the glucometer with a germicidal surface wipe for approximately five seconds;-He/She folded the barrier in half (the bottom side that touched the resident's bedside table and the top of the medication cart now faced up) and sat the glucometer on the barrier. 5. Observation on 03/03/26 at 7:50 P.M. showed the following: -CMT M lay an Assure glucometer and bottle of lancets on top of the medication cart without placing a barrier under the equipment; -CMT M did not wash his/her hands or use a hand sanitizer before he/she donned gloves; -CMT M wiped the front and back of the glucometer with an 80% isopropyl alcohol pad; -CMT M obtained a blood sample from Resident #44's finger. He/She collected a drop of blood onto a test strip in the glucometer to check the resident's blood glucose level; -CMT M place the glucometer directly on top of the medication cart without a barrier and wiped the front and back of the glucometer with an 80% isopropyl alcohol pad;-CMT M lay the glucometer back on top of the medication cart without a barrier; -CMT M removed his/her gloves and did not wash or sanitize his/her hands;-CMT M did not use an Environmental Protection Agency (EPA) registered disinfectant detergent or germicidal wipe as instructed per the facility policy. During an interview on 03/03/26 at 8:55 P.M., CMT M said the following: -Residents did not have individual glucometers; -He/She always used prepackaged 80% isopropyl alcohol wipes to clean glucometers between each resident; -He/She was not sure if, once it was cleaned, the glucometer needed to dry for any specific length of time before staff could use it again; -He/She was not sure when he/she should use a disinfectant wipe;-He/She was not sure the glucose manufacturer indicated if 80% isopropyl alcohol wipes were appropriate to clean the glucometer. During an interview on 03/05/26 at 5:47 P.M., the DON said the following:-Staff should clean the glucometer between each resident; -She did not think it was appropriate for staff to only clean the glucometer with alcohol wipes; -Staff should clean the glucometer with the facility provided germicidal wipes, and the glucometer should remain wet for the required amount of time. During an interview on 3/18/26 at 8:51 A.M., the Infection Preventionist said the following:-Staff should clean glucometers prior to and after each use; -Staff should always clean the glucometer between residents; -Staff should clean the glucometer with the facility provided germicidal wipes;-An alcohol wipe would not be an acceptable way to clean the glucometer; -Staff should always place the glucometer on a clean barrier. 6. The facility did not provide a policy related to caring for a resident with a urinary catheter. Review of Resident #9's care plan, updated 12/24/25, showed the following:-He/She had a urinary catheter;-Monitor/record/report to physician for signs/symptoms of urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns;-Monitor for signs/symptoms of UTI. Review of the resident's physician's orders, dated 1/31/26, showed an order for Macrobid (an antibiotic) oral capsule 100 mg, give by mouth two times a day for culture and sensitivity (C&S) urine culture for five days. Observation on 03/04/26 at 1:31 P.M., showed the resident's urinary catheter bag hung under the wheelchair and dragged on the floor as Nurse Aide (NA) A pushed the resident in the wheelchair from the resident's room to the shower room, approximately 100 feet. Observations on 03/05/26 at 8:33 A.M., 9:52 A.M., and 10:58 A.M., showed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident asleep in his/her room in his/her wheelchair. The urinary catheter bag hung under the wheelchair and touched the floor. The urinary catheter bag and tubing contained urine. The floor under the catheter bag was sticky. Observation on 03/05/26 at 1:27 P.M. showed the resident sat in his/her wheelchair in his/her room. The catheter tubing was looped up and around the catheter bag hook under the wheelchair which prevented the urine in the tubing from draining into the catheter bag. The urine in the catheter tubing was dark yellow and had mild sediment. During an interview on 3/18/26 at 8:51 A.M., the Infection Preventionist said the following:-Catheter bags and tubing should never touch or drag on the floor;-Catheter tubing should never be looped (to prevent the flow of urine);-Doing either of these things increased the risk for infection. 7. Review of the undated facility policy, Nebulizer Storage and Cleaning, showed the following:-To ensure safe storage, cleaning, disinfection, and maintenance of nebulizer equipment to prevent healthcare-associated respiratory infections, following current Centers for Disease Control (CDC), Centers for Medicare and Medicaid Services (CMS), Association for Professionals in Infection Control and Epidemiology (APIC), and respiratory-therapy clinical standards;-The policy applies to all staff who use, clean, store, transport, or provide nebulizer equipment;-CMS 42 CFR 483.80 requires facilities to maintain an infection prevention and control program with written policies for equipment cleaning and disinfection;-CMS respiratory care pathway requires nebulizers be used, cleaned, and stored per manufacturer instructions, with sterile water rinsing and air-drying between uses;-Store nebulizers in clean, dry, closed containers or covered bins labeled with resident name;-Tubing must not be rinsed or submerged, store in a clean sealed bag between uses;-Reusable nebulizer components (mask, mouthpiece, cup) must be stored only after full air-dried to prevent microbial growth;-After each use (required): -Disconnect tubing from nebulizer components, tubing should never be washed; -Wash nebulizer mask/mouthpiece/cup with warm water and mild detergent; -Rinse under running warm water for at least 30 seconds; -Perform a final rinse using sterile or distilled water, not tap water; -Shake off excess water and place on clean, lint-free towel to air-dry completely; -Once dry, store components in clean sealable bag or closed container with tubing stored separately;-Staff must perform hand hygiene before and after handling nebulizer equipment;-Between treatments, clean and disinfect components after each use, tubing check for moisture, drying by running compressor 10-20 seconds, never rinse;-Store only fully dry components in a closed, clean container;-Label with resident name, date last disinfected;-Maintain separation from dirty equipment areas;-All nursing and respiratory care staff must receive annual education on cleaning, disinfection, and storage protocols for nebulizers. Review of Resident #36's undated face sheet showed the following:-Diagnoses of chronic obstructive pulmonary disease (COPD; lung disease), acute respiratory failure (a sudden-onset emergency where the lungs cannot adequately exchange oxygen for carbon dioxide) with hypoxia (low oxygen levels), asthma (a chronic lung disease), pneumonia (infection and inflammation of the lung) due to COVID-19, and bronchiectasis (a chronic lung disease). Review of the resident's quarterly MDS, dated [DATE], showed moderate cognitive impairment. Review of the resident's Physician Orders, dated 2/20/26, showed the following:-Ipratropium-Albuterol inhalation solution (an inhaled medication to treat COPD) 0.5-2.5 3 milligram (mg)/3 milliliter (mL), one vial inhale orally every four hours as needed for shortness of breath or wheezing;-Ipratropium-Albuterol inhalation solution 0.5-2.5 3 mg/3 mL, one vial inhale orally every morning and at bedtime for chronic cough. Observation on 3/2/26 at 1:19 P.M. showed a nebulizer machine, mask, and tubing sat directly on the resident's bedside table and were not stored in a bag. There was no bag to store the nebulizer and components in the room. The mask and tubing were still connected to the nebulizer machine. Observation on 3/3/26 at 9:17 A.M. showed the resident sat on the edge of his/her bed and received his/her nebulizer treatment. There was no staff in the room. Observation on 3/3/26 at 11:04 A.M. and 3:57 P.M. showed the resident asleep in his/her bed. The nebulizer mask and tubing were still connected to the nebulizer machine and lay directly on the resident's bedside table. The nebulizer, mask and tubing were not stored in a bag. Observation on 3/3/26 at 10:00 A.M. showed Certified Medication Technician (CMT) H exited the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's room after he/she started the resident's nebulizer treatment. Observations on 3/4/26 at 11:41 A.M. and 1:04 P.M. showed the resident rested in bed. The resident's nebulizer mask and tubing sat directly on the resident's nightstand. The nebulizer, mask, and tubing were not stored in a bag, and no bag was available in the room. Observations on 3/5/26 at 8:30 A.M. and 9:52 A.M. showed the resident's nebulizer mask and tubing sat on the resident's bedside table. The nebulizer, mask, and tubing were not stored in a bag, and no bag was available in the room. During an interview on 3/5/26 at 5:18 P.M., Licensed Practical Nurse (LPN) A said the following:-Staff should rinse the nebulizer masks and canisters after every use; -Staff should lay the masks, canisters, and tubing out to dry, then store them in a bag when not in use; -He/She was unsure if the bag used to store the nebulizer should be dated or labeled;-He/She was unsure if staff should regularly change the mask, tubing, or bag. He/She did not change them. During an interview on 03/05/26 at 5:23 P.M., CMT H said the following:-Staff should rinse the nebulizer masks and canisters and lay them out to dry after every use; -The nebulizer parts should be stored in a bag when not in use;-He/She was unsure about changing out parts, he/she has never done this, it usually falls on nightshift duties. During an interview on 03/05/26 at 5:47 P.M., the DON said the following:-Staff should date, label and store nebulizer parts in a bag when not in use;-Whoever performed the treatment was responsible to clean the nebulizer components and to store them in a bag. During an interview on 3/18/26 at 8:51 A.M., the Infection Preventionist said staff should clean nebulizer masks and canisters with warm soapy water, allow them to air dry, and them place them in a bag after every use. 8. Review of the facility's undated policy, Infection Prevention and Control Program (IPCP) showed it only addressed COVID-19. A policy related to the facility's overall plan for preventing, identifying, reporting, investigating, and controlling all potential infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement, was requested, but none provided. During an interview on 3/18/26 at 8:51 A.M., the Infection Preventionist (IP) said the following:-She had been the IP for approximately 2.5 years;-She was part time and worked three weekends per month for a total of six shifts per month;-She ran a weekly report for new infections and used the report to update her infection tracking;-On the weekend each month she didn't work, no one ran the report with new infections, so she ran a two week report the following weekend;-If she was sick or took extra time off, no other staff tracked or monitored infections. During an interview on 3/5/26 at 4:04 P.M., the Assistant Director of Nursing (ADON) said the following:-She offered to help the IP with tracking, but the facility told her she could not help because there was already someone tracking infections;-She did not know if the IP was tracking infections. During an interview on 3/5/26 at 3:24 P.M., the DON said the following:-The IP worked part-time and only on the weekends;-The IP was the only staff who tracked and mapped infections; -She did not help with the infection tracking when the IP was not working. 9. Observation on 03/02/26 from 11:47 A.M. to 11:55 A.M., in the [NAME] Dining Room, showed the following:-NA D handed Resident #47 a glass of apple juice with a straw;-Without performing hand hygiene, NA D opened Resident #60's can of soda, picked up the resident's spoon and gave Resident #60 a bite of ham and potatoes;-Without performing hand hygiene, NA D picked up Resident #47's spoon and gave the resident multiple bites of pureed ham and potatoes;-Without performing hand hygiene, NA D picked up Resident #59's spoon and gave the resident bites of pureed ham and potatoes;-Without performing hand hygiene, NA D picked up Resident #60's fork and gave the resident bites of pickled beets;-Another unknown staff member entered the dining room and began feeding Resident #47;-NA D continued to sit between Resident #59 and Resident #60 and alternated back and forth giving bites of food to both residents. During interviews on 03/04/26 at 1:20 P.M. and 03/13/26 at 3:31 P.M., NA D said he/she usually kept alcohol based hand rub (ABHR) in his/her pocket and used it while feeding multiple residents, but he/she didn't have any ABHR with him/her. During an interview on 03/18/26 at 8:51 P.M., the Infection Preventionist said the following:-Staff should perform hand hygiene between residents while assisting multiple residents with eating;-At the very least, staff should use ABHR in between residents;-She was aware there were a few staff who fed multiple residents and didn't use ABHR between residents.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have an adequate audible system for residents to signal nursing staff for assistance and failed to ensure staff responded to call lights timely for two residents (Resident #19 and Resident #2) in a review of 19 sampled residents and two additional residents (Resident #39 and Resident #32). The facility census was 58. Review of the facility policy titled Resident Call System dated [DATE] showed the following:-Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation;-Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor;-Call system communication may be audible or visual. The system may be wired or wireless;-The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional;-If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan;-The resident call system is routinely maintained and tested by the maintenance department;-Calls for assistance are answered as soon as possible. Urgent requests for assistance are addressed immediately. 1.Review of the facility's exception for a wireless call light system, granted by the state agency on [DATE], showed an exception regarding the omission of indicator lights at the corridor entrance of each bedroom, and audible signals and indicating panels in each utility room which expired on [DATE]. Observation on [DATE] at the [NAME] Nurses' Station showed the following:-At 12:33 P.M. room [ROOM NUMBER] and room [ROOM NUMBER] were lit up green on the kiosk (signaling the call light was activated). The kiosk indicated the call lights were activated at 12:13 P.M. There was no light on outside room [ROOM NUMBER] and room [ROOM NUMBER];-At 12:37 P.M. room [ROOM NUMBER] and room [ROOM NUMBER] were lit up red on the kiosk (signaling the call light was activated). At 12:37 P.M. the call lights were answered by staff (24 minutes after the call light was activated);-At 12:39 P.M. room [ROOM NUMBER] was lit up green on the kiosk (signaling the call light was activated). There was no light on outside room [ROOM NUMBER];-At 12:49 P.M. room [ROOM NUMBER] was lit up red on the kiosk (signaling the call light was activated).There was no light on outside room [ROOM NUMBER];-At 12:55 P.M. Licensed Practical Nurse (LPN) E told Certified Nurse Aide (CAN) K that room [ROOM NUMBER] was lit up red on the kiosk and the call light needed to be answered;-At 12:55 P.M. the Assistant Director of Nurses (ADON) answered the call light in room [ROOM NUMBER] (16 minutes after the call light was activated);-A pager sat on the [NAME] Nurses' Station. It intermittently softly beeped three times in a row. 2. During an interview on [DATE] at 1:40 P.M. Resident #19's family member said the following:-The resident had lived at the facility approximately six months and previously lived at another facility;-The resident has a history of falls prior to admission to this facility;-The resident was on hospice and needed more help with activities of daily living;-The resident pushes his/her call light and must wait 30-35 minutes for staff to respond;-One day the resident called him/her because the resident had pushed his/her call light, and no staff came. He/She told the resident not to get up without help until he/she got to the facility. When he/she got to the facility, the resident's call light was still on, and no staff had come in to help. The resident still needed assistance;-He/She has talked to the Administrator about the prolonged call light response time and the Administrator told him/her to have the resident push the call light every five minutes until staff responded. 3. During an interview on [DATE] at 2:05 P.M. Resident #33 said sometimes it takes a very long time for staff to answer call lights. 4. During a group interview on [DATE] at 10:04 A.M. Resident #32 said he/she has waited two hours for his/her call light to be answered by staff. 5. During an interview on [DATE] at 12:28 P.M., Certified Nurse Assistant (CNA) L said the following:-The call lights made an audible (continued on next page)

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	265638	A. Building B. Wing	03/05/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chime at the nurses station, and there was a monitor at the nurses station that showed the room where the call light was activated. The indicator lights outside the resident rooms above the doors did not work;-Staff were to carry pagers, but no one carried them. Staff listened for the audible chime at the nurses station or check the call light monitors. This was the only way to know if a call light was activated. During an interview on [DATE] at 8:10 P.M. CNA C said the following:-There was only one pager for the [NAME] Wing, and it stayed at the nurses' station;-The pager beeps three times when a call light is activated;-The call lights do not sound down the hallway;-Staff know a call light is activated if they hear the pager sound or look at the kiosk at the nurses station;-No light comes on outside the resident's room when a call light is activated;-Staff don't carry pagers with them when on duty;-If he/she was in a room with a door shut and a call light activated, he/she could not hear the call light. 6. Review of Resident #2's care plan, last reviewed [DATE], showed the following: -The resident had an ADL self-care performance deficit related to hemiplegia (loss of motor function on one-half side of the body, usually after a stroke), and impaired balance; -The resident required a mechanical lift with two staff for assistance with transfers. Review of the resident's quarterly MDS, completed by facility staff on [DATE], showed the following: -Cognitively intact; -Upper extremity impairment on one side; -Lower extremity impairment on both sides; -Dependent for toileting; -Diagnosis of stroke. Observation on [DATE] at 9:01 A.M. showed the resident's room number highlighted in green (indicating the resident requested nursing assistance) on the kiosk positioned and secured to the wall in the 200-hall, no sound was emitted from the kiosk. During an interview on [DATE] at 9:01 A.M. the resident said he/she put the call light on because he/she needed to use the bathroom. Observation on [DATE] at 09:40 A.M. showed the resident's room number highlighted in red (indicating the resident had waited greater than 15 minutes for nursing staff) on the kiosk that positioned and secured to the wall in the 200-hall, no sound was emitted from the kiosk. Observation on [DATE] at 09:40 A.M. showed Certified Nurse Aide (CAN) O and another unidentified staff entered the resident's room and asked him/her what he/she needed, then closed the resident's door behind them. Continuous observation showed the resident's call light was on for 40 minutes before facility staff responded. During an interview on [DATE] at 9:55 A.M., the resident said the following: -This morning, he/she had to use the bathroom when he/she put the call light on; -He/She has had to wait for nursing staff for a long time; -It was very frustrating to have to wait that long. During an interview on [DATE] at 4:04 P.M., the Assistant Director of Nursing (ADON) said the following:-The call light system was wireless;-The lights above the doors did not work and staff do not carry pagers;-There were pagers for the call light system, and they were mounted at the nurses station. Staff did not carry the pagers anymore because staff kept losing them or took them home. The pagers were too expensive for the facility to replace;-There were call light monitors mounted at the nurses station and down the hallway. Staff were trained to check the monitors every time they exited a resident room. During an interview on [DATE] at 5:47 P.M. the Director of Nursing (DON) said the following:-The facility did not have enough pagers for all staff to carry;-She did not monitor call light response times but does look at the kiosks when she was on the hall. If it was red, she directed staff to answer the call light;-She has not seen any call light logs showing call light response times;-She thought staff could hear the call lights and check the kiosks;-Call lights should be answered quickly;-It was not appropriate for staff to answer a call light and shut it off without providing the care needed unless staff needed to get additional help. During an interview on [DATE] at 12:35 P.M. the Administrator said the following:-It would not be appropriate for residents to have to wait 30 minutes or more for their call light to be answered and needs to be met;-The facility does not do any active monitoring of call light response time;-Information was obtained from resident council meeting regarding prolonged call light response time and that was taken to the Quality Assurance (QA) department;-He does not have access to the call light logs;-He was unaware the facility's exception for the wireless call light system was expired.

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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, interview, and record review, the facility failed to adequately address strong and pervasive urine odor at its source. The facility census was 58. No policy regarding addressing odors was received from the facility upon request. 1. Observation on 03/02/26 at 11:50 A.M. showed the following: A strong, urine odor in the hallway outside of Resident #28's room and adjoining resident rooms on the hall; -Resident #28's door was partially open; -The resident appeared to be sleeping and lay on his/her bed, unclothed, with his/her private area covered by a towel;-The fitted sheet beneath the resident had a dark, circular ring just beneath the resident's buttocks that appeared wet. Observation on 03/02/26 at 4:15 P.M. showed the following: -A strong urine odor noted in the hallway outside of the resident's room, and adjoining resident rooms in the hall; -The resident's door was partially open; -The resident sat on the side of his/her bed; -The fitted sheet beneath the resident had a dark, circular ring just beneath the resident's buttocks that appeared wet; -A partially filled urinal, with no lid, sat on the floor beside the resident's legs. Observation on 03/03/26 at 09:00 A.M. showed a strong, urine odor noted in the hallway outside of the resident's room and adjoining resident rooms on the hall. Observation on 03/03/26 at 07:50 P.M. showed a strong, urine odor noted in the hallway outside of the resident's room adjoining resident rooms on the hall. Observation on 03/04/26 at 10:55 A.M. showed a strong, urine odor noted in the hallway outside of the resident's room and adjoining resident rooms on the hall. 2. During an interview on 03/04/26 at 11:00 A.M., Resident #32, who resided on the same hall and next door to Resident #28, said he/she noticed a terrible smell in the hallway outside of his/her room at times. 3. During an interview on 03/04/26 at 10:00 A.M., a family member of another resident, two rooms down from Resident #28's room, said he/she always noticed a bad smell in the hall when he/she visited daily. 4. During an interview on 03/03/26 at 10:50 A.M., Housekeeper B said the following: -Housekeeping tried to clean Resident #28's room every day, but sometimes the resident would holler at staff and tell them to get out of the room; -Sometimes housekeeping would go back to the resident's room when he/she was sleeping and at least mop the floor. During an interview on 03/03/26 at 7:15 P.M., Certified Nurse Aide (CNA) N said the following: -The resident was independent with using the bathroom; -Nursing staff attempted to help the resident with bathing/hygiene, but the resident would often refuse and yell at staff to get out; -Staff could not force the resident to clean up as that was his/her right. During an interview on 03/05/26 at 3:25 P.M., the Director of Therapy said the following: -The facility's therapy room was located around the corner and a short distance from Resident #28's room; -The therapy room was accessed by all residents on skilled services;-There was always a strong urine odor in the hallway outside Resident #28's room, sometimes it could be detected in the therapy room. During an interview on 03/05/26 at 05:47 P.M., the Director of Nurses (DON) said the following: -She was aware of the strong odors from Resident #28's room that permeated the hallway; -The resident refused assistance with hygiene/bathing; -Housekeeping tried to mop daily, and all staff tried to clean the room as best as they could, especially when the resident was asleep. During an interview on 03/16/26 at 12:35 P.M., the administrator said he would expect housekeeping staff to make additional efforts as needed/warranted to keep the facility free from odors when a resident refused housekeeping services.

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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 facility failed to monitor the drug regimen for unnecessary medications by not ensuring the as needed (PRN) psychotropic medication (a chemical substance that changes brain function and results in alterations in perception, mood, consciousness or behavior) orders were limited to 14 days unless specific duration and clinical rationale were provided for two residents (Resident #19 and #14), in a review of 19 sampled residents. The facility census was 58. Review of the facility policy, Antipsychotic Medication Usage, dated July 2022, showed the following:-Residents will not receive medications that are not clinically indicated to treat a specific condition;-Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period and are subject to gradual dose reduction and re-review;-PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use. The duration of the PRN order will be indicated in the order;-Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident;Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions):-Schizophrenia;-Schizoaffective disorder;-Schizophreniform disorder;-Delusional disorder; -Mood disorders (e.g., bipolar disorder, depression with psychotic features, and treatment refractory major depression);-Psychosis in the absence of dementia;-Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (e.g., high-dose steroids); -Tourette's Disorder; -Huntington Disease; -Hiccups (not induced by other medications); or -Nausea and vomiting associated with cancer or chemotherapy;-Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met:-The behavioral symptoms present a danger to the resident or others; AND:the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or behavioral interventions have been attempted and included in the plan of care, except in an emergency (see below);-In the case of an emergency (that is, an acute onset or exacerbation of symptoms or immediate threat to the health or safety of a resident or others) related to one or more of the above conditions or diagnoses, the use of antipsychotic medications must meet following additional requirements:-The acute treatment period is limited to seven days or less; and-A clinician in conjunction with the interdisciplinary team must evaluate and document the situation within 7 days, to identify and address any contributing and underlying causes of the acute psychiatric condition and verify the continuing need for antipsychotic medication; and-Pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented following the resolution of the acute psychiatric situation. 1. Review of Resident #19's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/01/26 showed the following:-Moderately impaired cognition;-Diagnoses of malnutrition and anxiety;-Hospice care;-Takes antipsychotic medication. Review of the resident's Care Plan, revised 01/09/26, showed the following:-The resident uses psychotropic medications related to disease process;-Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift;-The resident was at risk for adverse reactions related to polypharmacy. Review of the resident's Physician's Orders, dated 02/17/26, showed an order for Haldol (antipsychotic medication) 2 milligrams (mg)/milliliter (ml) give 0.5 ml by mouth every six hours PRN agitation/hallucinations (open ended order/no stop date). Review of the resident's February 2026 Medication Administration (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record (MAR) showed no documentation staff administered PRN Haldol to the resident between 02/17/26 and 02/28/26. Review of the resident's March 2026 Physician's Orders showed an order for Haldol 2 mg/ml, give 0.5 ml by mouth every six hours PRN agitation/hallucinations (start date 02/17/26, open ended order/no stop date). Review of the resident's March 2026 MAR, for review dates of 03/01/26 through 03/04/26, showed the following: -On 03/02/26 at 2:38 A.M., staff documented the resident received Haldol 0.5 ml by mouth. Staff documented the medication was effective;-On 03/02/26 at 10:10 P.M., staff documented the resident received Haldol 0.5 ml by mouth. Staff documented the medication was effective;-On 03/04/26 (16 days after the medication start date) at 1:00 A.M., staff documented the resident received Haldol 0.5 ml by mouth. Staff documented the medication was ineffective;-On 03/04/26 (16 days after the medication start date) at 4:34 P.M., staff documented the resident received Haldol 0.5 ml by mouth. Staff documented the medication was ineffective. Review of the resident's medical record, dated 02/01/26 through 03/04/26, showed no documentation of a pharmacy recommendation regarding the PRN Haldol and no documentation the resident's physician evaluated the resident for the appropriateness of PRN Haldol and documented the rationale for continued use. 2. Review of Resident #14's Significant Change MDS, dated [DATE], showed the following:-Cognitively intact;-No behaviors;-Diagnosis of stroke, dementia, anxiety and depression;-Hospice care;-Receives antianxiety medication. Review of the resident's Care Plan, revised 12/01/25, showed the following:-The resident has impaired cognitive function or impaired thought processes related to dementia;-The resident was at risk for falls related to psychoactive medication use and the potential side effects;-The resident used antianxiety medications related to anxiety disorder;-Administer antianxiety medications as ordered by the physician. Monitor for side effects and effectiveness as needed;-The resident was at risk for adverse reaction related to polypharmacy.Review of the resident's Physician's Orders, dated 01/24/26, showed an order for alprazolam (antianxiety medication) 0.25 mg, give one tablet PRN anxiety twice daily (open ended order/no stop date). Review of the resident's January 2026 MAR showed on 01/31/26 at 4:11 P.M., staff administered alprazolam 0.25 mg by mouth. Staff documented the medication was effective. Review of the resident's February 2026 Physician's Orders showed an order for alprazolam 0.25 mg, give one tablet PRN anxiety twice daily (open ended order/no stop date). Review of the resident's Quarterly MDS, dated [DATE], showed the following:-Moderately impaired cognition;-No behaviors;-Receives antianxiety medication. Review of the resident's February 2026 MAR showed the following:-On 02/04/26 at 9:47 P.M., staff administered alprazolam 0.25 mg by mouth. Staff documented the medication was effective;-On 02/06/26 at 7:05 P.M., staff administered alprazolam 0.25 mg by mouth. Staff documented the medication was effective;-On 02/07/26 (15 days after the medication start date) at 3:40 P.M., staff administered alprazolam 0.25 mg by mouth. Staff documented the medication was effective;-On 02/12/26 (20 days after the medication start date) at 5:15 P.M., staff administered alprazolam 0.25 mg by mouth. Staff documented the medication was effective;-On 02/14/26 (22 days after the medication start date) at 5:09 P.M., staff administered alprazolam 0.25 mg by mouth. Staff documented the medication was effective;-On 02/15/26 (23 days after the medication start date) at 11:30 P.M., staff administered alprazolam 0.25 mg by mouth. Staff documented the medication was effective;-On 02/17/26 (25 days after the medication start date) at 10:31 A.M., staff administered alprazolam 0.25 mg by mouth. Staff documented the medication was effective;-On 02/21/26 (29 days after the medication start date) at 7:03 P.M., staff administered alprazolam 0.25 mg by mouth. Staff documented the medication was effective. Review of the resident's March 2026 Physician's Orders showed an order for alprazolam 0.25 mg, give one tablet PRN anxiety twice daily (open ended order/no stop date). Review of the resident's March 2026 MAR showed no documentation the resident received PRN alprazolam. Review of the resident's Care Plan, revised 03/02/26, showed the following:-The resident used psychotropic medications;-Administer psychotropic medications as ordered by the physician;-Monitor for side effects and effectiveness every shift. Review of the resident's medical record dated 01/01/26 through 03/04/26 showed no (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of a pharmacy recommendation regarding the PRN alprazolam and no documentation the resident's physician evaluated the resident for the appropriateness of PRN alprazolam and documented the rationale for continued use. 3. During an interview on 3/5/26 at 5:47 P.M. the Director of Nursing said the following:-PRN antipsychotic medications should have 14 day stop dates;-Other PRN psychotropic medications, like antianxiety medications, can be ordered by the physician for six months;-PRN psychotropic medications are mostly monitored by pharmacy;-She tried to monitor the PRN psychotropic medication as well, but it sometimes slips through the cracks.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to develop a comprehensive care plan that included services to maintain the residents' highest practicable physical, mental, and psychosocial well-being, when the facility failed to include skin breakdown and pressure ulcers for one resident (Resident #9), and the use of a nebulizer due to chronic health conditions for one resident (Resident #36), in a review of 19 sampled residents. The facility census was 58.Review of the facility policy, Care Plans, Comprehensive Person-Centered, revised March 2022, showed the following:-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident;-The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident;-The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission;-The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment;-The comprehensive, person-centered care plan:-Includes measurable objectives and timeframes;-Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment or any specialized services to be provided as a result of PASARR recommendations and which professional services are responsible for each element of care;-Includes the resident's stated goals upon admission and desired outcomes;-Builds on the resident's strengths;-Reflects currently recognized standards of practice for problem areas and conditions;-Services provided for or arranged by the facility and outlined in the comprehensive care plan are provided by qualified persons, culturally competent, and trauma-informed;-Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making;-When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers;-Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change;-The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with the required quarterly MDS assessment. 1. Review of Resident #9's baseline care plan, dated 12/16/25, showed the resident had lesions to the scalp and had a history of skin integrity issues. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 1/1/26, showed the following:-Moderately impaired cognition;-The resident did not have any pressure ulcers or injuries;-The resident was at risk of developing pressure ulcers or injuries;-The resident did not have any open lesions, other than ulcers, rashes or cuts;-The resident had moisture-associated skin damage. Review of the resident's skin check, dated 2/1/26, showed the following:-New skin tear to the right elbow;-Old open lesion to the frontal scalp; -New moisture-associated skin damage to the right buttock;-New moisture-associated skin damage to the left buttock;-New open lesion to the genitalia. Review of the resident's Physician Orders, dated 02/01/26, showed an order for Calmoseptine (an over-the-counter moisture barrier designed to protect, soothe, and promote healing of skin irritations) to open/excoriated areas to genitalia and right and left buttocks every shift, until healed. Review of the resident's skin check, dated 2/11/26, showed the following:-Old skin tear to the right elbow, improving;-Old open lesion to the frontal scalp, improving;-New moisture-associated skin (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	damage to the right buttock;-New open lesion to the genitalia;-New moisture-associated skin damage to the left buttock. Review of the resident's Care Plan, updated 2/17/26, showed the resident required skin inspection weekly. (There was nothing documented indicating any active skin concerns, breakdowns, or interventions.) Review of the resident's skin check, dated 2/21/26, showed the following:-New moisture-associated skin damage to the right buttock;-New open lesion to the genitalia;-Old open lesion to the frontal scalp, improving;-New moisture-associated skin damage to the left buttock;-Old skin tear to the right elbow. Review of the resident's Skin and Wound note by Healing Partners (wound care provider), dated 2/24/26, showed the following:-The resident presented with open skin injury to coccyx (tailbone), etiology consistent with pressure;-Wound #1: coccyx, pressure ulcer/injury, stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) status is new, size is 1 centimeter (cm) by 0.5 cm by 0.1 cm, wound base was 50% epithelial (outer layer of the skin) and 50% granulation (new connective tissue and blood vessels that form on the surfaces of a wound);-Surgical wound debridement (medical removal of dead, damaged, or infected tissue from a wound to promote healing) was performed;-Wound #1: coccyx treatment recommendations: cleanse with normal saline, apply hydrogel to base of wound, secure with bordered dressing, change daily;-Follow treatment plan for wound, frequent repositioning and offloading cushion to wheelchair. Review of the resident's Physician Orders, dated 2/24/26, showed an order to cleanse the coccyx with normal saline, pat dry, apply hydrogel, cover with bordered dressing and change daily until healed. Review of the resident's skin check, dated 2/28/26, showed the following:-Old moisture-associated skin damage to the right buttock;-Old open lesions to the genitalia;-Old open lesion to the frontal scalp;-Old moisture-associated skin damage to the left buttock;-Old skin tear to the right elbow. Observation on 03/05/26 at 1:27 P.M. showed the resident had a pressure ulcer on his/her coccyx. Review of the resident's current Care Plan showed no documentation the resident had any skin concerns or pressure ulcers. 2. Review of Resident #36's undated face sheet showed his/her diagnoses included chronic obstructive pulmonary disease (COPD; a lung disease that restricts breathing), acute respiratory failure (a condition where the lungs cannot adequately exchange oxygen for carbon dioxide) with hypoxia (low oxygen levels), asthma (a chronic lung disease that causes inflammation, swelling, and narrowing of the airways, making it difficult to breathe), pneumonia (a lung infection) due to COVID-19, and bronchiectasis (a chronic lung disease where the airways become permanently widened, damaged, and inflamed). Review of the resident's Physician Orders, dated 2/20/26, showed the following:-Ipratropium-Albuterol inhalation solution (an inhaled medication to treat COPD) 0.5-2.5 3 milligram (mg)/3 milliliter (mL), one vial inhale orally every four hours as needed for shortness of breath or wheezing;-Ipratropium-Albuterol inhalation solution 0.5-2.5 3 mg/3 mL, one vial inhale orally every morning and at bedtime for chronic cough. Review of the resident's care plan, updated 2/20/26, showed no documentation the resident had COPD or required nebulizer treatments. During an interview on 3/5/26 at 5:47 P.M., the Director of Nursing (DON) said she expected care plans to be up to date, resident specific and revised with changes to the resident.

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	265638	A. Building B. Wing	03/05/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure staff transferred one resident (Resident #59), in a review of 19 sampled residents, using appropriate technique, consistent with the resident's abilities and condition, to ensure the resident's safety. The facility census was 58. Review of the facility policy, Safe Lifting and Movement of Residents, revised July 2017, showed the following:-In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents;-Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents;-Manual lifting of residents shall be eliminated when feasible;-Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include the following;-Resident's preferences for assistance; -Resident's mobility (degree of dependency); -Resident's size; -Weight-bearing ability; -Cognitive status; -Whether the resident is usually cooperative with staff; and -The resident's goals for rehabilitation, including restoring or maintaining functional abilities; -Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices; -Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. 1. Review of Resident #59's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 11/20/25, showed the following:-Severe cognitive impairment;-Dependent on staff for dressing, toileting hygiene and personal hygiene;-Dependent on staff for roll left and right, sit to stand, sit to lying, chair/bed to chair transfer, and toilet transfer;-Walking not attempted due to medical condition or safety concerns;-Always incontinent of bladder and bowel;-Diagnoses of stroke;-Weight 113 pounds;-Hospice care. Review of the resident's Care Plan, revised 12/01/25, showed the following:-The resident has activity of daily living (ADL) self-care performance deficit related to stroke;-The resident is totally dependent on one staff for repositioning, turning in bed, personal hygiene and eating;-The resident is totally dependent on two staff for transferring. Use Hoyer lift (full body mechanical lift) as needed (PRN). Up in Broda chair (specialized, highly adjustable medical wheelchair or positioning chair designed for superior comfort, safety, and pressure management in long-term care, nursing homes, and rehab centers);-The resident is non-weight bearing;-The resident has bladder incontinence related to impaired mobility and physical limitations;-The resident has bowel incontinence related to immobility. Observation on 03/03/26 at 7:27 P.M., in the resident's room, showed the following:-The resident sat in his/her Broda chair;-Certified Nurse Assistant (CNA) C removed the resident's shirt and placed a gown over the resident's head;-CNA C told the resident to give him/her a hug;-CNA C put his/her arms under the resident's arm pit area;-CNA C lifted the resident up out of the chair and moved the resident to his/her bed;-CNA C did not use a gait belt or mechanical lift during the transfer;-The resident's knees were bent during the transfer and he/she did not bear weight;-CNA C provided peri care and dressed the resident. During an interview on 03/03/26 at 8:38 P.M., CNA C said the following:-The resident can't stand on his/her own;-He/She was not sure if a gait belt would be appropriate to transfer the resident as he/she likes to have the resident hold onto him/her during the transfer;-He/She feels like the resident wouldn't be close enough to staff during a gait belt transfer;-The resident does not take steps and needs help standing up;-He/She feels like the resident tries to bear weight; -He/She can see the resident's care plan on the computer. Observation on 03/04/26 at 1:37 P.M., in the shower room, showed the following:-The resident sat in his/her Broda chair;-The resident was incontinent of urine;-Certified Medication Technician (CMT) J pushed the resident's chair close to the toilet;-CMT J stood in front of the resident on the left side and CNA G stood in front of the resident on the right side;-CMT J placed his/her arm under the resident's arm pit (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and CNA G placed his/her arm under the resident's arm pit and lifted the resident up out of his/her chair;-The resident's feet slid across the floor while CNA G and CMT J lifted the resident onto the toilet;-The resident was unable to stand, and his/her knees were bent during the transfer;-The resident urinated in the toilet;-CMT J placed his/her arms under the resident's arm pits, lifted upward and stood the resident while CNA G performed peri care;-The resident's knees were bent and the resident did not stand upright;-CNA G applied a clean disposable brief and pants;-CMT J pivoted the resident to his/her Broda chair;-The resident's feed slid across the floor while CMT J transferred the resident;-The resident did not bear weight during the transfer.-CMT J and CNA G did not utilize a gait belt, and did not use a mechanical lift for the resident who did not bear weight. During an interview on 03/04/26 at 1:42 P.M., CMT J said the following:-He/She doesn't usually work on the floor;-He/She was unsure if staff usually used a gait belt when transferring the resident;-The resident did not stand well and did not fully bear weight. During an interview on 03/04/26 at 3:30 P.M., CNA G said the following:-He/She usually transferred the resident without a gait belt but sometimes he/she used a gait belt when moving the resident from his/her chair to the bed;-Today (03/04/26), the resident did not bear weight well at all; he/she was very unsteady. During an interview on 03/05/26 at 3:25 P.M., the director of therapy said staff should use a mechanical lift for transfers if a resident was unable to bear weight. Staff should not pull up under a resident's arms during transfers. During an interview on 03/05/26 at 5:47 P.M., the Director of Nursing said if the resident was not bearing weight, staff should use the mechanical lift for transfers.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review of each nurse aide at least once every 12 months and provide regular in-service education based upon the outcome of the reviews for two Certified Nurse Aides (CNA F and CNA G), in a review of two CNA employee files. The facility census was 58. Review of the Facility Assessment, revised 04/01/2025, showed the following:-The facility makes a good faith effort to provide the staff training/education and competencies necessary to provide the level and types of support and care needed for the resident population;-Required in-service training for nurse aides. In-service training must:-Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff. 1.Review of Certified Nurse Aide (CNA) F's employee file showed the following:-Date of hire: 09/26/24;-No documentation of nurse aide evaluation/competencies or annual performance review. 2. Review of CNA G's employee filed showed the following:-Date of hire: 04/02/24;-No documentation of nurse aide evaluation/competencies or annual performance review. 3. During an interview on 03/05/26 at 5:47 P.M., the Director of Nursing (DON) said she had not done any nurse aide evaluations/competencies or annual performance reviews.During an interview on 03/16/26 at 12:35 P.M. the Administrator said the DON was responsible for annual CNA performance evaluations and he would expect CNAs employed greater than 12 months to have a performance evaluation completed and for that staff to receive additional education as needed based on the results of the evaluation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician provided his/her rationale for not making a medication change as recommended by the pharmacist during the monthly drug regimen review for one resident (Resident #9), in a review of 19 sampled residents. The facility census was 58.Review of the facility policy, Antipsychotic Medication Use, revised July 2022, showed the following:-All antipsychotic medications will be used within the clinically recommended dosage guidelines or clinical justification will be documented for dosages that exceed guidelines for more than 48 hours;-The physician shall respond appropriately by changing or stopping problematic doses or medications or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. Review of the facility policy, Psychotropic Medication Use, revised July 2022, showed the following:-Residents on psychotropic medications received gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications;-If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued and document the rationale for this decision. 1. Review of Resident #9's undated face sheet showed the following:-admitted [DATE];-Diagnosis of insomnia. Review of the resident's physician orders, dated 12/18/25, showed an order for melatonin (a hormone that regulates sleep) 3 milligrams (mg), give on tablet by mouth every 24 hours as needed for 14 days (stop on 12/30/25). Review of the resident's Physician Orders, dated 1/8/26, showed an order for melatonin 10 mg, give one tablet by mouth at bedtime. Review of the resident's progress notes, dated 1/28/26 at 9:24 P.M., showed the resident was sleeping in his/her wheelchair. Review of the resident's Pharmacist's Recommendation to Prescriber, dated 1/28/26, showed the following:-Medication management recommendation, melatonin dose greater than 6 mg per day;-High doses (greater than 6 mg) of exogenous melatonin can cause prolongation of elevated melatonin levels and desensitization. Large doses have been shown to produce supra-physiological levels in older adults which may result in drowsiness, somnolence, or unsteady feeling when waking up and may result in loss of efficacy for sleep. Multiple studies have shown some efficacy in regard to decreased sleep latency and improved sleep efficiency in doses ranging from 1 to 6 mg;-Recommendation section gave two options: reduce melatonin to 5 mg daily, one hour before bedtime, or continue current dose, no change is indicated at this time;-The physician selected the no change is indicated at this time;-No prescriber comments were provided as to why the change was not indicated;-The provider signed on 2/10/26. Review of the resident's physician orders, dated February 2026, showed an order for melatonin 10 mg, give one tablet by mouth at bedtime (original order dated 01/08/26). Review of the resident's progress notes, dated 2/1/26 at 11:51 A.M., showed the resident was up in his/her wheelchair all night. Review of the resident's progress notes, dated 2/4/26 at 1:15 P.M., showed the resident took his/her morning medications, then slept through breakfast, waking for lunch at 12:30 P.M. Review of the resident's progress notes, dated 2/10/26 at 10:44 A.M., showed the resident's physician reviewed the pharmacy recommendation to prescriber, related to the melatonin dose, the physician marked to continue current dose no change was indicated at this time. Review of the resident's progress notes, dated 2/17/26 at 8:58 A.M., showed the resident did not sleep the previous two nights. Review of the resident's progress notes, dated 2/18/26 at 5:10 A.M., showed the resident hollered out around 1:38 A.M. and was found on the floor in front of his/her wheelchair. Review of the resident's progress notes, dated 12/18/26 at 12:50 P.M., showed the resident was sleeping in his/her wheelchair. Review of the resident's physician orders, dated March 2026, showed an order for melatonin 10 mg, give one tablet by mouth at bedtime (original order dated 01/08/26). Observation on 03/02/26 at 1:55 P.M. showed the resident was asleep in (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her wheelchair in his/her room. Observations on 03/03/26 at 11:08 A.M. and 7:59 P.M. showed the resident was asleep in his/her wheelchair in his/her room. Observation on 03/04/26 at 1:01 P.M. showed the resident was asleep in his/her wheelchair in his/her room. Observation on 3/5/26 at 8:33 A.M. showed the resident was asleep in his/her wheelchair in his/her room. Observation on 3/5/26 at 9:52 A.M. showed the resident was asleep in his/her wheelchair in his/her room. During an interview on 3/5/26 at 5:47 P.M., the Director of Nursing said the following:-The pharmacy completed the monthly drug regimen reviews and made recommendations;-She sent the recommendation to the physician who reviewed and made a decision regarding the medication;-She documented the physician's decision in the medical record and made any changes if ordered. During an interview on 3/18/26 at 3:01 P.M., the resident's primary care physician said the following:-He was aware CMS expected him to give a rationale for continuing an abnormal dose or not completing a GDR;-He did not have the time to review every resident's medical record, including medications and behaviors, when reviewing the pharmacy recommendation;-When the facility gave updates on the resident, based on the pharmacy recommendations, it made it easier for him to give a rationale as to why he was or was not making the recommended changes.