STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265714	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baisch Nursing Center	3260 Baisch Drive DE Soto, MO 63020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46460 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment. This had the potential to affect all residents in the facility. The facility's census was 48. Review of the facility's policy, Environment/Homelike, undated, showed: - It is the policy of this facility to provide a safe, clean, comfortable and homelike environment. Including allowing residents to use personal belongings to the extent possible; - The facility will remain clean and sanitary; - The facility will be odor free; - The facility will maintain clutter and remove it if it poses a hazard; - Equipment will be kept in good repair; - The safety of the residents and staff will take precedence over resident choice. 1. Observation on 02/25/25 at 9:05 A.M. of the hallway near the front nurses' station showed a strong urine smell. 2. Observation of [NAME] Wing 2 on 02/28/25 at 12:40 P.M. showed: - room [ROOM NUMBER] with door casing bent, cracked near the floor, and pulling away from the door; - room [ROOM NUMBER] with door casing missing, exposing an old brown glue-like substance from the floor to approximately three feet up the door frame; - room [ROOM NUMBER] with door casing pulling away from the door; - Six ceiling tiles between room [ROOM NUMBER] and 127 with various sizes of round brown stains, and a ceiling tile missing and exposing ductwork; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Two ceiling tiles between room [ROOM NUMBER] and 122 with brown stains; - One ceiling tile near the shower room on [NAME] Wing 2 with a brown stain. 3. Observation of the facility on 02/28/25 at 4:00 P.M. showed: - room [ROOM NUMBER] with a large gray stain with red/brown edges covering approximately 80% of a ceiling tile, a ceiling tile with an approximate eight inch by eight inch brown stain and a six inch by six inch brown stain; - room [ROOM NUMBER] with three ceiling tiles with brown stains, one ceiling tile with an approximate three inch by two inch hole, a ceiling tile with an approximate four inch by five inch hole and another ceiling tile with an approximate 12 inch corner cracked; - Hallway outside of the Social Services office with a ceiling tile with an approximate four inch by three inch hole and crack; - Hallway by nurses' station with a ceiling tile with an approximate eight inch by three inch broken section and an approximate 12 inch crack; - 100 Hallway outside of the women's restroom across from the fire extinguisher with a ceiling tile with an approximate four inch by three inch hole; - Hallway outside of room [ROOM NUMBER] with a ceiling tile with an approximate two inch by three inch hole. During an interview on 02/27/25 at 12:45 P.M., the Maintenance Supervisor said he/she does a walk through of the facility twice a day, almost every day. For big jobs, residents or staff will write work orders and place at the nurses's station and he/she picks them up and takes to the shop and places them in a file in a drawer after completed. Sometimes residents will stop him/her and if he/she has time, the issue will be fixed then, and there is no log of those issues. He/She tries to address all issues pretty quickly. Stained, cracked ceiling tiles and tiles with holes should be replaced. Right now there are no extra tiles on hand and an order has been placed. During an interview on 02/28/25 at 4:45 P.M., the Administrator said she would expect ceiling tiles to be free from stains/holes and cracks, and to be repaired in a timely manner. Missing tiles are expected to be replaced, and door casings are to be in good repair and not be cracked, bent or missing. 49754

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39360 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for transfer for six residents (Resident #11, #21, #22, #33, #37, and #202) out of 12 sampled residents. The facility's census was 48. Review of the facility's Discharge/Transfer Policy, revised 06/25/20, showed: - Explain transfer and reason to resident and/or representative, give copy of signed transfer or discharge notice to resident and/or representative. If an emergency, the transfer or discharge notice should be given to ambulance personnel; - Explain and give copy of bed hold form to the resident and/or representative. If an emergency transfer, may be completed later, but as soon as possible; - Complete transfer form, copy any portion of the medical record necessary for care of the resident; - Send original transfer form and portions of medical records that was copied with the resident and place copy of transfer form in medical record; - Notify business office, social service, dietary and administration of transfer. 1. Review of Resident #11's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/09/25 and returned to the facility on [DATE]; -The resident transferred to the hospital on 02/18/25 and returned to the facility on [DATE]; -The resident transferred to the hospital on 02/20/25 and returned to the facility on [DATE]; - No documentation that the resident or resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 2. Review of Resident #21's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 01/08/25 and returned to the facility 01/08/25; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #22's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 03/26/24 and returned to the facility 04/01/24; - The resident transferred to the hospital on 04/13/24 and returned to the facility 04/15/24; - The resident transferred to the hospital on 12/10/24 and returned to the facility 12/13/24; - The resident transferred to the hospital on 01/27/25 and returned to the facility 01/28/25; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 4. Review of Resident #33's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 10/04/24 and returned to the facility on [DATE]; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 5. Review of Resident #37's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/21/24 and returned to the facility 02/22/24; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 6. Review of Resident #202's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 09/28/24 and returned to the facility on [DATE]; -The resident transferred to the hospital on 02/11/25 and returned to the facility on [DATE]; -The resident transferred to the hospital on 02/28/25 and returned to the facility on [DATE]; - No documentation that the resident or resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. During an interview on 02/28/25 at 10:40 A.M., the Director of Nursing (DON) said he/she could not find transfer notifications. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/25 at 10:48 A.M., the Assistant Director of Nursing (ADON) said the floor nurses send a copy of the transfer sheet to the hospital at the time of transfer. The families are notified by phone to let them know. We have never sent anything in writing; we just call. During an interview on 02/28/25 at 4:45 P.M., the Administrator said he/she would expect written transfer notifications to be given to residents or their representatives. 46460 49754

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39360 Based on interview and record review, the facility failed to provide written information to the resident and/or the resident's representative of the facility's bed hold policy at the time of transfer to the hospital for six residents (Resident #11, #21, #22, #33, #37 and #202) out of 12 sampled residents. The facility's census was 48. Review of the facility's Bed Hold Policy Notice, undated, showed: - It is the facility's policy to notify all residents and/or residents' representatives of the facility bed hold policy; - If the resident discharges to the hospital, the bed may be held by paying the room rate that is in effect at the time the reservation is made; - If the resident and/or representative wants to hold bed, a signed authorization must be obtained with each discharge; - Upon discharge, the nursing supervisor will re-inform the resident and/or representative of the bed hold policy. This requirement will be considered met if the resident's copy of the notice is sent with other papers accompanying the resident to hospital. 1. Review of Resident #11's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/09/25 and returned to the facility 02/09/25; - The resident transferred to the hospital on 02/18/25 and returned to the facility 02/19/25; - The resident transferred to the hospital on 02/20/25 and returned to the facility 02/20/25; - A bed hold policy, dated 02/09/25 and signed by staff as the Resident/Representative with a notation Patient unable to sign; - A bed hold policy, dated 02/18/25 and signed by staff as the Resident/Representative; - A bed hold policy, dated 02/20/25 and signed by staff as the Resident/Representative; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. 2. Review of Resident #21's medical record showed: - admitted on [DATE]; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on 01/08/25 and returned to the facility 01/08/25; - A bed hold policy, dated 01/28/25 and signed by the Assistant Director of Nursing as the Resident/Representative with a notation Patient unable to sign; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. 3. Review of Resident #22's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 03/26/24 and returned to the facility 04/01/24; - The resident transferred to the hospital on 04/13/24 and returned to the facility 04/15/24; - The resident transferred to the hospital on 12/10/24 and returned to the facility 12/13/24; - The resident transferred to the hospital on 01/27/25 and returned to the facility 01/28/25; - A bed hold policy, dated 12/10/24 and signed by the Assistant Director of Nursing as the Resident/Representative with a notation Patient unable to sign; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. 4. Review of Resident #33's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 10/04/24 and returned to the facility the same day; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. 5. Review of Resident #37's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/21/25 and returned to the facility 02/22/25; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. 6. Review of Resident #202's medical record showed: - admitted on [DATE]; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on 09/28/24 and returned to the facility 10/10/24; - The resident transferred to the hospital on 02/11/25 and returned to the facility 02/21/25; - The resident transferred to the hospital on 02/28/25 and returned to the facility 02/28/25; - A bed hold policy, dated 09/28/24 and signed by staff as the Resident/Representative with a notation Patient unable to sign; - A bed hold policy, dated 02/11/25 and signed by staff as the Resident/Representative with a notation Patient unable to sign; - A bed hold policy, dated 02/28/25 and signed by staff as the Resident/Representative with a notation Patient unable to sign; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. During an interview on 02/28/25 at 10:48 A.M., the Assistant Director of Nursing (ADON) said the floor nurses send a copy of the bed hold policy along with the transfer sheet to the hospital at the time of transfer. The families would be notified by phone. Staff have never sent anything in writing; they just call. She has signed the bed holds when the resident was unable to do so since she has worked here. During an interview on 02/28/25 at 4:45 P.M., the Administrator, Director of Nursing (DON) and ADON said they would expect bed hold policies to be given to residents or resident's representatives. The ADON said if the resident is unable to sign, staff sign the bed hold policy. 46460 49754

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39360 Based on interview and record review, the facility failed to update and revise care plans with specific interventions to meet individual needs for two residents (Resident #38 and #202) out of 12 sampled residents. The facility's census was 48. The facility did not provide a policy. 1. Review of Resident #38's medical record showed: - admitted [DATE]; - Diagnoses of chronic pain, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.) Review of the resident's care plan, revised 12/19/24, showed the resident is a smoker. During an interview on 02/25/25 at 2:49 P.M., the resident said he/she does not smoke anymore. During an interview on 02/27/25 at 2:30 P.M., the Director of Nursing said Resident #38 no longer smokes. The smoking assessments should be done quarterly with each Minimum Data Set (MDS - a federally-mandated assessment completed by the facility) assessment and the care plan updated as needed. 2. Review of Resident #202's medical record showed: - admitted [DATE]; - Diagnoses of heart failure (a condition where the heart doesn't pump blood as well as it should), absence of right leg below the knee, pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), chronic kidney disease, stage 5 (CKD-a longstanding disease of the kidneys leading to renal failure), end stage renal disease (a chronic condition where the kidneys have permanently lost their ability to function properly), dependence on renal dialysis (a medical procedure that removes waste products and excess fluid from the blood when the kidneys are unable to do so), and need for personal assistance with care; - A Physicians's order for dialysis three times per week on Monday, Wednesday, and Friday, dated, 10/11/24; - A Physician's order for bed cane rails for positioning, dated, 09/30/22; - A Physician's order for Apixaban (anticoagulant) 2.5 milligrams by mouth twice daily, dated 01/17/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised 05/02/22, showed: - Resident used a bed cane rail on either side of the bed for positioning and transfers; - Resident receives an anticoagulant, with no bleeding precautions listed; - A diagnosis of CKD stage 4, and received dialysis on Monday, Wednesday, and Friday, but also has listed that he/she received dialysis on Tuesday, Thursday, and Saturday. Observations of the resident from 02/25/25 through 02/28/25 showed: - On 02/25/25 at 11:30 A.M. showed no bed cane rail on either side of the resident's bed; - On 02/26/25 at 9:30 A.M. showed no bed cane rail on either side of the resident's bed; - On 02/27/25 at 2:30 P.M. showed no bed cane rail on either side of the resident's bed; - On 02/28/25 at 4:00 P.M. showed no bed cane rail on either side of the resident's bed. During an interview on 02/26/25 at 2:00 P.M., the resident said he/she has not been using bed rails and that he/she goes to dialysis on Monday, Wednesday, and Friday. During an interview on 02/28/25 at 4:45 P.M., the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) collectively said they would expect care plans to be updated to reflect changes and the current condition of the resident. 46460 49754

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 49754 Based on interview and record review, the facility failed to ensure that five nurse aides (NAs) completed a nurse aide training program within four months of his/her employment at the facility. This deficient practice had the potential to affect all residents. The facility's census was 48. Review of the facility's policy, Nurse Aide Training, dated 05/01/23, showed the policy did not address the requirement that nurse aides should be certified within four months of employment. 1. Review of Nurse Aide H's personnel file and schedule showed: - Hire date of 01/03/23; - Not currently enrolled in a Certified Nursing Assistant (CNA) class; - Scheduled to work day shift on 02/04/25, 02/05/25, 02/08/25, 02/09/25,02/13/25, 02/14/25, 02/18/25, 02/20/25, 02/22/25, 02/27/25, and 02/28/25; - The facility failed to ensure the NA was certified within four months of their employment. 2. Review of Nurse Aide I's personnel file and schedule showed: - Hire date of 11/17/23; - Not currently enrolled in a CNA class; - Scheduled to work day shift on 02/02/25, 02/03/25, 02/04/25, 02/09/25, 02/10/25, 02/11/25, 02/16/25, 02/17/25, 02/18/25, 02/23/25, 02/24/25, and 02/25/25; - The facility failed to ensure the NA was certified within four months of their employment. 3. Review of Nurse Aide J's personnel file and schedule showed: - Hire date of 01/10/24; - Not currently enrolled in a CNA class; - Scheduled to work day shift on 02/02/25, 02/03/25, 02/04/25, 02/09/25, 02/10/25, 02/11/25, 02/16/25, 02/17/25, 02/18/25, 02/23/25, 02/24/25, and 02/25/25; - The facility failed to ensure the NA was certified within four months of their employment. 4. Review of Nurse Aide K's personnel file and schedule showed: - Hire date of 02/12/24; (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Not currently enrolled in a CNA class; - Scheduled to work day shift on 02/04/25, 02/12/25, 02/13/25, 02/17/25, 02/19/25, 02/21/25, and 02/25/25; - The facility failed to ensure the NA was certified within four months of their employment. 5. Review of Nurse Aide L's personnel file and schedule showed: - Hire date of 02/12/24; - Not currently enrolled in a CNA class; - Scheduled to work night shift on 02/01/25, 02/02/25, 02/07/25, 02/08/25, 02/09/25, 02/14/25, 02/15/25, 02/16/25, 02/21/25, 02/22/15, 02/23/25, and 02/28/25; - The facility failed to ensure the NA was certified within four months of their employment. During an interview on 02/28/25 at 11:00 A.M., the Assistant Director of Nursing (ADON) said that the facility does not offer CNA classes right now. They currently don't have a teacher. All the NAs are supposed to start CNA classes at another skilled nursing facility nearby the first week of March, starting on Wednesday. During an interview on 02/28/25 at 4:45 P.M., the Administrator, Director of Nursing (DON), and ADON said they would expect NAs to be certified within four months of hire.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46460 Based on interview and record review, the facility failed to establish a system of records for the receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation of controlled medications to ensure nursing staff signed at the beginning and end of each shift. The facility failed to document the total number of narcotic drug cards counted for four of four narcotic count books checked. The facility's census was 48. Review of the facility's policy titled, Narcotic Count, revised 04/30/20, showed: - Purpose is to complete a physical inventory of narcotics at change of each shift by two licensed nurses, two Certified Medication Technicians (CMTs), or (any combination of) to identify discrepancies and need for reconciliation and accountability; to assure controlled drugs are handled, stored, and disposed of properly; and to assure proper record keeping for controlled drugs; - One licensed nurse or one CMT going off duty and one licensed nurse or one CMT coming on duty must count and justify accuracy of narcotics supply for each individual resident at the change of each shift; - Narcotic records are reconciled by a physical count of the remaining narcotic supply at the change of each shift by the oncoming and outgoing licensed nurse or CMT; - After the supply is counted and justified, each nurse or CMT must record the date and his/her signature verifying that the count is correct. 1. Review of the CMT narcotic count records on the short hall, dated January 1, 2025 through February 28, 2025, showed: - No signature and/or initials by the oncoming CMT on the shift verification of controlled substances count sheet for 51 shifts; - No signature and/or initials by the offgoing CMT on the shift verification of controlled substances count sheet for 52 shifts; - Total narcotic cards not documented on the card count verification form as counted by both oncoming and offgoing staff for 73 shifts. 2. Review of the CMT narcotic count records on the long hall, dated January 1, 2025 through February 28, 2025, showed: - No signature and/or initials by the oncoming CMT on the shift verification of controlled substances count sheet for 47 shifts; - No signature and/or initials by the offgoing CMT on the shift verification of controlled substances count sheet for 57 shifts; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265714	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baisch Nursing Center	3260 Baisch Drive DE Soto, MO 63020

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Total narcotic cards not documented on the card count verification form as counted by both oncoming and offgoing staff for 82 shifts. 3. Review of the CMT narcotic count records on the [NAME] Wing 2 hall, dated January 1, 2025 through February 28, 2025, showed: - No signature and/or initials by the oncoming CMT on the shift verification of controlled substances count sheet for 53 shifts; - No signature and/or initials by the offgoing CMT on the shift verification of controlled substances count sheet for 53 shifts; - Total narcotic cards not documented on the card count verification form as counted by both oncoming and offgoing staff for 52 shifts. 4. Review of the nurse narcotic count records, dated January 1, 2025 through February 28, 2025, showed: - No signature and/or initials by the oncoming CMT on the shift verification of controlled substances count sheet for eight shifts; - No signature and/or initials by the offgoing CMT on the shift verification of controlled substances count sheet for eight shifts; - No documentation of total narcotic cards counted. During an interview on 02/27/25 at 2:00 P.M., Certified Medication Technician (CMT) M said he/she had already signed out for end of shift count even though the shift isn't over, and he/she understands that's probably not a good idea. During an interview on 02/27/25 at 2:05 P.M., CMT N said he/she had already signed out for end of shift count even though the shift isn't over. He/She just did it about 30 minutes ago because he/she knew the CMT for the next shift was here, but he/she thinks that's probably not a good idea to do that. During an interview on 02/27/25 at 3:24 P.M., CMT M said both the on coming and the off going nurse should sign the narcotic sheet and card count verification form at each shift change. During an interview on 02/28/25 at 4:45 P.M., the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) said they would expect on coming and off going staff to both sign the card count verification form and they shouldn't sign ahead of time prior to the end of their shift. The Administrator said she has a sign posted near the time clock that says Did you count? During an interview on 03/07/25 at 10:44 A.M., the Administrator said the nurses had not been doing a card count.

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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 - Few	Ensure medication error rates are not 5 percent or greater. 49754 Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent, when medications were administered. There were 29 opportunities with three errors made, for an error rate of 10.34%. This affected three residents (Resident #1, #9, and #31) outside of the 12 sampled residents, and had the potential to affect all residents. The facility's census was 48. The facility did not provide a policy. 1. Review of insulin aspart pen (insulin in a pen-type device) directions showed: - Remove cap; - Attach needle; - Prime pen by turning dose selector to select two units; - Press and hold button to make sure drop of insulin appears; - Select dose; - Give injection; - After dose counter reaches zero, count to six; - After injection, remove needle and place in sharps container. 2. Review of Fiasp insulin pen directions showed: - Pull pen cap straight off; - Select new needle, twist needle on till tight; - Turn the dose selector to select two units, press and hold the dose button until dose counter reaches zero; - Turn the dose selector to the number of units you need to inject, insert the needle into your skin and slowly count to six; - Pull the needle out of your skin, remove the needle from the pen and throw it away; - Replace the pen lid. 3. Review of Lantus insulin pen instructions showed: (continued on next page)

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Baisch Nursing Center	3260 Baisch Drive DE Soto, MO 63020

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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 - Few	- Attach a new needle to the pen; - Select a dose of two units, hold the pen upright and press the injection button all the way in, ensure insulin comes out of the needle; - Select prescribed dose; - Stick needle into skin; - Press the injection button all the way in and slowly count to 10, then withdraw the needle; - Put the outer needle cap back on the needle and use it to unscrew the needle from the pen; - Dispose of the needle safely, put the cap back on the pen. 4. Observation on 02/27/25 at 11:05 A.M. showed: - Licensed Practical Nurse (LPN) F obtained the finger stick blood sugar (FSBS) for Resident #1; - LPN F obtained the insulin aspart pen from the medicine cart and adjusted the pen to the amount of insulin ordered; - LPN F did not prime the pen with two units of insulin per the manufacturer's directions prior to administering the ordered dose to the resident. 5. Observation on 02/27/25 at 11:10 A.M. showed: - LPN F obtained the FSBS for Resident #9; - LPN F obtained the Fiasp insulin pen from the medicine cart and adjusted the pen to the amount of insulin ordered; - LPN F did not prime the pen with two units of insulin per the manufacturer's directions prior to administering the ordered dose to the resident. 6. Observation on 02/27/25 at 11:25 A.M. showed: - LPN F obtained the FSBS for Resident #31; - LPN F obtained the Lantus insulin pen from the medicine cart and adjusted the pen to the amount of insulin ordered; - LPN F did not prime the pen with two units of insulin per the manufacturer's directions prior to administering the ordered dose to the resident. During an interview on 02/27/25 at 11:30 A.M., LPN F said he/she has never been shown to prime an insulin pen. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/25 at 4:45 P.M., the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), all collectively said they would expect the medication error rate to be less than 5%. They would also expect insulin pens to be primed per manufacturer's instructions.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46460 Based on observation, interview, and record review, the facility failed to label and store medications in a safe and effective manner. This deficient practice affected one resident (Resident #202) out of 12 sampled residents and two residents (Resident #9 and #13) outside the sample and had the potential to affect all residents. The facility's census was 48. Review of the facility's policy titled, Medication Expiration Dates, dated [DATE], showed: - Purpose is to identify medication expiration dates and provide recommendations for disposal in accordance with manufacturer recommendations; - Medications and supplies that have reached their expiration date will be disposed of in accordance with facility policy; - The date of the opening should be noted on the medication package or container at the time of opening; - Specific manufacturer recommendations should be followed for storage and expiration of insulin; - Specific manufacturer recommendations for prescription medications and solutions will be followed based on specific time frames after opening - Tuberculosis PPD (Aplisol) vials 30 days. Review of the facility's policy titled, Medication Storage, dated [DATE], showed: - Purpose is to ensure that medications and biologicals are stored in a safe, secure storage and safe handling; - No discontinued, outdated, or deteriorated medications should be available for use in the facility. All such medications are destroyed per policy; - Medications requiring refrigeration should be stored in the refrigerator located in the drug room at the nurses' station. Please refer to package insert for specific temperature requirements of medication; - Vials must be dated upon opening and discarded within 30 days unless otherwise specified by manufacturer. Review of the package insert for Aplisol (a solution used in a skin test to help diagnose tuberculosis, a serious illness that mainly affects the lungs), updated [DATE], showed: - Do not freeze; - This product should be stored between 36 and 46 degrees Fahrenheit (F) and protected from light; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. Review of the package insert for NovoLog insulin (a hormone that helps the body use glucose for energy) pen, revised ,d+[DATE], showed to throw away all opened NovoLog vials after 28 days, even if they still have insulin left in them. Review of the package insert for Fiasp insulin pen, revised ,d+[DATE], showed the pen is to be thrown away after 28 days, even if it still has insulin left in it and the expiration date has not passed. Review of the package insert for Humalog (lispro) insulin, revised [DATE], showed to throw away the in-use Humalog Pen after 28 days, even if it still has insulin left in it. Review of the Food and Drug Administration website, www.fda.gov, showed according to the product labels from all three United States insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36 degrees F to 46 degrees F. Observation on [DATE] at 11:15 A.M. of Resident #9's insulin administration showed Licensed Practical Nurse (LPN) F administered three units of Fiasp insulin from a pen opened on [DATE]. Observation on [DATE] at 1:45 P.M. of the medication refrigerator in the utility room behind the nurses station showed one vial of Aplisol with an opened date of [DATE]. During an interview on [DATE] at 1:45 P.M., LPN F said another LPN usually takes care of replacing the Aplisol when it is expired or out of date. Observation on [DATE] at 12:09 P.M. of the insulin pens in the top drawer of the treatment cart showed: - Resident #202's Novolog insulin pen with an opened date of [DATE] and a second Novolog insulin pen with an opened date of [DATE]; - Resident #9's Fiasp insulin pen with an opened date of [DATE]; - Resident #13's Humalog (lispro) insulin pen with an opened date of [DATE] and a Lantus insulin pen with no opened date. During an interview on [DATE] at 12:13 P.M., LPN F said they use these insulin pens for the residents. The overstock insulin is kept in the refrigerator in the utility room behind the nurses' station. Discarding the insulins that are past their date is kind of a team effort. We all kind of pitch in and do it. Another LPN may take care of it when he/she works Monday through Thursday. Review of the Vaccine Storage Temperature Log, dated [DATE] and February ,d+[DATE], 2025, showed: - Vaccine must be stored between 35 degrees F and 46 degrees F to maintain potency with 32 handwritten over 35, and 40 handwritten over 46; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Instructions to please put a check in the box that corresponds with the temperature, day of the month, and A.M. or P.M. for the temperature check. Then enter initials and the time monitored in the boxes at the top of the chart; - If the temperature is in the gray range (32 - 34 degrees F and 47 - 49 degrees F), store the vaccine under proper conditions as quickly as possible, call the vaccine manufacturer to determine whether the potency of the vaccines has been affected; - No temperature documented for [DATE] or [DATE]; - On ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], a documented temperature of 33 degrees F, which falls in the gray range; - On ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] a documented temperature of 34 degrees F, which falls in the gray range; - On ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] a documented temperature of 32 degrees F, which falls in the gray range; - On ,d+[DATE], a documented temperature of 31 degrees F; - On ,d+[DATE] P.M. shift, a documented temperature of 22 degrees F. Review of the Refrigerator Temperature Log, dated [DATE] to [DATE], showed: - Refrigerator temperature must be 45 degrees or below; - On ,d+[DATE], a documented temperature of 28 degrees F; - On ,d+[DATE], a documented temperature of 30 degrees F; - On ,d+[DATE], a documented temperature of 30 degrees F; - On ,d+[DATE], a documented temperature of 28 degrees F. During an interview on [DATE] at 2:15 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said the refrigerator just got replaced and that is why the temperature log starts just a few days ago. The old one was holding its temperature, but the knob was broken on it. The ADON said of the refrigerator temperature logs she provided, there are some holes in it, meaning some blanks where it wasn't filled out. During an interview on [DATE] at 4:15 P.M., LPN F said the midnight shift does refrigerator temperature checks. If the refrigerator temperature was out of range, he/she would tell the DON, and if not available, he/she would tell the Administrator. He/She isn't sure what the range should be. He/She doesn't pay much attention to that unless it feels warm when he/she sticks his/her hand in there. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:45 P.M., the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) said they would expect medications to be stored properly. Expired insulin pens and Aplisol are not to be used; they should be discarded. If the refrigerator temperatures are out of the 32 to 40 degrees F range, we would throw the medications away and replace the refrigerator. The night shift checks refrigerator temperatures or day shift if night shift didn't check. No staff has reported out of range temperatures to administration. During an interview on [DATE] at 1:26 P.M., the Administrator said the appropriate temperatures for the medication refrigerators are ,d+[DATE] degrees, and she is adding to the temperature log to inform the DON and/or ADON if temperature is below or above and to adjust the thermostat accordingly and recheck. When asked about the logs that were in use, both the log with the numbers handwritten over the numbers and also the log with the direction of a temperature of 45 degrees or below, the Administrator said staff would not know what to do.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46460 Based on interview and record review, the facility failed to maintain quarterly Quality Assurance & Performance Improvement (QAPI) meetings with the required members. The facility's census was 48. Review of the facility's policy titled Quality Assurance and Improvement Program (QAPI), dated 05/31/24, showed: - The primary purpose of the QAPI program is to establish data-driven, facility-wide processes that improve the quality of care, quality of life, and clinical outcomes of our residents; - Members of facility management are accountable for QAPI efforts; - The QAPI Committee will include at minimum: the Administrator, Director of Nursing; Medical Director; Activities Director; Social Services Director; Dietary Manager; Housekeeping and Laundry Supervisor; Maintenance Director; additional facility staff; and contracted staff including Pharmacy Consultant, Dietician, and Rehab Director; - The committee shall maintain minutes of all regular and special meeting that include at least the following: the date committee met, start and adjourned time, and the names of the members present and absent; - The policy does not address the requirement of the Infection Preventionist (IP) as a committee member. 1. Review of the QAPI Meeting sign in sheet, dated 04/25/24 and provided by the Administrator, showed the following required members attended: - Administrator; - Director of Nursing; - Infection Preventionist; - At least two other staff members; - No record of the Medical Director attending. 2. Review of the QAPI Meeting sign in sheet, dated 07/17/24 and provided by the Administrator, showed the following required members attended: - Administrator; - Nurse Practitioner; (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At least two other staff members; - No record of the Director of Nursing or Infection Preventionist attending. During an interview on 02/28/25 at 1:30 P.M., the Administrator said she would expect the required members to be present at all QAPI meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39360 Based on observation, interview, and record review, the facility failed to maintain infection control practices to prevent the development and transmission of infection when proper surveillance was not done. The facility failed to use a blood glucose monitor that could be disinfected and shared between residents for six residents (Resident #1, #9, #10, #13, #31, and # 202) out of six sampled residents. The facility's census was 48. 1. Review of the facility's Infection Control Policy, dated 04/10/19, showed: - Policies and procedures will be utilized as the standards of the Infection Prevention and Control Program (IPCP); - The IPCP will be driven by coordination, oversight, surveillance, data analysis, outbreak management, prevention of infection, immunization and monitoring; - The IPCP will be coordinated and overseen by the Director of Nursing (DON); - The IPCP committee will review surveillance data, and reporting data to determine potential issues or trends; - The outbreak management process will consist of determining the presence of an outbreak, managing the affected resident, preventing the spread to others, documenting information about the outbreak, reporting the information to appropriate public health, education, monitoring for reoccurrence, review after outbreak and updating policies and procedures as needed; - Prevention of infection and immunization included, but not limited to, education, screenings, appropriate isolations, identification of possible infections, widespread immunization and monitoring; - The committee will be made up of, but not limited to the DON, Administrator, Medical Director, Activities Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Supervisor and additional staff as requested by the DON; - The IPCP committee will oversee implementation of infection control policies and assist department supervisors to ensure that they are implemented and followed; - The IPCP will meet at least quarterly and as needed between regular scheduled meetings. Review of the facility's Policy and Procedure, Cleaning and Disinfection of a Glucometer, dated 10/24, showed: - Policy: To provide guidelines to adequately clean and disinfect glucometer uses by multiple residents, in accordance with manufacturer recommendations; - All glucometers will be cleaned and disinfected using a 1:10 bleach (sodium hypochlorite) solution or commercially prepared EPA germicidal bleach wipe; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- All glucometers that are shared among multiple residents will be thoroughly wiped with the disinfectant and allowed to air dry after every use and between each resident; - Cleaned and disinfected glucometers should be stored in approved containers in a clean location, such as a medication room or medication cart; - Cleaned and disinfected glucometers should not be stored in the pockets of scrubs, uniforms or lab jackets; - Isopropyl alcohol will not provide disinfection and is not recommended; - Procedure: Gather necessary equipment for procedure; - Perform hand hygiene and apply gloves; - Wipe all external surfaces, including top, bottom and sides, using the bleach solution or commercially prepared EPA germicidal wipe; avoid allowing the solution to penetrate the test strip and /or key code ports of the meter; - Ensure the meter remains wet for one minute and allow to air dry for an additional minute before using on the next resident; - If blood is visibly present on the meter, the procedure should be repeated a second time; - Discard soiled items in approved containers; - Remove gloves and perform hand hygiene. Review of the facility's Monthly Infection Log for December 2024 showed: - Six residents started on antibiotics; - No cultures performed; - One Urinary Tract Infection (UTI); - One Respiratory Infection (RI); - Two wound/skin infections; - Two sinus infections. Review of the facility's Infection Surveillance Monthly Report for December 2024 showed: - Six out of eight residents did not have signs and/or symptoms documented; - Five out of eight residents did not have documentation of the antibiotic ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Monthly Infection Log for January 2025 showed: - Seventeen residents started on antibiotics; - Two cultures performed; - Eight UTIs; - Six respiratory infections; - One skin infection; - One Gastrointestinal Infection (GI); - One Clostridium difficile Colitis (C Diff-inflammation in the colon resulting from disruption of normal healthy bacteria in the colon, often from antibiotics). Review of the facility's Infection Surveillance Monthly Report for January 2025 showed: - Five out of 15 residents did not have signs and/or symptoms documented; - Seven out of 15 residents did not have documentation of the antibiotic ordered. During an interview on 02/28/25 at 12:52 P.M., the Administrator said since he/she had been at the facility for about one year, and they had not reviewed/updated the IPCP. He/She added that corporate would assist in this. During an interview on 02/28/25 at 12:53 P.M., the Director of Nursing (DON), who also served as the Infection Preventionist (IP), said the charge nurse will observe for signs and symptoms of an infection and talk to the nurse practitioner (NP), who is there twice a week, or physician to have them see the resident. The DON will add the antibiotic to the paper infection log. When an antibiotic is ordered in the electronic charting system, it will trigger for the Infection Prevention/Control (IPC) stop sign symbol to go up at the top of the screen. Staff hover over this and it will show suspected or confirmed. The infection is considered suspected until confirmed by diagnostics/labs or the physician. Once the physician confirms, it should show confirmed. He/She should be more vocal on assuring the NP and/or Physician order labs and cultures when indicated. The nurses are supposed to do an Infection Screen (under Assessments) when started on an antibiotic, then they should do an Antibiotic Timeout (under Assessments) three days later. Updates or whether the infection resolved or not are not documented on the tracking tool. The Administrator can run reports from the electronic charting system, and infections had been plotted on a facility map for the past three months on Tuesday, but that had not been done before. If several residents on a hall have the same type of infection, such as a UTI, it could be due to dehydration, but a root cause analysis had not been done to find out why infections are occurring, nor are the infections being tracked. 2. Review of the CareSens N blood glucose monitoring system user manual showed: - For single user/home use only; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baisch Nursing Center	3260 Baisch Drive DE Soto, MO 63020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Caring for the system, use a soft cloth or tissue to wipe the meter exterior; - If necessary, dip the soft cloth or tissue in a small amount of alcohol; - Do not use organic solvents such as benzene, acetone, or any household and industrial cleaners that may cause irreparable damage to the meter. Review of Microdot bleach wipe user guide, showed: - Use one or more wipes, as necessary to wet the surface sufficiently and thoroughly clean the surface; - To disinfect, the surface must remain wet for three minutes to achieve complete disinfection of pathogens listed on this label; - Allow surfaces to air dry. Observation on 02/27/25 at 11:05 A.M. showed: - Licensed Practical Nurse (LPN) F obtained Resident #10's fingerstick blood sugar (FSBS) using the CareSens N blood glucose monitor; - After obtaining the FSBS, LPN F wiped off the glucometer with a Microdot bleach wipe and placed the glucometer on top of a paper barrier on the nurse's medication cart; - LPN F failed to properly sanitize the glucometer. Observation on 02/27/25 at 11:10 A.M. showed: - LPN F obtained Resident #1's FSBS using the CareSens N blood glucose monitor; - After obtaining the FBS, LPN F wiped off the glucometer with a Microdot bleach wipe and placed the glucometer on top of a paper barrier on the nurse's medication cart; - LPN F failed to properly sanitize the glucometer. Observation on 02/27/25 at 11:15 A.M. showed: - LPN F obtained Resident #9's FSBS using the CareSens N blood glucose monitor; - After obtaining the FBS, LPN F wiped off the glucometer with a Microdot bleach wipe and placed the glucometer on top of a paper barrier on the nurse's medication cart; - LPN F failed to properly sanitize the glucometer. Observation on 02/27/25 at 11:20 A.M. showed: - LPN F obtained Resident #202's FSBS using the CareSens N blood glucose monitor; (continued on next page)

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	265714	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baisch Nursing Center	3260 Baisch Drive DE Soto, MO 63020

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- After obtaining the FBS, LPN F wiped off the glucometer with a Microdot bleach wipe and placed the glucometer on top of a paper barrier on the nurse's medication cart; - LPN F failed to properly sanitize the glucometer. Observation on 02/27/25 at 11:25 A.M. showed: - LPN F obtained Resident #31's FSBS using the CareSens N blood glucose monitor; - After obtaining the FBS, LPN F wiped off the glucometer with a Microdot bleach wipe and placed the glucometer on top of a paper barrier on the nurse's medication cart; - LPN F failed to properly sanitize the glucometer. Observation on 02/27/25 at 11:30 A.M. showed: - LPN F obtained Resident #13's FSBS using the CareSens N blood glucose monitor; - After obtaining the FBS, LPN F wiped off the glucometer with a Microdot bleach wipe and placed the glucometer on top of a paper barrier on the nurse's medication cart; - LPN F failed to properly sanitize the glucometer. During an interview on 02/27/25 at 11:32 A.M., LPN F said to clean and sanitize a glucometer, he/she wipes the surface off with a Microdot bleach wipe. During an interview on 02/28/25 at 4:45 P.M., the Administrator said the facility should review the IPCP, at least annually and it should include standards, policies and procedures that are current, as well as an infection surveillance program. He/She would expect glucometers to be cleaned/sanitized per manufacturer's recommendations. 49754

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Baisch Nursing Center	3260 Baisch Drive DE Soto, MO 63020

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 39360 Based on interview and record review, the facility failed to maintain an Infection Prevention and Control Program (IPCP) that included an effective antibiotic stewardship program. This deficient practice had the potential to affect all residents in the facility. The facility's census was 48. Review of the facility's Infection Control Policy, dated 04/10/19, showed: - Policies and procedures will be utilized as the standards of the IPCP; - The IPCP will be driven by coordination, oversight, surveillance, data analysis, outbreak management, prevention of infection, immunization, and monitoring; - The IPCP will be coordinated and overseen by the Director of Nursing (DON); - The IPCP committee will review surveillance data, and reporting data to determine potential issues or trends; - The outbreak management process will consist of determining the presence of an outbreak, managing the affected resident, preventing the spread to others, documenting information about the outbreak, reporting the information to appropriate public health, education, monitoring for reoccurrence, review after outbreak, and updating policies and procedures as needed; - Prevention of infection and immunization included, but not limited to, education, screenings, appropriate isolations, identification of possible infections, widespread immunization, and monitoring; - The committee will be made up of, but not limited to the DON, Administrator, Medical Director, Activities Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Supervisor and additional staff as requested by the DON; - The IPCP committee will oversee implementation of infection control policies and assist department supervisors to ensure that they are implemented and followed; - The IPCP will meet at least quarterly and as needed between regular scheduled meetings. Review of the Antibiotic Stewardship Policy, last revised 03/24, showed: - Antimicrobial Stewardship (AMS) is a systematic approach to optimizing use of antimicrobials to reduce inappropriate use, improve patient outcomes and reduce adverse consequences of antimicrobials; - Staff will ensure microbiology guides therapy, when possible, indications should be evidence based, narrowest spectrum required, dosage appropriate, minimize duration, and tracking to assure correct antibiotic is prescribed; - Prescribers are responsible for complying with principles of good antimicrobial prescribing, documenting indication, and expected duration; (continued on next page)

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	265714	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baisch Nursing Center	3260 Baisch Drive DE Soto, MO 63020

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nurses are responsible for ensuring antimicrobials are administered in accordance to the prescription and if therapeutic drug monitoring is required, ensure blood is sampled at appropriate time and result reviewed prior to administering next dose, or as specified by doctor or pharmacist; - The nurse will complete the Infection Screening Evaluation and Antibiotic Time Out Assessments in the electronic medical record, criteria form specific to individual's clinical symptoms and notify physician if meets specific criteria for antibiotic order; - The DON will put this information on the Infection Control Log; - Specific cultured organisms, when required, will also be logged on the Monthly Quality Assurance Infection Control Log; - The Quality Assurance Team will track and monitor appropriate use of the narrowest spectrum antibiotics and any trends related to microorganisms. 1. Review of the facility's Monthly Infection Log for December 2024 showed: - Six residents started on antibiotics; - No cultures performed; - One Urinary Tract Infection (UTI); - One Respiratory Infection (RI); - Two wound/skin infections; - Two sinus infections. Review of the Infection Tracking Log for December 2024, showed: - Two out of six residents did not have prescribed antibiotic documented; - Four out of six residents did not have signs or symptoms documented; - Six out of six residents did not have the date infection was resolved, or if resolved; - No documentation of organism for wounds or UTI diagnoses; - Four out of six residents did not have documentation that showed if appropriate antibiotic was ordered. Review of the facility's Infection Surveillance Monthly Report for December 2024 showed: - Six out of eight residents did not have signs and/or symptoms documented; - Five out of eight residents did not have documentation of the antibiotic ordered. (continued on next page)

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	265714	A. Building B. Wing	02/28/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's Monthly Infection Log for January 2025 showed: - 17 residents started on antibiotics; - Two cultures performed; - Eight UTIs; - Six respiratory infections; - One skin infection; - One Gastrointestinal Infection (GI); - One Clostridium difficile Colitis (C Diff-inflammation in the colon resulting from disruption of normal healthy bacteria in the colon, often from antibiotics). Review of the Infection Tracking Log for January 2025 showed: - 17 out of 17 residents did not have the date infection was resolved, or if resolved; - No documentation of organism for wounds or UTI diagnoses; - One resident showed appropriate antibiotic was not ordered, with no other documentation; - One resident showed antibiotic changed in hospital; - Two residents had shortness of breath (SOB) documented as signs of infection; - 15 residents had no documentation that showed if appropriate antibiotic was ordered. Review of the facility's Infection Surveillance Monthly Report for January 2025 showed: - Five out of 15 residents did not have signs and/or symptoms documented; - Seven out of 15 residents did not have documentation of the antibiotic ordered. During an interview on 02/28/25 at 12:52 P.M., the Administrator said since he/she had been at the facility for about one year, and they had not reviewed/updated the IPCP program/policy. He/She added that corporate would assist in this. (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/25 at 12:53 P.M., the Director of Nursing (DON), who also served as the Infection Preventionist (IP), said the charge nurse will observe for signs and symptoms of an infection and talk to the nurse practitioner (NP), who is there twice a week, or physician to have them see the resident. The DON will add the antibiotic to the paper infection log. When an antibiotic is ordered in the electronic charting system, it will trigger for the Infection Prevention/Control (IPC) stop sign symbol to go up at the top of the screen. Staff hover over this and it will show suspected or confirmed. The infection is considered suspected until confirmed by diagnostics/labs or the physician. Once the physician confirms, it should show confirmed. He/She should be more vocal on assuring the NP and/or Physician order labs and cultures when indicated. The nurses are supposed to do an Infection Screen (under Assessments) when started on an antibiotic then they should do an Antibiotic Timeout (under Assessments) three days later. Updates or whether the infection resolved or not are not documented on the tracking tool. The Administrator can run reports from the electronic charting system, and infections had been plotted on a facility map for the past three months on Tuesday, but that had not been done before. If several residents on a hall have the same type of infection, such as a UTI, it could be due to dehydration, but a root cause analysis had not been done to find out why infections are occurring nor are the infections being tracked. During an interview on 02/28/25 at 4:45 P.M., the Administrator, DON and Assistant Director of Nursing (ADON), collectively said they would expect the facility to have an on-going antibiotic stewardship program that includes documentation of the indication, dosage, duration, outcome of antibiotic use, proper diagnosis, labs and cultures if/when indicated. The Administrator said the facility should review the IPCP at least annually and it should include standards, policies and procedures that are current, as well as an infection surveillance program. 46460