STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720 Based on observation, interview, and record review, the facility failed to ensure residents who required staff assistance with bathing received baths and/or showers to meet the needs of one sampled resident (Resident #68) out of 18 sampled residents. The facility census was 76 residents. Review of facility policy Bath, Shower/Tub revised 2/2018 showed: -The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. -Document date and time the bath or shower was preformed. -Document the name and title of the individual(s) who assisted the resident with the shower/tub bath. -Document all assessment data (e.g., any reddened areas, sores, etc., on the residents skin) obtained during shower/tub bath. -Document if the resident refused the shower/tub bath, reason(s) why and the interventions taken. 1. Review of Resident #68's Face Sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of Parkinson's disease (a chronic nervous disease characterized by a fine slowly spreading tremor, muscle weakness, muscle stiffness and a peculiar gait). Review of the resident's Care Plan dated 3/11/24 showed the resident required substantial assistance from staff for bathing. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 10/24/24 showed the resident: -Was cognitively intact. -Required substantial assistance/maximum assistance by staff for bathing. (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
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Electronic Medical Record (EMR) on 12/9/24 showed baths for the previous 30 days were provided to the resident on 11/23/24, 12/7/24, and 12/8/24. Staff documented no on 11/14/24 and 11/15/24 with no documentation if the bath was offered and refused by the resident or was not offered to the resident. Review of the resident's paper bath sheets for the previous three months showed baths were offered and/or received: -The resident received five baths in September 2024. No baths were documented between 9/1/24 - 9/13/24. The resident was without a bath and/or shower for 13 consecutive days. -The resident received four baths in October 2024. No baths were documented after 10/12/24. -The resident received two baths in November 2024. No baths were documented between 10/12/24 - 11/8/24. No baths were documented between 11/10/24 - 11/22/24. The resident was without a bath and/or shower for 28 consecutive days. -The resident did not have any documented baths in December 2024. -NOTE: The resident was without a bath and/or shower 14 consecutive days when comparing the EMR and paper bath sheet record from 11/23/24 - 12/7/24. Observation on 12/6/24 at 11:59 A.M. the resident had a body odor and had greasy appearing hair. During an interview on 12/6/24 at 12:00 P.M., the resident said: -He/She did not get baths twice a week. -He/She thought it had been a couple of weeks since his/her last bath or shower. -He/She did not get any baths a couple of months ago when he/she had COVID (a new disease caused by a novel (new) coronavirus) sometime in October 2024. -He/She had asked for baths, but staff were not available to assist him/her. -He/She wished he/she could get baths at least twice a week. During an interview 12/13/24 at 10:41 A.M. Nursing Assistant (NA) A said: -The facility did have bath aides. -Charge nurse was responsible for daily bath schedules and would let him/her know what residents had needed baths for the day. -He/She was not aware the resident had missed multiple baths. -He/She would document baths on the bath sheet and in EMR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Baths should be offered to residents twice a week. -He/She would report to the charge nurse if a resident refused a bath. During an interview on 12/13/24 at 10:53 A.M. Licensed Practical Nurse (LPN) B said: -The facility did not use bath aides and the charge nurses would be responsible for scheduling residents and making sure that they are completed. -Baths would be documented on bath sheets and the residents EMR. -He/She was not aware the resident had not gotten his/her baths for long periods of time and did not notice any odors. -Residents should be offered baths at least two times per week. During an interview on 12/13/24 at 10:57 the Assistant Director of Nursing (ADON) said: -Bathing should be offered to all residents two times a week unless care plan specifies otherwise. -Bathing would be documented on bath sheets and in the residents EMRs. -He/She had not notice any body odors or unkept residents. -He/she and the Director of Nursing (DON) would be responsible to make sure baths were completed as scheduled. During an interview on 12/13/24 at 12:26 the DON said: -He/She would expect baths to be completed as scheduled weekly. -He/She would expect the charge nurses would follow up with staff every day to make sure baths are completed. -The charge nurse, ADON, DON and administrator would help out to get daily baths completed. -He/She would expect baths to be documented on bath sheets and in EMR. -He/She would be responsible for bath audits along with the ADON. -He/She was not aware the resident was not getting his/her baths and did not notice any odors or resident not being groomed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43345 Based on interview and record review, the facility failed to have a process in place to ensure Cardiopulmonary Resuscitation (CPR- an emergency procedure that combines chest compressions often with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person who was in cardiac arrest) staff were able to identify who was CPR certified staff on all shifts. The facility census was 76 residents. Review of the facility's Emergency Procedure-Cardiopulmonary Resuscitation policy revised February 2018 showed: -Personnel have completed training on initiation of cardiopulmonary resuscitation and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. -The chances of surviving sudden cardiac arrest may be increased if CPR was initiated immediately upon collapse. -Select and identified a CPR team for each shift in the case of an actual cardiac arrest. -To the extend possible, designated a team leader on each shift who was responsible for coordinating the rescue effort and directed other team members during the rescue effort. -The CPR Team in this facility would include at least one nurse and two Certified Nurse's Aides (CNA), all of whom had received training on CPR/BLS. 1. Review of facility staffing sheets dated [DATE] showed no designation for employees that were CPR certified, the CPR team, or CPR team leader. Review of facility staffing sheets dated [DATE] showed no designation for employees that were CPR certified, the CPR team, or CPR team leader. Review of facility staffing sheets dated [DATE] showed no designation for employees that were CPR certified, the CPR team, or CPR team leader. Review of facility staffing sheets dated [DATE] showed no designation for employees that were CPR certified, the CPR team, or CPR team leader. Review of facility staffing sheets dated [DATE] showed no designation for employees that were CPR certified, the CPR team, or CPR team leader. Review of facility staffing sheets dated [DATE] showed no designation for employees that were CPR certified, the CPR team, or CPR team leader. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility staffing sheets dated [DATE] showed no designation for employees that were CPR certified, the CPR team, or CPR team leader. During an interview on [DATE] at 8:43 A.M., Nurse's Aide (NA) A said: -He/She thought all the nurses were CPR certified. -The staffing sheet did not designate who was on the CPR team or the CPR team leader. -The staffing sheets did not designate who was CPR certified. During an interview on [DATE] at 8:56 A.M., Housekeeping Supervisor said: -There was no documentation on the staffing schedule that showed who was CPR certified and there was no CPR team notated on the schedule. -The CPR team leader was not marked on the staffing schedule. During an interview on [DATE] at 8:59 A.M., the Staffing Coordinator said: -Not all the nurses or CNAs were CPR certified. -He/She did not have a list of all CPR certified staff. -He/She knew all the CPR certified staff. -There was no CPR team designated on the schedule. -He/She did not know that a CPR team was needed to be designated on the schedule. -He/She completed the staffing schedule and would post it. During an interview on [DATE] at 9:04 A.M., Certified Nurses Aide (CNA) C said: -The CPR team was not listed on the daily schedule. -The team leader of the CPR team was not listed on the schedule. -The schedule did not list who was CPR certified. During an interview on [DATE] at 9:10 A.M., Certified Medication Technician (CMT) A said: -He/She was CPR certified. -He/She did not know any other staff that were CPR certified. -He/She did not of any staff being listed as on the CPR team. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The CPR team was not listed on the schedule. During an interview on [DATE] at 9:14 A.M., Licensed Practical Nurse (LPN) A said: -The staffing sheet did not designate who was CPR certified. -The staffing sheet did not designate who was on the CPR team each shift nor who was the CPR team leader. During an interview on [DATE] at 12:25 P.M., Director of Nursing (DON) said: -The daily staffing schedule did not designate who was CPR certified. -The daily staffing sheet did not designate a CPR team with a nurse as the leader. -In the event that CPR was required the staff would have to ask who was CPR certified. -The fact staff were not designated on the staff schedule might cause a delay in starting CPR. -The DON or the Staffing Coordinator would be responsible for the list of CPR certified staff and having it placed at the nurse's station.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720 Based on observation, interview, and record review, the facility failed to ensure weekly wound tracking for one sampled resident (Resident #2) with a history of a chronic Stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction); and failed to ensure services to prevent and heal pressure ulcers for one sampled resident (Resident #58) who was at high risk for skin breakdown out of 18 sampled residents. The facility census was 76 residents. Review of the facility Wound Care Policy, revised 10/2010 showed: -The following documentation should be recorded in the resident's medical record: --The type of wound care given. --The date and time the wound care was given. --All assessment data (i.e., wound bed color, size, drainage, ect.) obtained when inspecting the wound. Review of www.medline.com/strategies/skin-health/evidence-based-best-practices-heels-npiap-guidelines-help-prevent-pressure-injuries/ dated 7/2020 showed: -For residents at risk for heel pressure injuries, elevate the heels using a specifically designed heel suspension device or a pillow or foam cushion. -Be sure to offload (minimize or removing weight placed on the foot to help prevent and heal ulcers) the heel completely to distribute the weight of the leg along the calf. 1. Review of Resident #2's Face Sheet showed he/she was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of a Stage IV pressure ulcer in the sacral area (large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity). Review of the undated Physician's Order Sheet (POS) showed an order for skin assessments to be completed weekly on Friday by licensed nurse. Review of the resident's weekly wound reports showed no documentation of a detailed wound assessment on the following dates: -1/18/24. -2/1/24 and 2/8/24. -4/4/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/22/24 and 5/29/24. -7/17/24. -8/8/24 and 8/29/24. -9/4/24 and 9/11/24. -10/28/24. -11/8/24 and 11/22/24. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 10/14/24 showed the resident: -Had a Stage IV pressure ulcer. -Was cognitively intact, During an interview with the resident on 12/6/24 at 1:13 P.M., he/she said: -He/She had a Stage IV pressure ulcer on his/her buttocks region. -He/She had the Stage IV pressure ulcer for years. It would heal and open back up frequently. Observation on 12/10/24 at 10:47 A.M. showed the resident's Stage IV pressure ulcer on his/her sacral area was healed with no open areas. During an interview on 12/10/24 at 11:00 A.M., Licensed Practical Nurse (LPN) A said: -The resident had a Stage IV pressure ulcer on his/her sacral area. -The resident's pressure ulcer would heal and open back up frequently. -The facility wound nurse documented the wound assessments. 46890 2. Review of Resident #58's Face Sheet showed he/she was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses of Flaccid Hemiplegia (a condition characterized by paralysis and loss of muscle tone on one side of the body). Review of the resident's Significant Change of Condition MDS dated [DATE] showed the resident: -Had moderate cognitive impairment. -Had upper and lower extremity impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Was dependent on staff for mobility. -Was always incontinent of bowel and bladder. -Was at risk for pressure ulcers. Review of the resident's Care Plan, initiated 12/4/24 showed: -Staff were to provide total assist with bed mobility. -Had history of pressure ulcers and immobility. -His/Her skin would remain intact. Observation on 12/6/24 at 9:26 A.M. showed: -The resident lying in bed on his/her back. -His/Her heels were resting directly on his/her mattress. Review of the resident's Braden Scale (a risk assessment tool to identify residents at risk for developing pressure ulcers) dated 12/8/24 showed he/she was high risk for developing pressure ulcers. Observation 12/9/24 at 8:15 A.M. showed: -The resident lying in bed on his/her back. -His/Her heels were resting directly on his/her mattress. Observation on 12/10/24 at 8:47 A.M. showed: -The resident lying in bed on his/her back. -His/Her heels were resting directly on his/her mattress. Observation and interview on 12/10/24 at 9:17 A.M. Licensed Practical Nurse (LPN) A said: -The resident was lying in bed on his/her back. -His/Her heels were directly resting on his/her mattress. -His/heels were observed to be red. -LPN A had stated that he/she noticed redness on the heels 12/7/24 and had ordered heel protectors. -LPN A described the heels as feeling boggy (a feeling of sponginess in the tissue). -LPN A was not aware that heel protectors had not been on the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/11/24 at 8:28 A.M. showed. -The resident lying in bed on his/her back. -His/Her heels were resting directly on his/her mattress. Observation on 12/13/24 at 8:45 A.M. showed: -The resident sitting up in his/her wheelchair. -His/Her heels resting directly on his/her wheelchair foot rests. 3. During an Interview on 12/13/24 at 8:59 A.M. Certified Nursing Assistant (CNA) D said: -If a resident was at high risk for skin breakdown he/she would reposition resident every two hours. -He/She would get a daily report from the charge nurse if residents had a change in skin condition and needed new interventions. -He/She believed the resident care plans were at the nursing station. -He/She would report skin changes to the charge nurse. -He/She was not aware that Resident #58 was to have heel protectors. -The charge nurses were responsible for weekly skin assessments. During an interview on 12/13/24 at 9:08 A.M. Certified Medication Technician (CMT) B said: -He/She would get daily report from the charge nurse of any care need changes. -Charge nurses were responsible for weekly skin assessments. -He/She was not aware that Resident #58 needed heel protectors or heel pressure relief. During an interview on 12/13/24 at 9:20 A.M. LPN B said: -Residents who were at high risk for skin breakdown should be turned and checked for incontinence frequently, barrier cream after incontinence. -Charge nurses were responsible for weekly skin assessments, including detailed wound assessments, and documented the the resident electronic medical record. -The Care Plan Coordinator was responsible for updating the resident's care plan. During an interview on 12/13/24 at 9:30 A.M. the MDS Coordinator said: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There should be interventions in the resident's care plan if the resident was at high risk for pressure ulcers. -He/She was responsible for updating resident care plans. -He/She was not aware that Resident #58 did not have high risk for skin breakdown interventions in place related to his/her heels. -Charge nurses were responsible for completing weekly skin assessments, including detailed wound assessments. -The Assistant Director of Nursing (ADON) and Director of Nursing (DON) are responsible to make sure weekly skin assessments are completed. During an interview on 12/13/24 at 11:21 A.M. the ADON said: -All residents who were high risk for skin break down should have interventions in place including heel protectors. -He/She along with the DON were responsible to make sure weekly skin assessments, including detailed wound assessments, were done and interventions were in place in the residents care plan. During an interview on 12/13/24 at 12:26 P.M. the DON said: -He/She would expect weekly skin assessments to be completed by charge nurses. -He/She would be responsible to audit and make sure weekly skin assessments, including detailed wound assessments, were completed. -He/She would expect appropriate interventions be put in place for residents who were at high risk for skin breakdown. -He/She would expect Resident #58 to have heel protectors for prevention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32720 Based on interview and record review, the facility failed to complete a thorough fall investigation to include interviews of staff and/or potential witnesses, failed to complete fall assessments after each fall, and failed to implement appropriate interventions for a significantly cognitively impaired resident (Resident #32) out of 18 sampled residents. The facility census was 76 residents. Review of the facility policy Assessing Falls and Their Causes Revised 3/2018 showed: -When a resident falls, the following information should be recorded in the resident's medical record: --The condition of which the resident was found. --Assessment data, including vital signs and any obvious injuries. --Interventions, first aid, or treatment administered. --Notification of physician and family, as indicated. --Completion of a falls risk assessment. --Appropriate interventions taken to prevent future falls. -Define details of falls. -Identify causes of falls. -Perform a post-fall evaluation. 1. Review of Resident #32's face sheet showed he/she was admitted to the facility 5/1/21 with the following diagnoses: -Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses). -Delusional disorder (delusions - fixed false beliefs). -History of repeated falls. Review of the resident's care plan dated 5/19/21 and revised on 9/14/24 showed: -The resident was at risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Make sure call light is nearby and remind the resident to use the call light. -Educate resident and family safety reminders and what to do if a fall occurs. -Educate resident to wear non-skid shoes/socks when not in bed -The resident had non-injury falls on 12/16/23, 1/10/24, 2/17/24, 2/24/24. -The resident had injury falls on 5/11/23 and 5/29/24. --NOTE: No documentaion or care plan updates for the resident's falls on 8/27/24, 9/1/24, or 12/4/24. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 6/14/24 showed he/she: -Was severely cognitively impaired. -Had one injury fall since the prior assessment. Review of the resident's fall investigation dated 8/27/24 showed: -The resident was seen on the floor with his/her back against the bed. -The resident stated he/she was just sitting there waiting on the staff member. -The resident was not a good historian. -The resident was assessed with no apparent injuries. -The resident was wearing slide socks with no grips or shoes at the time. -The nurse educated the resident on using the call light, however the resident was not capable of retaining new information due to diagnosis. -NOTE: The investigation did not include interviews with staff or any other potential witnesses and it was noted the intervention was not appropriate for the resident due to the resident's impaired cognition. The investigation did not include a root cause analysis. Review of the resident's fall investigation dated 9/1/24 showed: -The nurse was called to the resident's room by a Certified Nursing Assistant (CNA). Upon entering the room, the resident was observed to be on the floor with his/her head slightly lifted off of the floor. The resident's feet were crossed over each other and his/her right shoe had fallen off. -The resident's walker was unlocked and call light was not being used at the time of the fall. -The resident said he/she was trying to get to out of the bathroom. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was assessed with no apparent injury other than an abrasion to his/her right elbow. -The resident was educated on using the call light and waiting for assistance. -The resident had a prior fall on 8/27/24 when he/she attempted to get out of bed barefoot. The intervention for that fall was to educate on call light usage, however the resident was unable to retain information due to increased confusion. -NOTE: The investigation did not include interviews with staff or any other potential witnesses and it was noted the intervention was not appropriate for the resident due to the resident's impaired cognition. The investigation did not include a root cause analysis. Review of the resident's annual MDS dated [DATE] showed he/she: -Was severely cognitively impaired. -Had one injury fall and one non-injury fall since the prior assessment. Review of the resident's Fall Risk assessment dated [DATE] showed the resident: -Did not have any falls within the last three months. -Was disoriented times three (person, place, situation/time) at all times. -Was ambulatory and incontinent. -Required assistive devices such as a wheelchair or walker for ambulation. -Received 1-2 of a list of medications within the last seven days. The medications included psychotropic medication (mind altering medication used to treat mental illnesses). -The fall risk assessment did not include a total score to determine the resident's risk for falls, did not include any interventions or clinical suggestions as indicated on the form. --NOTE: A new fall risk assessment was not completed after the resident's fall on 8/27/24, 9/1/24, or 12/4/24. Review of the resident's quarterly MDS dated [DATE] showed he/she: -Was severely cognitively impaired. -Had one injury fall and one non-injury fall since the prior assessment. Review of the resident's fall investigation dated 12/4/24 showed: -The resident was found on the floor with a laceration (cut) to the back of his/her head. The resident was assessed and assisted back to bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was alert, oriented to person only, was confused with impaired memory. -No staff interviews were included in the investigation. No further information describing the incident was included in the investigation. The investigation did not include a root cause analysis. During an interview 12/13/24 at 10:42 A.M. Nursing Assistant (NA) A said: -He/She would be informed by the charge nurses if any new fall interventions are added. -He/She would not think using the intervention Remind Resident To Use Call Light was appropriate for a resident with memory loss. During an interview 12/13/24 at 10:46 A.M. Licensed Practical Nurse (LPN) B said: -He/She would assess the resident after a fall for injuries. -He/She would start a fall risk management assessment, would include resident interview, staff interview and put an immediate intervention in place. -He/She would be made aware of new interventions for residents during shift report. -He/She would not use Remind Resident To Use Call Light as an intervention for a resident with memory loss. -The Assistant Director Of Nursing (ADON) and Director Of Nursing (DON) are responsible for reviewing fall investigations and appropriate interventions for falls. During an interview 12/13/24 at 10:59 A.M. the (Assistant Director of Nursing) ADON said: -If a resident fell a full assessment should be done to check for injuries. -A fall assessment and a fall risk assessment was completed. -An immediate intervention would be put in place and all falls would be reviewed as a team in the weekly risk meeting. -He/She would interview staff witnesses related to a fall. -The charge nurse would put in the immediate intervention after a fall. -He/She and the Director of Nursing (DON) were responsible to make sure all fall documentation was complete and the fall interventions were appropriate. -Remind to use call light for an intervention for a resident with memory loss would not be appropriate. During an interview 12/13/24 at 12:26 A.M. the DON said: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She would expect fall investigations to be complete and thorough with appropriate interventions. -He/She would be responsible to audit and review all fall investigations. -He/She was aware not all fall investigations were completed per facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43345 Based on observation, interview, and record review, the facility failed to accurately assess a resident's Percutaneous Endoscopic Gastrostomy tube (PEG tube - a tube that is placed into a patient's stomach as a means of feeding them when they are unable to eat) for proper placement for one sampled resident (Resident #74) out of 18 sampled residents. The facility census was 76 residents. Record review of the facility's Confirming Placement of Feeding Tubes policy revised November 2018 showed: -The exit site of the feeding tune would be marked (by incremental marking on the tube or by documented tube length) at initial time of placement. -If a change in the incremental length was observed, use additional method(s) to test whether the tube was properly positioned: --Observed for symptoms of elevated gastric residual volume (GRV): ---A sharp increase in residual volume might have indicated that a small bowl tube has migrated into the stomach. ---Little to no residual might have suggested the tube has migrated from the stomach to the esophagus. --Observed and checked pH (scale measures how acidic or basic a substance) of the residual. ---Fasting stomach contents would have a clear and colorless or grassy green and brown appearance. ---Fluids from the lung space might have pale yellow clear appearance. ---Post-pyloric (after stomach)/small bowel contents might be bile stained, light to dark yellow or greenish-brown. ---Fasting stomach acid will have a pH of five or less. ---Fluid from the lung space will have a pH of seven or higher. ---A pH of five or less suggests that the tube is placed in the stomach. ---A pH of six or higher was not definitive of placement outside the stomach. 1. Review of Resident #74's Admission Record showed he/she was admitted to the facility on [DATE] and had a PEG tube. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 11/24/24 showed he/she: -Had moderate cognitive impairment. -Received his/her over 51 percent (%) nutrition through tube feeding. Review of the resident's care plan revised on 11/29/24 showed he/she: -Was dependent on staff for all cares. -Had a PEG tube for nutrition. -Staff were to check for PEG tube placement and check for gastric residual. -The care plan did not show to check the PEG tube by measurement. Review of the resident's December 2024 Order Summary Report (OSR) showed: -Check for gastric residual each shift from the resident's PEG. -Every shift check and record tube feeding residual. If residual is greater than 150 ml, hold feeding and call doctor. -Every shift check tube placement prior to administration of medication and tube feeding. -Note: There were no orders of how to check placement or measure the tube feeding for placement. Observation on 12/10/24 at 9:39 A.M. of the resident showed: -Licensed Practical Nurse (LPN) A administered an air bolus through the resident's PEG tube and auscultated (listen) for sound through the resident's abdomen. -He/She then aspirated for gastric contents, then flushed the resident's PEG tube with water. -LPN C did not check for the external length/measurement of the PEG tube. During an interview on 12/10/24 at 9:58 A.M., LPN A said: -Staff were to verify PEG tube placement by auscultation and aspiration (to use a syringe to withdraw a small amount of stomach contents (the residual) from a feeding tube to assess how well the stomach is emptying, by checking the volume of fluid that remains after a feeding of gastric contents). -He/She has never measured a resident's external PEG tube length. -He/She followed facility policy on checking PEG tube placement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not remember seeing anywhere in the residents' charts what the external length of tubing should be for their PEG tubes. During an interview on 12/13/24 at 12:25 P.M., the Director of Nursing (DON) said: -Staff should verify placement of a resident's PEG tube by aspiration of gastric contents and auscultation. -The facility policy was to verify placement by auscultation and residual of gastric contents. -He/she expected staff to follow the physician's order on how to assess a PEG tube. -He/she expected the care plan to include how to assess the resident's PEG tube to include auscultation and aspiration of gastric contents. -The orders did not include measuring the tube to check for placement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19016 Based on interview and record review, the facility failed to ensure the Dietary Manager (DM) met one of the qualifications for a Certified Dietary Manager (CDM) by having an approved certification for food service management and safety from a certifying body, an associate's degree in food service management or hospitality, or had 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and had completed a course of study in food safety and management. This practice potentially affected all residents. The facility census was 76 residents. Review of the facility's Dietitian policy, revised November, 2022 showed if a Dietitian is not employed full time (35 or more hours per week) a Director of Food and Nutrition Services will be designated. This individual will: -Be a certified dietary manager, a certified food services manager, or be nationally certified in food service management and safety, or -Have an associate degree or higher in food service management or hospitality if the course includes food service or restaurant management from an accredited institution, or -Has two or more years' experience in the position of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management by no later than October 1, 2023 that includes topics integral to managing dietary operations, including, but not limited to foodborne illness, sanitation procedures, and food purchasing/receiving and meet any state requirements for food service or dietary managers, and -Receives frequent scheduled consultations from a qualified dietitian or nutrition professional. -For designations made before November 28, 2016 the director of food service management will meet the requirements no later than November 28, 2021. For designations made after November 28, 2016 the requirements will be met no later than November, 2017. 1. During an interview on 12/10/24 at 2:05 P.M., the DM said: -He/she had worked as a DM for the past two months since the previous DM manager left without notice. -He/She has no certification or education of any kind to qualify him/her for the DM position. -He/She had been a kitchen supervisor for the past [AGE] years, but had not worked as a DM. His/Her responsibilities involved scheduling and supervising kitchen staff. -There had been no training scheduled yet to meet the qualifications of a DM, so he/she didn't know when his/her classes would start. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/16/24 at 12:32 P.M., the Administrator said: -The previous DM abruptly quit one morning weeks ago, and they had been using someone with several years' experience cooking in the kitchen as the DM. - He/She realized the employee they were currently using as a DM needed the appropriate qualifications to be a DM, but the employee hadn't yet been enrolled in any dietary management training program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 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. 19016 Based on observation and interview, the facility failed to ensure condiments were stored properly, clean grease and food from condiment and spice containers, clean grease build up from kitchen surfaces including the stove and oven, remove build-up of soap or other substances from soap dispensers, a soap dish, and dish washing machine trays, and to ensure trays and food containers were not stored on surfaces that were chipped and therefore unable to be sanitized. This practice potentially affected all residents who ate food from the kitchen. The facility census was 76 residents. 1. Observation on 12/05/24 from 9:31 A.M. to 12:55 P.M. showed: -At 9:31 A.M. bits of debris were all over the kitchen floor, most of which were one-half inch and smaller, with a few bits larger. There were multiple spills on the floor. -The stove knobs, surface surrounding the knobs, and two oven handles of the stove (stove/griddle/oven appliance) had a build up grease. The six burners had a crusty charred built-up coating. The sides of the appliance had a light film of grease with adhering dust. The gas line including the gas valve behind the appliance had a thick build up of grease covered with dust. -The knobs, surface surrounding the knobs, and the handle of the baker's oven was greasy. The gas line behind the baker's oven was covered with grease and dust. -In the drink area (juice, coffee, ice machine room) a tray near the coffee pot contained: --A syrup bottle with syrup running down the sides and on the nozzle lid. The tip of the nozzle was open and uncapped. --An opened container of mustard, almost empty, and a red container with contents that looked and smelled like ketchup were both smeared on the sides with dried product. --Four spice containers had a film of grease and opened holes at the top. -In the kitchen, the microwave was greasy with multiple fingerprints on the door, handle, and buttons. -There were 24 spice containers in the kitchen with an oily film on the outside and adhering dust on the sides and lids. Four spice container lids were open approximately one-third to one-half inch exposing the contents to dust. -The eye wash bottle, soap and sanitizer dispensers at the hand-washing sink had a dried film coating on them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The bottom shelves of the microwave table and three food prep tables each had several chips, some as big as a couple of inches, exposing a rusty-colored surface below which could not be effectively sanitized. All four bottom shelves had built-up greasy stains on the horizontal surface near the outside perimeters. Another food prep table with wheels had four trays with water cups sitting on the chipped surface and a tray with plastic cups with lids. -Below a stationary prep table four floor tiles were missing, exposing broken up concrete and/or gravel. -Twelve dish washer trays used for washing dishes were stacked near the dishwasher. Each tray was coated with a charcoal/mold-like color. The prongs where plates and glasses were stacked had a lighter grayish color. -The tiled wall behind the steam table was wet with steam and had built-up dust. Observation on 12/9/24 from 10:42 A.M. to 11:45 A.M. showed: -In the drink area the tray near the coffee maker contained the following: --The bottle of syrup with syrup on the sides and lid and no cap for the opened nozzle lid. --The red container had a sticky film and an opened nozzle lid with no cap. --The mostly empty mustard container had dried debris on the sides. The opened container was not labeled or dated. --A large plastic container of grape jelly had been opened and a little bit of the jelly had been used. The opened container was not dated or stored in a refrigerator. The container instructions were to Refrigerate after opening. --A grinder container of pink Himalayan salt had an oily film. The lid of the container was missing. --A jar of fennel spice had a greasy film. The lid was turned to where two holes were open. The top of the spice container was gritty with the spice or other debris. --A Creole seasoning container had greasy sides. The top was gritty with the spice or other debris and the lid was turned to where four holes were open. --A fourth jar had a piece of tape with someone's name on it and the word fennel handwritten on a piece of masking tape. A white substance resembling salt was in the see-through container. The lid was gritty and stained. All holes on the lid were open. -In the main kitchen area the bottom shelves below the microwave and the food prep tables had oily stains, chipped surfaces, and with containers, soup cans, and trays stored on them. -The microwave contained multiple greasy fingerprints on the handle, front door, and buttons. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A circle-shaped cereal piece was on the broken concrete where tile was missing under the stationary food prep table. -Spice containers in the kitchen had a greasy film to which dust adhered. -The baking oven door handle was smeared with oily fingerprints and the gas line was coated with built-up grease and dust. -The stove had built-up greasy oven handles, knobs, and knob panel. The six burners were black with crusty, oily build-up. The gas line behind the stove had built up grease and dust. -At 11:00 A.M. food was on the steam table. The wall behind the table was moist and dirty with dust. -Thirteen dish washer trays were stacked near the dishwasher, all with a charcoal/mold colored coating on the sides. The eye wash saline bottle and paper towel dispenser by the hand-washing sink were dirty with dust and the soap and sanitizer dispensers were soiled. -The floor was sticky in areas and had debris on the floor throughout the kitchen. -The mop bucket area floor was dirty with debris and the tray for soap or scouring pads was coated in a crusty dark substance. Observation on 12/10/24 from 1:00 P.M. to 2:20 P.M. showed: -In the drink area the mustard, ketchup, grape jelly, and spice containers sat on a tray near the coffee maker and were dirty and opened as they were the day before. The jelly was not refrigerated. -The kitchen floors were dirty with debris. -The mop bucket area soap/scour pad tray was crusted with a coating and the mop bucket area floor had built up dirt and debris. Review of the facility's monthly cleaning checklists for July, 2024 through 12/10/24 showed: -In July, 2024 cleaning tasks for the baker's oven and the stove (stove/griddle/oven appliance) had not been dated and initialed as having been completed. Cleaning for two refrigerators, sprinkler heads, vents, and the clock and dumpster inspections hadn't been dated and initialed as having been done. -In August, 2024 the following was not dated and initialed as having been cleaned: --Hood system and all vents. --Date and clean all spices. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Oven/grill/stove appliance. --Steam table and wall behind it and floor below it. --Four gray drawers and slides. --Hood system above dish machine. --Dish machine and chemical dollies and floor below the dish machine. --Garbage disposals and wall underneath. --Floor under baker's table and around tilt skillet. --Pot and pan shelves and floor below it. --Refrigerator number two and three shelves, wall, floors, and door. --Pot/pan sink and mop bucket sink. --Drink room machines, doors and walls and floor below machines. --Dry storage room. Check that all items are labeled and dated. Sweep and mop floor under shelves. --Sprinkler heads, vents, and clock. -In September, 2024, 16 of 20 monthly cleaning tasks were left blank. -In October, 2024, 16 of 20 monthly cleaning tasks were left blank. -There was no cleaning schedule completed for the month of November, 2024 and a cleaning schedule for December, 2024 had not been started. Review of the facility's daily cleaning checklist for 11/17/24 through 12/9/24 showed: -The same tasks were to be done daily on both the day and evening shifts, including: --Sweeping and mopping all floors (kitchen, drink room, and storage room). --Cleaning microwaves inside and out. --Removing outdated foods. --Cleaning the stovetop. --Refrigerating, labeling, and securing all food items. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The day shift left all tasks blank on 12/8/24 and the evening shift left all tasks blank on 11/21/24, 11/22/24, and 11/30/24. The bottom of the form showed spaces for the supervisor's daily initials. Supervisor initials were only marked on the day shift for November 18 and 19. During an interview on 12/10/24 at 1:00 P.M. Dietary Server B said: -They store ketchup in the red plastic bottle and keep mustard in the original mustard container. -They always kept the ketchup, mustard, jelly, and syrup out on the tray in the drink area during breakfast and lunch. They were left out on the tray near the coffee pot when he/she left for the day at 2:00 P.M. and were always out on the tray when he/she arrived in the mornings. They just leave the four condiments stored out on the tray. -Nobody cleaned the condiment containers that he/she knew of. He/She only cleaned the counter surfaces and the coffee maker and juice machine trays by running them through the dishwasher. -Floors were supposed to be swept and mopped daily after each meal. They sometimes cleaned after the breakfast or lunch meal if they had time. Nobody had swept or mopped yet today. -The lower shelves under the microwave and prep tables should all be kept clean. All dietary staff were responsible for cleaning all kitchen surfaces as well as the eye wash container and soap and sanitizer dispensers near the handwashing sink. They should be cleaned daily as needed. -He/She didn't know why the mop bucket area was so dirty. All dietary staff were responsible for cleaning it. -The grill and burners should be cleaned between each meal. -He/She didn't know if there was a cleaning schedule for kitchen surfaces. -It was fine to store trays and pans on the chipped bottom shelves below the microwave counter and the food prep tables. During an interview on 12/10/24 at 1:20 P.M. Dietary [NAME] A said: -There was a cleaning schedule for monthly and daily cleaning tasks and one for periodic cleaning that the Dietary Manager (DM) kept. -Whoever used the baking oven needed to clean it. The inside had to be cleaned monthly. -The monthly cleaning tasks were done any time during the month whenever dietary staff had time to do them, but each task should be done every month. If a task was not marked as having gotten done that meant it wasn't done or staff didn't mark it as having been done. -They had always stored pans and trays on the bottom chipped shelves under the microwave and food prep tables. The surfaces probably should be cleaned with a sanitizer every couple of weeks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The cook was supposed to clean the stove burners. The charred burners have to be scraped off monthly. Anyone can clean the burner knobs with a degreaser or scouring pad. -The gas lines going to the baker's oven and stove should be cleaned on the special duty cleaning schedule which the DM has. -There used to be a spigot where the floor tiles were missing and the concrete was loose. Water used to go from the floor at that spot to the tilt skillet. The concrete kept breaking up and dietary staff just sweep around it. -Normally a dietary aide will sweep and mop the floor on the evening shift. -Whoever does the dishes should clean the dishwasher trays. They don't come clean in the dishwasher. He/She thought the darkened color was just soap build up. During an interview on 12/10/24 at 1:55 P.M. Dietary [NAME] B said floors should be cleaned at the end of each meal. During an interview on 12/10/24 at 2:05 P.M. the DM said: -Once the jelly, mustard and ketchup containers are opened they should be stored when not in use in a refrigerator that is not over 40 degrees Fahrenheit. The syrup and ketchup container nozzle lids should have a cap on them. -The spice and condiment containers should be wiped off with the sanitizer solution daily. The spice containers in the kitchen get greasy from the hood vent they are under. Lids on spice containers should all be closed. -When staff use the tilt skillet grease goes everywhere. -Dietary staff should try to clean floors three times daily after each meal. -The flat top griddle should be cleaned between breakfast and lunch. -An oven cleaner can be used to clean burners. They should be cleaned off at least every two weeks. -All dietary staff should be cleaning kitchen surfaces. Whoever uses a surface or an appliance should clean them. -The cook was responsible for cleaning knobs on the ovens and stove. -Oil on the back of the baker's oven and stove builds up fast. It should be cleaned at least weekly to make sure dust and debris doesn't build up on it. -He/She wasn't sure of the protocol for cleaning off the gas lines to the oven and stove. A company came out every six months to clean the hood. They should clean the gas lines then as well. They were just out in late November this year. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff should clean the wall behind the steam table monthly. -Dietary staff filled out maintenance logs several times related to the missing tiles and broken concrete in the kitchen. Several people put in a request at different times and the floor hasn't gotten fixed yet. He/She just kind of gave up on it getting fixed. -Whoever does a monthly task should date and initial beside the task they did. Every dietary staff member was responsible for the monthly and daily cleaning tasks. Staff have a whole month to complete each task on the monthly lists. He/She and the cook were responsible for checking to see that the cleaning tasks were being done as scheduled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46890 Based on observation, interview, and record review, the facility failed to follow appropriate infection control practices for three sampled residents (Resident #58, #27, and #74) who was on Enhanced Barrier Precautions (EBP - refer to an infection control intervention designed to reduce transmission of multi-resistant organisms that employs targeted gown and glove during high contact resident care activities) failed to use adequate hand hygiene during incontinence care for (Resident #58); failed to ensure infection control was maintained during wound care for one sampled resident(Resident #2); failed to perform proper hand hygiene during cares for one sampled resident (Resident #74); and failed to ensure yearly tuberculosis (TB - a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) test was completed for two sampled residents (Resident #32 and #2) out of 18 sampled residents. The Facility census was 76 residents. Review of the facility policy Handwashing/Hand Hygiene dated 2001 showed: -Hand hygiene is indicated: --Immediately before touching a resident, before performing an aseptic (aiming at the complete exclusion of harmful microorganisms) tasks, after contact with blood, body fluids, or contaminated surfaces, after touching residents, after touching residents environment, before moving from work on a soiled site to a clean body site on the same resident and immediately after glove removal. Review of the facility policy Wound Care revised 10/2010 showed: -Gather supplies (gauze, tape, scissors, etc.), personal protective equipment (gowns, gloves, masks etc.). -Wash and dry hands thoroughly. -Glove and remove dressing. -Pull glove over dressing and discard. Wash and dry hands thoroughly. -Glove. -Cleanse wound, pat dry. -Remove gloves and wash hands thoroughly. -Glove and apply treatment. Use no touch technique. -Remove gloves and wash hands thoroughly. Review of the facility policy Perineal Care revised 2/2018 showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Many	-The purpose of the procedure are to provide cleanliness and comfort to the resident, to prevent infection and skin irrigation, and observe the resident's skin condition. Review of facility policy Tuberculosis, Screening for Residents revised August 2019 showed: -The facility would screen all residents for tuberculosis infectious disease (TB). -The admitting nurse would screen referrals for admission and readmission for information regarding exposure to or symptoms of TB. -If a potential resident had been exposed to active TB or is at increased risk of TB infection, he or she would be screened for latent tuberculosis infection (LTBI residents do not feel sick, do not have any symptoms, but can potentially develop active TB disease) using a tuberculin skin test (can tell if you have TB germs in your body). -Screening of new admissions or readmissions for tuberculosis infection and disease was in compliance with Sate regulations. -The facility would have conducted an annual risk assessment to determine risk of exposure. -Risk factors for exposure to TB were: --those born in or who frequently traveled to countries where TB was common. --People who currently (or previously) lived in large group settings where TB was common (homeless shelters, prisons, etc.); or --Those who have spent time with a person who has had active TB disease. -Residents who had health conditions or have taken medications that predisposed them to developing active TB disease once infected are tested regularly according to their exposure risk assessment. Review of the facility policy EBPs dated 9/2024 showed: -EBPs are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. -Gloves and gown are applied prior to performing high contact resident care activities. -High-contact resident activities include: --Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube etc.) and wound care (any skin opening requiring a dressing). 1. Review of Resident #58's Face Sheet showed he/she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Many	-Flaccid hemiplegia (a condition characterized by paralysis and loss of muscle tone on one side of the body). -Feeding tube (a method of providing nutrition, fluids, and medication directly to the stomach or small intestine through a tube). Review of resident's significant change Minimum Data Set (MDS- a federally mandated assessment instrument completed by the facility staff for care planning) dated 11/24/24 showed the resident: -Had moderate cognitive impairment. -Had upper and lower extremity impairment. -Was dependent on staff for toileting. -Was always incontinent of bowel and bladder. -Had a feeding tube. Review of the resident's Electronic Medical Record (EMR) Physician's Order Summary (POS) dated 12/2024 showed he/she had feeding tube. Review of the resident's care plan dated 12/4/24 showed: -Staff was to provide total assist with toileting due to bowel and bladder incontinence. -Staff was to provide local care to feeding tube site and monitor for signs and symptoms of infection. Observation 12/9/24 at 11:03 A.M., of resident care showed: -The resident had EBP signage posted on the door. -Certified Nursing Assistant (CNA) A entered the resident's room and applied his/her gloves without washing his/her hands. CNA B was already in the room with his/her gloves on. CNA A and CNA B did not use Personal Protective Equipment (PPE) gown. -The resident was in bed on his/her back. CNA A and CNA B had pulled the resident's pants down to his/her ankles. -CNA A had released the residents incontinence brief and stuffed the brief between the resident's inner thighs. **NOTE: The residents brief was soiled with urine. -CNA A had used one wipe and had washed down the resident inner left thigh crease one time and had stuffed the wipe down into the brief between the resident legs and repeated that process on the right inner thigh crease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Many	**NOTE: CNA A did not to wash the front genitalia of the resident. -CNA B assisted CNA A to roll the resident on his/her left side and CNA A completed the resident's peritoneal cares. -CNA A and CNA B had pulled the residents pants up then placed his/her blankets over him/her without removing their soiled gloves and handwashing. -CNA A had discarded his/her gloves into the trash, had exited the residents room to retrieve a mechanical lift and had not washed his/her hands. During an interview 12/9/24 at 11:22 A.M., CNA A said: -He/She would have used more wipes and washed his/her hands more. -He/She had not known the resident was on EBP and should have worn gown during the resident care. -He/She would be told by the charge nurse if a resident was on EBP. -He/She should also be looking for EBP signage on the resident door. -He/She should have provided cleansing to the front genitalia on the resident. -He/She had perineal care and EBP training recently. 43345 2. Review of Resident #27's Admission Record showed the resident was admitted to the facility on [DATE] with neuromuscular dysfunction of bladder (a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition). Record review of the resident's quarterly MDS dated [DATE] showed he/she had an indwelling catheter (drains urine from your bladder into a bag outside your body). Observation on 12/6/24 at 2:13 P.M. showed: -There was no PPE cart outside the resident's room. -There was no EBP sign on the door or the door frame to the room. -Staff entered room without putting on PPE and moved the resident's catheter bag. During an interview on 12/6/24 at 2:33 P.M., CNA A said that he/she should have used PPE when handling the resident's catheter bag. 3. Review of Resident #74's Admission Record showed he/she was admitted to the facility on [DATE] and had a (PEG tube - a tube that is placed into a patient's stomach as a means of feeding them when they are unable to eat). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Many	Review of the resident's admission MDS dated [DATE] showed he/she: -Had a moderate cognitive impairment. -Received his/her over 51 percent (%) nutrition through tube feeding. -Required extensive staff assistance for transfers, bed mobility, dressing, and eating. -Required total staff assistance for bathing and toileting. Review of the resident's care plan revised on 11/29/24 showed he/she: -Was dependent on staff for all cares. -Had a PEG tube for nutrition. Observation on 12/10/24 at 9:41 A.M., of LPN A showed: -He/she had prepared all the resident's medications and removed his/her gloves and did not sanitize/wash hands. -He/she used a swab to stir medications and put gloves back on without sanitizing/washing hands. -He/she removed his/her gloves did not sanitize/wash hands and grabbed the bed control and adjusted the bed. -He/she removed his/her gloves and did not sanitize/wash hands and grabbed more gloves to put on the bedside table. -Cleaned the resident's PEG tube then put his/her dirty gloved hand into a bag of clean gauze to grab more gauze out. -He/she removed gloves and did not sanitize/wash his/her hands. -He/she did not have a gown on while administering medication through the resident's PEG tube or providing cares. During an interview on 12/13/24 at 9:14 A.M., LPN A said: -All residents with wounds and indwelling devices like catheters and PEG tubes would be on EBP. -For a resident on EBP you would wear a gown and gloves at a minimum. -Residents on EBP would have a yellow triangle with the letters EBP on the triangle and this would be on the resident's door. -He/She said that he/she should have had the gown on when doing PEG tube medications and cares. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Many	-If a resident was on EBP, and there was no sign on the door he/she would put one on the door. 32720 4. Review of Resident #2's annual MDS dated [DATE] showed the resident: -Had a Stage IV pressure ulcer. -Was cognitively intact. Review of the resident's undated POS showed: -Wound treatment: Sacrum (large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity), cleanse with wound cleanser of facility choice, apply A&D Ointment (used to prevent, treat, and relieve rashes caused by incontinence) every shift for wound care. -Wound treatment: Stoma (surgical opening), cleanse with wound cleanser and apply collagen powder moistened with normal saline to open areas every day shift every Friday for wound care and as needed. Observation of wound care for the resident with LPN A on 12/10/24 at 10:41 A.M. showed: -LPN A sanitized his/her hands, donned a clean gown, entered the resident's room, applied a barrier on the resident's bedside table, placed the wound care and colostomy (an alternative exit from the colon created to divert waste through a hole in the colon and through the wall of the abdomen) care supplied on the barrier, removed a pair of scissors from a lanyard on his/her uniform and placed the unsanitized pair of scissors on the clean barrier next to the wound care supplies. -Without sanitizing his/her hands, he/she donned clean gloves. -He/She cut the ostomy wafer (the piece of the pouching system that sticks to your body. It holds your pouch in place and should help protect the skin around your stoma from damage) to fit the stoma site without sanitizing the scissors. -After performing hand hygiene and changing gloves, he/she cleansed the resident's stoma site, removing stool as he/she was cleansing the site. Then with the same gloves, he/she reached into the gauze package, removed additional gauze. -After performing hand hygiene, he/she continued to cleanse the stoma site, then with the same gloves applied the collagen wound treatment, picked up the bottle of colostomy collagen powder and applied powder to the site. He/She then removed one glove and without sanitizing donned a new clean glove, applied the colostomy wafer and colostomy bag. -He/She removed his/her gloves and with ungloved hands, touched the resident's Foley catheter (a tube with retaining balloon passed through the urethra into the bladder to drain urine) tubing and bag, and placed it on the bed next to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Many	-Without washing or sanitizing his/her hands, he/she donned clean gloves and touched the resident as he/she assisted the resident to turn to his/her side, and with the same gloved hands, reached into the package of gauze to remove clean gauze, then cleansed the resident's healed sacral wound. With the same gloved hands, he/she applied ointment to the resident's sacral area. -He/She removed his/her gloves, then without washing or sanitizing his/her hands, with ungloved hands, he/she removed the Foley catheter from the resident's mattress, touched the resident's bedding, removed the remaining wound and ostomy supplies and scissors from the top of the bedside table and exited the room. -He/She placed the wound and ostomy supplies on top of the treatment cart, including the bottle of wound cleanser, the open package of gauze, and the scissors. -He/She opened the wound treatment cart and began to put the contaminated bottle of wound cleanser and opened package of gauze in the bottom drawer for later use. -He/She cleansed his/her scissors with an alcohol wipe. During an interview on 12/10/24 at 11:00 A.M., LPN A said: -He/She should have sanitized his/her hands with each glove change and before donning gloves. -He/She should not have removed just one glove, he/she should probably have removed both then sanitized his/her hands before putting on clean gloves. -He/She did not recall putting his/her gloved hands into the package of gauze to remove gauze after cleaning the resident's stoma and wound. He/She should not have done that. He/She should not put the contaminated package of gauze in the wound cart as he/she could not use the gauze for anyone else now. -He/She should have sanitized the wound cleanser bottle he/she brought into the resident's room before placing it in the wound treatment cart. -He/She used alcohol wipes to sanitize the scissors after using them. He/She did not sanitize them before using them on this resident. He/She should have used bleach wipes to sanitize the scissors. 5. During an interview on 12/13/24 at 8:34 A.M., Nurse Aide (NA) A said: -EBP meant PPE was required when doing cares on wounds and indwelling devices. -The minimum PPE wore is gown and gloves. -The residents that were on EBP would have a small triangle on the door frame with the letters EBP in the center of the triangle, and there would be a PPE cart near the room or right outside the door. -The PPE would be removed after cares, and hands were washed/sanitized before leaving the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Many	During an interview on 12/13/24 at 8:59 AM, LPN B said: -PPE had to be worn when providing cares on wounds or devices that were indwelling in residents such as catheters. -The minimum equipment would be gown and gloves. -The residents on EBP were designated by a yellow triangle outside the room and all residents with wounds and indwelling devices were on PPE. -If a resident had wounds or indwelling devices and the room did not have a triangle he/she would get one and place it on the door. During an interview on 12/13/24 at 9:04 A.M., CNA C said: -Enhanced barrier precautions were known as EBP. -This meant that gown and gloves had to be worn when working with a resident's catheter. -Resident's on EBP were marked by a yellow triangle on the door with EBP in the triangle. -If a resident was on EBP and there was no triangle on the door he/she would tell the nurse. During an interview 12/13/24 at 9:08 A.M., Certified Medication Technician (CMT) B said: -EBP was to be used on residents with urinary catheters (a thin flexible tube inserted into the urethra (the tube that carries urine from the bladder to the outside of the body) to drain urine from the bladder), wound infections and colostomy's (a surgical procedure that creates an opening in the abdominal wall was to bring one end of the colon to the surface). -He/She had been educated on EBP about a month ago. -The facility used to have EBP signs on the door but, does not think that was done anymore. -He/She would get report from the charge nurse on what residents would require EBP. -Hand washing should be done before and after gloving, before entering a resident room and before leaving a residents' room. During an interview 12/13/24 at 9:20 A.M., LPN B said: -EBP was posted outside resident doors. -Gowns and gloves should be worn when direct care was being provided. -The charge nurses would be responsible to make sure care givers are wearing PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Many	-The Assistant Director of Nursing (ADON) would be responsible for posting EBP on the outside of resident doors. -He/She would be responsible to make sure peritoneal care was being provided appropriately. During an interview 12/13/24 at 12:24 A.M., the Director of Nursing (DON) said: -He/She would expect staff to wear gowns and gloves when giving direct care to resident on EBPs. -He/She would expect staff to wash hands and change gloves as per facility protocol when proving incontinence and wound care. -All resident's with wounds and indwelling devices would be on enhanced barrier precautions. -It was his/her expectation staff would use PPE gown and gloves at a minimum for these residents when doing cares on those things. -Residents on EBP would have the correct signage on the door, and if it was not there the nurse would it on the door. -Staff needed to wash/sanitize hands when staff removed gloves. -It was his/her expectation staff would have the EBP PPE on when doing medications through a PEG tube or cares on a PEG tube, and when handling a foley drainage bag. -He/She was responsible for auditing staff to ensure that staff were following the EBP precautions. 6. Review of Resident #32's Face Sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's EMR showed the last TB testing and/or screening was completed May 2021. TB testing for 2023 and 2024 was requested from the facility but not received at the time of exit. 7. Review of Resident #2's Face Sheet showed he/she was admitted to the facility on [DATE] and readmitted on [DATE] . Review of the resident's EMR showed the last TB testing and/or screening was completed in 2019. TB testing for 2023 and 2024 was requested from the facility but not received at the time of exit. During an interview on 12/12/24 at 2:54 P.M. the DON said: -He/she could not locate any other TB testing for the residents. -He/she expected TB testing to be completed annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 09895 Based on interview and record review, the facility failed to develop and implement an antibiotic stewardship protocol/program and a system to monitor appropriate antibiotic use for residents. The facility census was 76 residents. Review of the facility Antibiotic Stewardship policy, revised December 2023 showed: -Antibiotics would be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. -Instruction that physician's orders for antibiotics would include the drug name, dose, frequency of administration, duration of treatment, start and stop date or number of days of therapy, route of administration and the indications for use. -If a laboratory test was ordered, the results and the resident's current clinical situation would be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. Review of the facility Infection Prevention and Control Program policy, revised December 2023 showed: -Culture reports, sensitivity data and antibiotic usage reviews were to be included in surveillance activities. -Medical criteria and standardized definitions of infections were to be used to help recognize and manage infections. -Antibiotic usage was to be evaluated and feedback was to be provided to practitioners. 1. Review of the facility Antibiotic Stewardship information for January 2024 through November 2024 showed no information was provided regarding antibiotic stewardship for September 2024 through November 2024. During an interview on 12/10/24 at 12:40 P.M. the Director of Nursing (DON) said: -Antibiotic stewardship information should be gathered, and data analyzed monthly. -He/she and the facility Infection Preventionist were both responsible for and worked together on monthly tracking and antibiotic stewardship. -He/she was responsible for ensuring antibiotic stewardship was completed monthly. -Antibiotic stewardship had not been completed for September through November 2024 due to management activities and system changes related to new ownership. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility corporation was currently developing a method for conducting antibiotic stewardship. -The Infection Preventionist joined the interview and said: --He/She and the DON worked together on antibiotic stewardship. --Antibiotic stewardship had not been completed September 2024 through November 2024. During an interview on 12/13/24 at 11:58 A.M. the Administrator said he/she was not aware that antibiotic stewardship was not being completed. The Infection Preventionist was responsible for completing antibiotic stewardship.