STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265791	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooking Park	307 South Woods Mill Road Chesterfield, MO 63017

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on interview and record review, the facility failed to maintain an effective grievance process for residents and family members to voice grievances and to promptly resolve grievances for one resident (Resident #1). The facility failed to follow-up on concerns expressed at Resident Council meetings. In addition, the facility failed to identify a Grievance Official responsible for overseeing grievances in their policy. The failure has the potential to affect all residents. The census was 52 with 25 in certified beds. Review of the facility's grievance policy, dated 2017, showed: -Preface: It is the policy of this facility that each resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal; Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furbished, the behavior of the staff and of other residents, and other concerns regarding their Long Term Care (LTC) facility stay; The facility will ensure prompt resolution to all grievances, keeping the resident and residents representative informed throughout the investigation and resolution process; The facility grievance process will be overseen by a designated Grievance Official who will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations, maintaining the confidentiality of all information associated with grievances, communicate with residents throughout the process to resolution and coordinate with staff; The facility will provide a mechanism for filing a grievance/complaint without fear of retaliation and/or barriers of service and will provide residents, resident representatives, and other information about the mechanisms and procedure to file a grievance; The facility will provide a designated individual to oversee the grievance process, provide a planned systematic mechanism for receiving and prompting action upon issues expressed by residents and resident representatives; The facility will provide ongoing system for monitoring and trending grievances and complaints; -Procedure: -The facility will help promote the grievance process through the organization; This includes notifying residents of their rights related to grievances as well as education to all those affected by potential grievances or concerns on the family grievance processes, including but not limited to: -Resident; (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident representative; -Employees; -Volunteers; -Vendors; -And other stakeholders. -Grievance Official: The facility will train and designate an individual who is responsible for: -Overseeing the grievance process in conjunction with facility administration; -Receive and track all grievances through to their conclusion; -Lead any necessary investigations by the facility; -Work with facility staff utilizing root cause analysis processes for resolution of the grievance or concern; -Maintain confidentiality of all information associated with grievances; -Complete written grievance resolutions/decisions to the resident involved; -Resident Council: -The facility will review the grievance policy and procedure with the resident council on an annual or as needed basis; The Grievance Official will attend the resident council meeting as agreed upon in the resident council charter; All grievances identified during the resident council meeting will be submitted immediately to the Grievance Official for investigation and resolution; Reporting of resolution outcome will be given to the resident council per protocol; -A grievance or concern can be expressed orally to the Grievance Official or facility staff or in writing using a grievance form; -Grievances may be give to any staff member who will forward the grievance to the Grievance Office, or they may file the grievances anonymously in the designated box; -Response: An employee of the facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority; If a compliant cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official. -The policy did not address the name or title of the facility Grievance Official. 1. Review of Resident #1's admission Minimum Data Set (MDS, a federally mandated assessment instrument competed by facility staff), dated 11/5/24, showed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An admitted [DATE]; -Severe cognitive impairment; -Diagnoses included: Alzheimer's disease and Parkinson's disease (a neurological disease that causes tremors and shaking of the body). Review of e-mails provided by Family Member K showed: -An email, dated 11/15/24 at 5:19 P.M., to the Director of Nursing (DON) from Family Member K with questions related to the resident's care, physician appointments and medications; -An e-mail, dated 11/19/24 at 8:34 A.M. to the DON from Family Member K, asking the DON if she had received his/her previous e-mail; -An e-mail, dated 11/30/24 at 4:07 P.M. to the DON from Family Member K, providing dates and times that Family Member K would be in town and a request to meet with the DON. -There were no responses or to the e-mails sent to the DON by Family Member K or an out of office e-mail automated response. During an interview on 12/5/24 at 10:55 A.M., Family Member K said he/she lives out of town and the resident was admitted to the facility on [DATE]. He/She had some concerns about the resident and the resident's care. He/She was provided the DON phone number by a staff member. Family Member K said he/she left two voicemails on 11/8/24, one voicemail on 11/12/24, and two voicemail messages on 11/14/24. After getting no response, Family Member K e-mailed the DON on 11/15/24 at 5:19 P.M.,with his/her concerns. Family Member K said he/she still did not get a response and e-mailed the DON again on 11/19/24 at 8:34 A.M. questioning the DON if she had received his/her messages. On 11/21/24, Family Member K said he/she called the front desk, and the person who answered the phone said that the DON was on vacation and that the facility recently had their phone system redone and that the facility was working out the kinks. The person who answered the phone did not offer any other staff member who he/she could speak with or offer to take a message with his/her concerns. Family Member K left one voicemail message on 11/26/24. Family Member K still did not get a response from the voicemails and e-mailed the DON on 11/30/24 at 4:07 P.M., stating in the e-mail that Family Member K was going to be in town on 12/2/24 and would like to meet with the DON. The DON called Family Member K on 12/4/24 and left a message requesting a time to meet with Family Member K. Review of the facility's grievance log for June 2024 through December 2024, showed two grievances, dated, 8/14/24 and 8/23/24. During an interview on 12/6/24 at 11:00 A.M., the Administrator said that the two grievances filed in August 2024 were the only ones of which he was aware. 2. Review of the Resident Council meeting minutes, dated 11/27/24, Start time: 2:08 P.M., End time: 2:40 P. M., showed: -Residents in attendance: Blank; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident comments, concerns or recommendations: The residents asks questions, have concerns and never get answers. During an interview on 12/9/24 at approximately 10:00 A.M., the Life Enrichment Director said she e-mails all department heads the Resident Council meeting minutes and what specific things need to be addressed for their specific department. She never gets a response. There is no follow through on resident grievances. There are only a couple of residents who come to the Resident Council meetings. They feel it is useless because nothing every gets resolved. She thought the Grievance Officer was the Social Worker but wasn't sure. 3. During an interview on 12/6/24 at 8:42 A.M., Licensed Practical Nurse (LPN) F said there was very little follow through on resident complaints. There used to be Unit Managers who would assist the nurses and smooth things over when resident issues came up. Resident care was a lot better and there were less complaints when there were Unit Managers available. LPN F said he/she will try to solve resident issues him/herself or inform the Assistant Director of Nursing (ADON) or the DON about the residents' issues. LPN F does not who the Grievance Officer is. 4. During an interview on 12/9/24 at 10:35 A.M., Registered Nurse (RN) G said he/she receives complaints all the time from the residents and resident's family members about resident care and staff issues. RN G said she tries to address their concerns, but if he/she cannot solve the problem, he/she will try to call the DON. There are two phone numbers for staff to call the DON, and they will always go to voicemail. There is no follow through on resident issues and complaints. There are no Unit Mangers to assist with resident issues or complaints. It all lands on the shoulders of the floor nurse to solve the problems the residents are having, in addition to all the other tasks that the nurses have to do. Most of the nursing staff are agency staff and are only in the building working a couple of shifts a month and do not follow through on resident complaints or issues. RN G thought the Grievance Officer was the Administrator or the Social Worker but wasn't sure. 5. During an interview on 12/9/24 at approximately 11:30 A.M., the Social Service Director (SSD) said there is 100% lack of communication between administration and managers and the residents who have grievances and complaints. She is not the Grievance Officer but will try to handle resident issues to the best of her ability. She does not have a grievance log or book. She thought the Social Worker who recently left had a grievance book, and that the Administrator may have it now. 6. During an interview on 12/9/24 at 1:00 P.M., the DON said she was on vacation 11/15 through 11/25/24. She did not review her e-mails while on vacation. They recently had a new phone system installed and the were some issues initially, but they are resolved now. She receives some of the Resident Council meeting minutes via e-mail. She would expect staff to call her or the ADON directly on their cell phone for resident concerns. The Administrator or Social Worker can also address resident concerns and issues. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview on 12/9/24 at 1:30 P.M., the Administrator said he is not the official Grievance Officer. He thought it was the Social Worker. The DON and ADON were on vacation at the same time, which was approved without his knowledge and it should not have occurred. He encouraged the DON to have her e-mail say she was out of the office but didn't think she did so. The Resident Council meeting minutes are not always provided to him and thought the activity staff forget to give the minutes to him. He expects staff and department heads to address residents grievances to the best of their ability in a timely manner. He would expect managers to answer e-mails and voicemails in a timely manner. He would expect non-management staff members to try to assist residents and their representatives if no one is readily available. This is the residents' home, and they should be happy and satisfied with the care they receive at the facility. MO00246155

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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** 42795 Based on observation, interview and record review, the facility failed to ensure residents who required assistance with activities of daily living (ADLs, bathing, dressing and toileting) received the necessary services to maintain adequate personal hygiene when staff did not provide showers to two residents (Resident #1 and Resident #2). The sample was eight. The census was 52 with 25 residents in certified beds. Review of the facility's Bathing policy, review date February 2019, showed; Policy: To cleanse the skin on micro-organisms (small bacteria) thus preventing infections and preserving the integrity of the skin; To provide comfort and relaxation, stimulate circulation, encourage passive and active range of motion (ROM) and improve self-esteem through appearance; Bath days and the type of bath to be given will be assigned by the Charge Nurse. 1. Review of Resident #1's admission Minimum Data Set (MDS, a federally mandated assessment instrument competed by facility staff), dated 11/5/24, showed: -Severe cognitive impairment; -Requires substantial assistance for staff with toileting hygiene, shower and bathing, upper body dressing; -Requires moderate assistance from staff for personal hygiene; -Dependent on staff assistance going from lying to sitting position, sitting to standing position, chair to bed and bed to chair transfers; -Has indwelling urinary catheter (a tube that drains the bladder); -Diagnoses included: Diabetes, urinary tract infection (UTI) in the last 30 days, Alzheimer's disease, and Parkinson's disease (a neurological disease that causes tremors and shaking of the body). Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has a history of UTIs; -Interventions: Resident/Family/Caregiver teaching should include good hygiene practices. -Need: The resident has an ADL self-care performance deficit; -Interventions: The resident requires extensive assist by one staff member for showering and bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/5/24 at 9:36 A.M., showed the resident lay in bed and Certified Nursing Assistant (CNA) A and CNA B provided perineal care (peri-care, cleansing of the genitals) and assisted the resident change his/her clothing. The resident's hair appeared very oily, flat and stringy. The resident raised his/her arms up and CNA A removed the resident's shirt. The resident had a strong body odor. CNA A applied roll-on deodorant and placed a clean shirt on the resident. CNA A and CNA B placed the resident in his/her wheelchair and propelled him/her to the dining room. During an interview on 12/5/24 at 10:25 A.M., Family Member K said he/she did not think that the resident has ever had a shower since admission on 11/1/24. The resident always looks disheveled and his/her hair is oily. The only time the resident's hair was washed was when the beautician did it, which was only two times. The staff just keep adding deodorant to cover up the smell. During an interview on 12/9/24 at 1:00 P.M., the Director of Nurses (DON) said she did not have any shower sheet documentation for the resident. 2. Review of Resident #2's admission MDS, dated [DATE], showed: -Severe cognitive impairment; -Dependent on staff for toileting, showering, bathing, and bed to chair transfers; -Always incontinent of bowel and bladder; -Diagnoses included arthritis, Alzheimer's disease, anxiety, and depression. Review of the resident's care plan, in use at the time of the survey, showed: -Need: The resident had an ADL self-care deficit related to Alzheimer's disease; Interventions: The resident requires maximum assist for staff with showering twice weekly and as needed; Provide a sponge bath when a full bath or shower cannot be tolerated; The resident is to be shaved on shower days. Observations on 12/5/24 at 7:48 A.M., showed the resident in his/her room with very oily hair and had approximately one fourth of an inch beard. At 2:20 P.M., the resident was in the activities room with very oily hair and had approximately one fourth of an inch beard. Observation on 12/9/24 at 9:40 A.M., showed the resident sitting in the dining room on Aspen Hall with very oily hair and approximately one half an inch of a beard. Review of the shower sheets, dated October, 2024 showed: -On 10/23/24 and 10/31/24 showers were completed. During an interview on 12/9/24 at 1:00 P.M., the DON said that was all the shower sheets she had for the resident. There were no shower sheets for November, 2024 or December, 2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 12/6/24 at 8:15 A.M., CNA M said he/she was the shower aide for the day. There normally was not a shower aide for the Aspen and Birch Halls. Staff fill out shower sheets once the showers are completed. Staff should shave residents when requested or as needed. 4. During an interview on 12/6/24 at 11:15 A.M., CNA A said showers should be completed twice a week. There is a schedule that is followed at the nurses' station for the showers. Staff fill out shower sheets when the showers are completed and give the sheets to the Assistant Director of Nursing (ADON). 5. During an interview on 12/9/24 at 10:35 A.M., Registered Nurse (RN) G said the showers are rarely completed for residents twice a week. The CNAs do what they want, and the nurses do not check to make sure the showers are done. There has not been a nursing manger for the nursing units for a couple of months, and the care has really gone downhill because there is no accountability for the staff from management. 6. During an interview on 12/9/24 at 1:00 P.M., the DON said the residents should receive showers twice a week. The nurses should sign off on the shower sheets. Any skin issues that are new or old should be marked on the shower sheets. Staff should shave residents on the residents' shower days. MO00246155

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 42795 Based on observation, interview and record review, the facility staff failed to ensure one resident (Resident #1) who developed a newly acquired pressure ulcer (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body) had weekly skin assessments completed, according to the resident's care plan. Facility staff also failed to notify the physician of the new pressure wound and obtain new treatment orders in a timely manner. In addition, the facility staff failed to complete weekly skin assessments, according to facility policy, on one resident (Resident #2) who had a history of pressure ulcers. The sample was eight. The census was 52 with 25 residents in certified beds. Review of the facility's Prevention and Treatment of Skin Breakdown and Other Skin Conditions policy, dated 2017, showed: Policy: -It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcer/injuries; To implement preventative measures and to provide appropriate treatment modalities for wounds according to industry standards; -Procedure: -Prevention of pressure ulcers or injuries: -A skin body audit will be done weekly during a resident's entire stay; -Skin will be observed daily with care of the nursing assistant; -If any skin concerns are noted, they are to reported promptly to the designated nurse; -Weekly skin audits on the bath/shower day will be performed by the licensed nurse and documented in the electronic medical record (EMR). 1. Review of Resident #1's admission Minimum Data Set (MDS, a federally mandated assessment instrument competed by facility staff), dated 11/5/24, showed: -An admitted [DATE]; -Severe cognitive impairment; -Requires substantial assistance for staff with toilet hygiene, shower and bathing, upper body dressing; -Requires moderate assistance from staff for personal hygiene and rolling left to right; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dependent on staff assistance going from lying to sitting position, sitting to standing position, chair to bed and bed to chair transfers; -Has indwelling urinary catheter (a tube that drains the bladder); -The resident is at risk for developing pressure ulcers; -Diagnoses included: diabetes, urinary tract infection (UTI) in the last 30 days, Alzheimer's disease, and Parkinson's disease (a neurological disease that causes tremors and shaking of the body). Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has a potential for impairment to skin integrity related to incontinence, history of weight loss, and need for assistance with mobility, positioning and transfers; -Interventions: Elevate the resident's heels off of the bed; Encourage good nutritional and hydration: Follow facility protocol for treatment of injury; weekly skin documentation of any new areas, documentation to include measurement of each new areas of skin breakdown's width, depth, type of tissue and drainage and any other notable changes; Turn and position during rounds and as needed. Review of the resident's Braden Scale (an assessment tool completed by nursing staff that predicts pressure ulcer risk), dated 11/18/24, showed the resident's score was 13, moderate risk for developing a pressure wound. Review of the resident's skin observations under the assessment tab in the electronic medical record showed: -On 11/8/24 at 2:25 P.M., skin intact; -No documented skin assessments between 11/9/24 and 11/27/24; -On 11/28/24 at 12:39 P.M., no new skin issues at this time; -On 12/6/24 at 4:41 P.M., Site: Sacrum (tailbone); Type: Pressure; Notes: Cleansed, educated and teaching was done with resident to decrease redness to his/her sacrum. Observation and interview on 12/5/24 at 9:36 A.M., showed the resident lay in bed on his/her back. Certified Nursing Assistant (CNA) B assisted CNA A turn the resident to his/her left side. The resident had two quarter-sized deep red maroon-colored circles to the right and left of his/her sacrum and the two circles merged to the center of the sacrum. The areas were not opened and did not have drainage. CNA A cleansed the resident's rectal area and applied Zinc (a cream used to prevent or treat skin irritations). Family Member K was at the bedside and asked CNA A why the resident's sacrum was red. CNA A said to Family Member K that it was due to the resident lying in one spot for too long, and it is not supposed to occur. The resident needs to be turned and repositioned by staff because the resident cannot do it him/herself. Repositioning the resident is to prevent the redness from occurring. The resident said his/her bottom hurt. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/6/24 at approximately 10:00 A.M., showed the resident lay in bed on a regular mattress, and CNA D assisted the resident with getting dressed. The resident had two quarter-sized deep red, maroon-colored circles to the right and left of his/her sacrum, and the two circles merged to the center of the sacrum. The areas were not opened and did not have drainage. During an interview on 12/6/24 at 10:25 A.M. and at 1:15 P.M., Licensed Practical Nurse (LPN) E said the CNA did not inform him/her that the resident had a red area on his/her sacrum on 12/5/24. LPN E said he/she examined the resident's sacrum and said the area was a pressure wound. During an interview on 12/6/24 at 11:15 A.M., CNA A said the resident had the red areas on his/her sacrum about a week ago and he/she told the nurse at that time but did not inform the nurse on 12/5/24. Review of the resident's progress notes, dated 10/31 through 12/9/24, showed no documentation that the resident's physician was notified of the new pressure area or new treatment orders or interventions put in place for the resident's sacrum. Review on 12/9/24 at 8:29 A.M. of the resident's physician order sheets (POS), dated December 2024, showed no orders related to the resident's newly acquired pressure wound. During an interview on 12/5/24 at 2:00 P.M., LPN N said skin observations should be documented on the skin observation tool. Even if there are no skin issues, the skin assessment tool was required to be filled out. If a new area is assessed, the nurse should measure it and describe how it looks. Staff should obtain orders immediately. During an interview on 12/9/24 at 10:35 A.M., Registered Nurse (RN) G said the resident has dementia and would not understand being educated about a newly acquired pressure wound. Any nurse can stage a wound. They have cards attached to their badges for reference on how to stage the wound. The nurse needs to describe the wound to the best of his/her ability to the physician. The minimum that should be done for a newly acquired pressure wound, is obtain an order for a low air loss (LAL) mattress immediately. The facility always has the LAL mattresses in the building. 2. Review of Resident #2's admission MDS, dated [DATE], showed: -Severe cognitive impairment; -Dependent on staff for toileting, showering, bathing, and bed to chair transfers; -Always incontinent of bowel and bladder; -At risk of developing a pressure wound; -Diagnoses included arthritis, Alzheimer's disease, anxiety, and depression. Review of the resident's care plan, in use at the time of the survey, showed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Need: The resident has an actual and potential impairment to skin integrity related to a history of Stage 2 pressure ulcer (partial thickness skin loss, presenting as shallow open ulcer) on his/her sacrum; -Interventions: Weekly treatment documentation to include measurement of each new area of skin's breakdown's width, length and type of tissue, drainage and any other notable changes or observations. The resident's Braden score, dated 11/6/24 at 2:04 P.M. was 14, moderate risk for developing pressure wounds. Review of the resident's skin observations in the assessment tab in the resident's EMR showed: -On 10/9/24 at 11:07 P.M., Site: Right buttock; Type: pressure; Site: left buttock; Type: Pressure; Notes: Stage 2 pressure ulcer, redness and irritation noted. -No further skin assessments were documented. Review of the resident's progress notes showed: -On 10/18/24 at 1:41 P.M., sacral wound healed, no open areas noted at this time. Review of the shower sheets, dated October, 2024 showed: -On 10/23/24 and 10/31/24 showers were completed. During an interview on 12/9/24 at 1:00 P.M., the Director of Nursing (DON) said that was all the shower sheets she had for the resident. There were no shower sheets for November, 2024 or December, 2024. Observation on 12/5/24 at 7:48 A.M., showed the resident lay in bed and CNA C was assisting the resident applying socks, shoes, and pants. CNA D entered the room and assisted CNA C with a mechanical lift transfer of the resident into his/ her wheelchair. Once the resident was finished using the toilet, CNA C raised the resident off the toilet with the use of the mechanical lift. The resident had no skin issues to the sacrum or buttocks. 3. During an interview on 12/6/24 at 11:15 A.M., CNA A said showers should be completed twice a week. There is a schedule that is followed at the nurses' station for the showers. Shower sheets are filled out when the showers are completed and given to the Assistant Director of Nursing (ADON). Any new skin issues are circled on the shower sheets and reported to the nurse. 4. During an interview on 12/9/24 at 10:35 A.M., RN G said skin assessments should be completed on every resident, especially if the resident previously had a pressure wound or is at a higher risk of developing one. Staff were not completing skin assessments. RN G knows that the assessments are not being done because the system will alert you in the computer if the skin assessments are past due, and he/she sees that occur frequently. There are no managers or regular staff to follow up and ensure that skin assessments are being completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During an interview on 12/9/24 at 1:00 P.M., the DON said the nurses were expected to sign off on the shower sheets and review the sheets for any new skin issues. Any skin issues that are new or old are to be marked on the shower sheets by the person completing the shower. Licensed nurses should complete residents' weekly skin assessments and document them in the assessment tab. An RN is the only nurse that can stage wounds. Newly acquired skin conditions should be reported to the physician and family immediately. MO00246155 MO00245478

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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. 42795 Based on observation, interview and record review, the facility failed to follow their policy and the resident's care plan and ensure two staff members assisted residents who required a sit-to-stand mechanical lift for transfers (Resident #2). The sample size was eight. The census was 52 with 25 residents in certified beds. Review of the facility's Sara lift (a type of sit-to-stand mechanical lift) policy, dated September, 2017, showed: Purpose: To provide a safe transfer for all residents who are unable to be transferred by staff due to a physical condition; Procedure: Two nursing persons must be used for a Sara lift transfer; Note: Nursing staff not using two nursing personnel for a Sara lift transfer will begin counseling process for failure to follow facility policy and procedures for safe transfer. Review of Resident #2's admission Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 10/4/24, showed: -Severe cognitive impairment; -Dependent on staff for toileting, showering, bathing, and bed to chair transfers; -Always incontinent of bowel and bladder; -Diagnoses included arthritis, Alzheimer's disease, anxiety, and depression. Review of the resident's care plan, in use at the time of the survey, showed: -Need: The resident has an activities of daily living (ADL) self-care performance deficit; -Interventions: The resident requires max of two staff assistance to move between surfaces as necessary. The resident requires mechanical lift sit-to-stand with two person staff assistance. Review of video footage, dated 10/23/24 at 7:40 A.M., showed the resident lay in bed. Certified Nursing Assistant (CNA) A assisted the resident with peri-care (cleansing of the genitals) and getting dressed. CNA A assisted the resident to the side of the bed and applied the Sara lift belt to the resident's upper torso and attached the belt to the lift. CNA A then left the resident's room for approximately one minute while the resident was attached to the lift. CNA A returned to the resident's room and Unknown Staff Member I entered the room and stood at the doorway. CNA A transferred the resident into the wheelchair using the Sara lift while Unknown Staff Member I stood at the door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of video footage, dated 10/25/24 at 10:12 A.M., showed the resident lay in bed. CNA A assisted the resident by providing peri-care and help with dressing. CNA A assisted the resident to the side of the bed and applied the Sara lift belt to the resident's upper torso and attached the belt to the lift. CNA A then left the resident's room for approximately one minute while the resident was attached to the lift. When CNA A returned to the room, he/she transferred the resident into his/her wheelchair. CNA A did not have a second staff member in the room. Observation on 12/5/24 at 7:48 A.M., showed the resident lay in bed and CNA C assisted the resident applying socks, shoes, and pants. CNA D entered the room and assisted CNA C with applying the Sara lift belt. CNA C and CNA D placed the resident into his/her wheelchair, and CNA D transferred the resident into the bathroom and positioned the resident on the toilet. CNA D left the room. Once the resident was finished using the toilet, CNA C raised the resident off the toilet with the Sara lift. CNA C cleansed the resident, applied Desitin (barrier) cream to the resident's buttocks and applied a new brief. CNA C transferred the resident from the bathroom, approximately 25 feet across the bedroom using the Sara lift, to the resident's wheelchair. CNA C then lowered the resident into the wheelchair with the use of the lift. CNA C transferred the resident by himself/herself from the bathroom to the bedroom. During an interview on 12/6/24 at 9:05 A.M., Physical Therapist (PT) J said he/she has been working with the resident, and the resident's current transfer status was a two person transfer utilizing the Sara lift. During an interview on 12/9/24 at 10:35 A.M., Registered Nurse (RN) G said staff should use two staff to assist residents with mechanical sit-to-stand lift transfers. The resident should never be left unattended in the lift, and the second staff member should be next to the resident during the transfer, in case the resident's legs buckle and they begin to fall. During an interview on 12/9/24 at 12:25 P.M., CNA H said two staff members are to assist the resident when utilizing a mechanical sit-to-stand lift. The staff member should remain with the resident when attached to the lift. A staff member standing in the doorway does not count as the second person. The second staff member should be standing very close and assisting with the transfer, in case the lift stops working or the resident begins to fall. During an interview on 12/9/24 at 1:00 P.M., the Director of Nursing (DON) said she expected staff to use two persons assistance when using the mechanical sit-to-stand lift with a resident. The resident should not be left unattended when attached to the lift, and the second person should be hands on with the transfer, not standing at the doorway. The Sara lift required two persons in case the resident's knees buckle or the machine began to topple over. MO00245478 MO00246155

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42795 Based on observation, interview and record review, the facility failed to provide one resident (Resident #1) with proper urinary catheter (tube that drains the urine from the bladder) care by failing to have catheter supplies readily available to ensure the resident's catheter was changed, and failed to obtain a urine specimen, according to physician orders, in a timely manner. The staff failed to place the resident's urinary catheter below the resident's bladder during a transfer, which put the resident at greater risk for infection. The sample was eight. The census was 52 with 25 in certified beds. Review of the facility's catheter policy, review date February 2019, showed: -Catheter Care should be given every shift and as needed; -Never lift bag above bladder level (source of infection); -Change drain bag and tubing every 30 days; -Change indwelling Foley catheter as indicated based on assessment or per physician order. 1. Review of Resident #1's admission Minimum Data Set (MDS, a federally mandated assessment instrument competed by facility staff), dated 11/5/24, showed: -Severe cognitive impairment; -Requires substantial assistance for staff with toilet hygiene, shower and bathing, upper body dressing; -Requires moderate assistance from staff for personal hygiene; -Dependent on staff assistance going from lying to sitting position, sitting to standing position, chair to bed and bed to chair transfers; -Has indwelling urinary catheter; -Diagnoses included: Diabetes, urinary tract infection (UTI) in the last 30 days, Alzheimer's disease, and Parkinson's disease (a neurological disease that causes tremors and shaking of the body). Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has a history of UTIs; -Interventions: Resident/Family/Caregiver teaching should include good hygiene practices; Obtain and monitor lab and diagnostic work as ordered; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Need: The resident has a urinary catheter related to his/her diagnosis of urinary retention (inability to empty bladder completely); Interventions: Catheter care and treatment per current physician orders; Position catheter bag and tubing below the level of the bladder. Review of the resident's urologist (a kidney and bladder specialist) physician orders showed: -An order dated, 12/4/24 at 1:21 P.M., catheter needs to be changed 12/4/24 using a 16 french (fr) indwelling Foley catheter and filling the balloon with 10 milliliters (mls) of sterile water; -After the exchanged foley, obtain a urine culture (a test to check the urine for an infection)from the new exchanged Foley. Review of the resident's progress notes showed: -On 12/5/24 at 8:28 A.M., Foley catheter to be changed today but the supplies are not available, this nurse will order the 16 fr, 10 mls and it will be done tonight; -On 12/5/24 at 3:43 P.M., the resident's Foley was not changed today; The Nurse Practitioner (NP) at the hospital clinic was called to advise how to proceed; The catheter is to be changed now every 30 days using a 16 fr indwelling Foley filled with 10 mls of sterile water; The resident is to have a urine culture with every new exchange; -On 12/6/24 at 12:47 P.M., order clarification for Foley catheter per NP; May use a 16 fr, 5 ml indwelling catheter and fill with 10 mls of sterile water; -On 12/7/24 at 9:11 A.M., the resident's catheter was changed, urine specimen was obtained, was informed by the lab that there was no coverage for lab to pick up specimen on the weekend; The nurse will schedule specimen pick up on 12/9/24 at 6:00 A.M. During an interview on 12/5/24 at 10:25 A.M., Family Member K said the resident returned from a urologist visit on 12/4/24, and Family Member K gave the new urinary catheter related orders to the nurse on duty. During an interview on 12/5/24 at approximately 12:00 P. M., the Central Supply Technician O said he/she did not have the correct Foley catheter supply for the resident. His/Her computer was down so he/she could not check to see if he/she could order it. He/She thought the nurse was going to call the physician and see if they could use the catheter the facility had on hand. During an interview on 12/6/24 at 8:42 A.M. and on 12/9/24 at 1:42 P.M., Licensed Practical Nurse (LPN) F said the facility did not have the Foley 16 fr, 10 ml balloon and only had the Foley 16 fr, 5 ml balloon. LPN F said the nurse did not change the catheter on 12/6/24. LPN F said he/she changed the catheter on 12/7/24 between 12:00 A.M. and 2:00 A.M., and a urine specimen was obtained. He/She called the lab to have the specimen picked up, but they said there was not enough lab staff to pick the urine up on the weekend. LPN F said the urine specimen was rescheduled for 12/9/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/24 at 10:35 A.M., Registered Nurse (RN) G said the facility does not have adequate supplies for the nurses to do their jobs. The residents should get the services, products and supplies they need. The facility should have the supplies readily available. The resident's catheter orders should have been reviewed immediately and physician's office should have be called that day on 12/4/24 for clarification. The resident should not have to wait three days to have his/her catheter changed and a urine specimen sent. During an interview on 12/9/24 at 1:00 P.M., The Director of Nursing (DON) said that the resident's catheter exchange and urine specimen took way to long to complete. She would expect staff to problem solve with the physician's office in a timelier manner, and she would expect the facility to have the correct supplies available. 2. Observation on 12/5/24 at 9:36 A.M., showed the resident lay in bed on his/her back. Certified Nursing Assistant (CNA) A assisted the resident by providing perineum care (peri-care, cleansing of the genitals and rectal area). At 9:37 A.M., CNA B entered the room and assisted CNA A with getting the resident dressed and to apply a Hoyer lift (a specialized lift to assist with transfers) by turning the resident side to side. CNA A and CNA B raised the resident up in the Hoyer lift, and CNA A hung the resident's catheter bag on the hooks on the Hoyer lift approximately 12 inches above the resident's bladder. CNA A and CNA B placed the resident in his/her wheelchair. CNA A assisted the resident by adjusting the resident's clothing and raised the resident's catheter bag approximately 12 inches above the resident's bladder while he/she was sitting in his/her wheelchair. During an interview on 12/9/24 at 10:25 A.M., RN G said the resident's urinary catheter and bag should always be kept below the resident's bladder, so the urine does not go back into the bladder and cause a UTI. During an interview on 12/9/24 at 12:25 P.M., CNA H said the resident's catheter bag should be positioned below the waist so that the urine does not go back into the bladder. During an interview with on 12/9/24 at 1:00 P.M., the DON said she would expect staff to position the resident's urinary catheter below the resident's bladder, to prevent a UTI from occurring. MO00246155

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview, and record review, the facility failed to ensure the residents were served meals in a timely manner, which included two sampled residents (Resident #1 and Resident #2). The sample was eight. The census was 52 with 25 in certified beds. 1. Review of the facility's menus labeled Bistro 307 showed: -Breakfast is served at 7:30 A.M. through 9:00 A.M.; -Lunch is served at 11:30 A.M. through 1:00 P.M.; -Dinner is served at 4:30 P.M. through 6:30 P.M. 2. Review of Resident #1 's admission Minimum Data Set (MDS, a federally mandated assessment instrument competed by facility staff), dated 11/5/24, showed: -Severe cognitive impairment; -Requires moderate assistance from staff with eating; -Dependent on staff assistance going from lying to sitting position, -Diagnose included: Diabetes, urinary tract infection in the last 30 days, Alzheimer's disease, and Parkinson's disease (a neurological disease that causes tremors and shaking of the body). Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has a nutritional problem due to his/her need for a therapeutic diabetic diet. -Interventions: Provide and serve therapeutic diet. Observation on 12/5/24 at 9:36 A.M., showed the resident lay in bed. Certified Nursing Assistant (CNA) A and CNA B provided the resident assistance with dressing and getting out of bed. At 10:00 A.M., the resident was assisted out of bed and placed in his/her wheelchair. CNA A propelled the resident into the dining room. Staff served the resident a bowl of oatmeal in a Styrofoam cup and a glass of juice. During an interview on 12/5/24 at 10:25 A.M., Family Member K said the resident was frequently left in bed until after breakfast and served cold food or whatever was left over. 3. Review of Resident #2's admission MDS, dated [DATE], showed: -Severe cognitive impairment; (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Requires moderate assistance from staff with eating; -Dependent on staff for bed to chair transfers; -Diagnoses included arthritis, Alzheimer's disease, anxiety, and depression. Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has a potential nutritional problem related to his/her dementia, with need for cueing and a history of swallowing difficulties; -Interventions: Provide and serve meal as ordered. Observation on 12/9/24 at 9:40 A.M., showed staff in the resident's room getting the resident dressed and into a wheelchair. Staff brought the resident to the dining room in his/her wheelchair. At 9:46 A.M., staff served the resident juice and coffee. At 9:48 A.M., staff served the resident fresh fruit in a bowl that the resident ate with his/her fingers. 4. During an interview on 12/5/24 at 7:48 A.M., Dietary Aide L said breakfast was always served late because dietary staff run late for their shifts. 5. During an interview on 12/9/24 at 10:35 A.M., Registered Nurse (RN) G said the meals were always served late. There was not enough staff in the kitchen. There is a lot of nursing agency staff who show up late to their shift, are not familiar with the residents and do not get the residents up in a timely manner to go out to the dining room for meals. Sometimes residents will miss meals. 6. During an interview on 12/9/24 at 12:25 P.M., CNA H said meals were usually served in the residents' rooms because the residents were not out of bed yet or the food comes to the hall late. 7. During an interview on 12/9/24 at 11:40 A.M., the Director of Culinary Services said he is aware the meals are late because they have a shortage of staff and the staff come in late for their shifts. He is new to the role and is working on getting staff and providing meals in a timely manner. 8. During an interview on 12/9/24 at 1:00 P.M., the Director of Nursing (DON) said she would expect meals to be served timely. There are a lot of agency nursing staff, and they are not familiar with the residents and the meal time process. 9. During an interview on 12/9/24 at 1:30 P.M., the Administrator said he would expect meals to be served timely and within the stated times on the menus. He would expect nursing staff and dietary to work together to serve the residents meals. MO00245478 MO00246155

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multi drug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for one resident with a urinary catheter (a tube that drains the bladder) for one resident (Resident #1). The facility failed to ensure staff used acceptable infection control practices with one resident when providing perineal care (peri-care, cleansing of the genitals) (Resident #1). In addition, the facility staff failed to use acceptable infection control practices when administering medications for one resident (Resident #2). The sample was eight. The census was 52 with 25 residents in certified beds. Review of the facility's Enhanced Barrier Precautions policy, dated April, 2024, showed: -Policy statement: It is the policy of this facility that EBP, in addition to standard contact precautions (a set of infection control practices used regardless of if the resident appears ill)will be implemented during high-contact resident care activities when caring for residents who have an increased risk for acquiring MDRO, residents with wounds, indwelling medical devices or residents with infection or colonization (organism that is in the body but does not produce symptoms) with an MDRO. -Purpose: The purpose of EBP is to prevent opportunities for transfer of all MDROs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids; -High contact resident care activities include: -Dressing; -Bathing or showering; -Transferring; -Providing hygiene; -Changing linens; -Changing briefs or assisting with toileting; -Device care or use: Central line (a thin tube surgically inserted into a large vein used for medications and fluids),urinary catheter, feeding tube (a surgically inserted tube place in the abdomen to provide liquid nutrition and medications), and tracheostomy tube (a tube surgically inserted into the windpipe to assist with breathing); -Wound Care: Any skin opening requiring a dressing; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Procedure: -EBP are to be implemented in addition to other standard precautions; -Post clear signage on the door/wall outside the resident's room with the type of precautions to be used: -Personal protective equipment (PPE, isolation gowns and gloves) is required by all staff providing high-contact resident care activities; -EBP will be in place for the duration of the resident's stay or until a wound is resolved or the indwelling medical device is discontinued. Review of the facility's policy for Hand Hygiene, undated, showed: -Policy: It is the policy of this facility that hand hygiene (handwashing and or alcohol-based hand rub (ABHR), also known as alcohol-based hand sanitizer (ABHS)), is to be performed consistent with accepted standards of practice in order to reduce the potential of the spread of pathogens; Hand hygiene continues to be the primary means of preventing the transmission of infection. -Procedure: -ABHS are the most effective for reducing the number of germs on the hands of healthcare employees, it is the preferred method of use in most clinical situations and are the most effective products for reducing the number of germs on the hands of healthcare providers; ABHS should be used: Immediately prior to touching a resident; before performance of an aseptic procedure (technique of preventing an infections) or handling invasive medical devices; -When caring for a resident, when moving from a soiled body site to a clean body site of the same resident; -After touching a resident or the resident's immediate environment; -After any contact with blood, body fluids or contaminated surfaces; -Immediately upon removal of gloves and PPE. Review of the facility's Medication Administration policy, dated July, 2021, showed: -Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so; -Procedures: The person administering medications adheres to good hand hygiene; Hands are washed before putting on examination gloves and upon removal for administration of typical, ophthalmic, injectable, enteral (medications that are administered into the gastrointestinal tract by a feeding tube and by mouth), rectal and vaginal medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #1's admission Minimum Data Set (MDS, a federally mandated assessment instrument competed by facility staff), dated 11/5/24, showed: -Severe cognitive impairment; -Requires substantial assistance for staff with toilet hygiene, showers and bathing, upper body dressing; -Requires moderate assistance from staff for personal hygiene; -Dependent on staff assistance going from lying to sitting position, sitting to standing position, chair to bed and bed to chair transfers; -Has indwelling urinary catheter; -Diagnoses included: MDRO, diabetes, urinary tract infection (UTI) in the last 30 days, Alzheimer's disease, and Parkinson's disease (a neurological disease that causes tremors and shaking of the body). Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has a history of UTIs; -Interventions: Resident/Family/Caregiver teaching should include good hygiene practices. -The care plan did not address the use of EBP precautions. Review of the resident's physician order sheets (POS), dated December, 2024, showed: -An order, dated 10/31/24 for EBP. Observation on 12/5/24 at 9:36 A.M., showed no EBP sign posted outside the resident's room. The resident's door had a caddy hanging on it with PPE supplies. The resident lay in bed on his/her back. Licensed Practical Nurse (LPN) F was at the resident's bedside changing the resident's catheter bag with gloved hands. After LPN F changed the catheter bag,Certified Nursing Assistant (CNA) A with gloved hands, removed the resident's covers and lowered the resident's brief. CNA A cleansed the resident's peri-area and around his/her catheter. At 9:37 A.M., CNA B entered the room with no isolation gown and applied gloves, without washing hands or applying hand sanitizer. CNA B assisted CNA A turn the resident to his/her left side. CNA A cleansed the resident's rectal area and applied Zinc (a cream used to prevent or treat skin irritations). CNA A then removed a peri-area cleansing wipe out of a container that was located on the resident's bedside table. CNA A then used the wipe to remove excess Zinc cream off his/her gloved hands. CNA A readjusted the resident's clean brief, pulled the resident's pants up and apply the Hoyer lift (a mechanical device used to transfer residents) pad by turning the resident side to side with the same gloved hands. CNA A and CNA B transferred the resident into the resident's wheelchair by utilizing the Hoyer lift. CNA A continued to assist the resident by adjusting the resident's clothing and catheter with the same gloved hands. CNA A removed his/her gloves and did not perform hand hygiene. CNA A propelled the resident into the dining room. LPN F, CNA A, and CNA B did not wear an isolation gown while providing care 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
	265791	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooking Park	307 South Woods Mill Road Chesterfield, MO 63017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/6/24 at 8:40 A.M., LPN F said he/she should have been wearing an isolation gown when he/she changed the resident's catheter bag. During an interview on 12/9/24 at 12:25 P.M., CNA H said EBP are used when there is a sign and PPE is located outside of the door. Staff should wear gown and gloves when providing care. 2. Review of Resident #2's admission MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included arthritis, Alzheimer's disease, anxiety, and depression. Observation on 12/5/24 at 9:02 A.M., on Aspen/Birch Hall, showed LPN E stood at the medication cart and popped multiple pills out of different bubble packs, by placing the medications in his/her hands. LPN E then crushed the medications and mixed the medications with applesauce and administered them to Resident #2. Observation on 12/5/24 at 8:45 A.M. and 9:21 A.M., showed LPN E removed multiple bubble packs out of the cart and popped the medication into his/her hand and then placed them into a medicine cup. LPN E then took the cup of pills and walked down the Birch Hall into a resident's room, and after several minutes LPN E exited the resident's room without the cup of pills. 3. During an interview on 12/9/24 at 10:35 A.M., Registered Nurse (RN) G said gloves should be changed when completing peri-care, and hand washing or hand sanitizer should be used before applying new gloves. The resident, the resident's clothing or catheter should not be touched with soiled gloves. EBP are for residents who have MDROs, catheters or wounds. Staff are to wear gown and gloves when providing direct care. A sign should be placed outside of the room and staff should wear gowns and gloves when providing care. Medications that are in a bubble pack should be popped directly into the medicine cup. 4. During an interview on 12/9/24 at 1:00 P.M., the Director of Nursing (DON) said she would expect there to be a sign on the door for residents requiring EBP. Staff are to use gown and gloves for residents who have catheters, wounds,or any indwelling medical device. The staff are expected to change gloves and use hand sanitizer after providing peri-care. Staff should not be touching the resident with soiled gloves. Staff are expected to use hand sanitizer or wash hands before and after providing care. Medications that are in a bubble pack should not be directly popped into the staff member's hand. The medications should be directly popped into the medicine cup. MO00245478