STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: Birch Pointe Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3705 S Jefferson Ave Springfield, MO 65807	

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on interview, and record review, the facility failed to promote each resident's right to self-determination of care when staff did not provide showers as preferred and care planned for six resident (Resident #6, #7, #10, #30, #39, and #66) reviewed for showers out of 34 sampled residents This failure could lead to decreased quality of life and dignity. Review of the facility's policy titled, Bath, Shower/Tub, revised February 2018, showed the following: -Purposes of the procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin; -Staff to document each bathing and notify the supervisor if any resident refuses the shower/tub bath; -The bathing documentation requirement included the the date and time the shower/tub bath was performed and if the resident refused the shower/tub bath, the reason; -Notify the supervisor if the resident refuses the shower/tub bath. Review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, revised ,d+[DATE], showed the following: -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene; -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene. 1. Review of Resident #10's Admission Record, undated, located in the resident's electronic medical record (EMR) under the Profile tab, showed the an admitted [DATE]. (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: 265865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of [DATE] and located in the EMR under the MDS tab, showed the following: -The facility assessed the resident as moderately cognitively impaired; -The resident was dependent on staff to completion of the shower task. Review of the resident's Point of Care (POC) documentation showed the resident did not receive a scheduled shower or bed bath on the following dates: -On [DATE]; -On [DATE]; -On [DATE]; -On [DATE]; -On [DATE]; -Staff did not document any resident refusals of their showers or bed baths. During an interview on [DATE], at 9:57 A.M., the resident said he/she gets one shower a week and he/she would like to get two showers a week. He/she only gets one on Monday and not the Thursday shower. The shower aide gets pulled to work on the floor instead. 2. Review of Resident #30'sAdmission Record, undated, located in the resident's EMR under the Profile tab, showed an admitted [DATE]. Review of the resident's quarterly MDS, with an ARD of [DATE] and located in the resident's EMR under the MDS tab, showed the following: -The facility assessed the resident as cognitively intact; -The resident was being dependent on staff to complete showers. Review of of the resident's POC documentation showed the resident did not receive a scheduled shower or bed bath on the following dates: -On [DATE], -On [DATE]; -On [DATE]; -On [DATE]; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE]; -Staff did not document any resident refusals of their showers or bed baths. During an interview on [DATE], at 10:29 A.M., the resident said he/she had been at the facility about 13 months. He/she only got one shower a week and would like to get more than one shower. The facility does not two showers due to the shower aide being needed out on the floor instead. 3. Review of Resident #66's Admission Record, undated and located in the resident's EMR under the Profile tab of the EMR, showed an admitted [DATE]. Review of the resident's significant change in status MDS, with an ARD of [DATE] and located in the resident's EMR under the MDS tab, showed the following: -The facility assessed the resident was cognitively intact; -The resident was dependent on staff to complete showers. Review of the resident's POC showed the resident did not receive a scheduled shower or bed bath on the following dates: -On [DATE] -On [DATE]; -On [DATE]; -On [DATE]; -On [DATE]; -Staff did not document any resident refusals of their showers or bed baths. During an interview on [DATE], at 10:17 A.M., the resident said he/she doesn't get his/her showers. There was one week he/she did not get a bath for one week. He/she would like to get two showers a week, but there's not enough staff to help out. One time they gave him/her a little shower. They took him/her in there and put him/her under the water, let the water fall on him/her, and then took him/her out as quick as they took him/her in. They did not wash him/her and called that a shower. 4. Review of Resident #39's Admission Record, undated, located in the resident's EMR under the Profile tab, showed an admitted [DATE]. Review of the resident's annual MDS, with an ARD of [DATE] and located in the resident's EMR under the MDS tab, showed the following: -The facility assessed as cognitively intact. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident to used a wheelchair and was dependent on staff for tub or shower transfers and to shower or bath him/herself. Review of the resident's Care Plan, located in the resident's EMR under the Care Plan tab, showed the following: -Initiated [DATE], ADL self-care performance deficit with limited mobility related to cerebrovascular accident (CVA - stroke) with hemiplegia (one-sided muscle paralysis or weakness); -Initiated [DATE], resident required dependent assistance by x 2 staff with bathing; -Initiated [DATE], resident prefers to have a whirlpool once a week and a sponge bath for his/her 2x week Tuesday/Friday. He/she prefers to have them after lunch with no set days. He/she agreed to have 2 whirlpools a week until his skin is healed. Review of the resident's Care Plan Item/Task Listing Report, dated [DATE], showed the facility scheduled the resident to receive bathing as his care plan stated each Tuesday, Friday, and as needed. During the interview on [DATE], at 11:28 A.M., the resident said his/her last shower was about two weeks ago, with no bathing in between. He/she placed a bath request to the bath aides about two weeks ago, but no staff ever gave him/her one. Review of the resident's monthly Documentation Surveyor Report V2, dated [DATE] to [DATE], showed the following: -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a whirlpool bath; -On [DATE], the resident refused a bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident refused a bath; -On [DATE], the resident received a bath. -Staff did not document the resident was offered an opportunity to receive a bath or shower when the resident refused or missed their regularly scheduled bathing day. During the interview on [DATE], at 3:35 P.M., the DON reviewed the resident's records and the monthly Documentation Surveyor Report V2 report for the resident's no-bathing days. The DON said there was no documentation that bathing was reoffered every day before the next scheduled bathing day. The DON stated that if a resident refuses to bathe, the staff should re-offer and document it. 5. Review of Resident #7's Admission Record, undated, located in the resident's EMR under the Profile tab, showed an admitted [DATE]. Revive of the resident's quarterly MDS, with an ARD of [DATE], and located in the resident's EMR under the MDS tab, showed the following: -The facility assessed was cognitively intact; -The resident did not exhibit behavioral symptoms including rejecting care; -The resident used a wheelchair and required staff's supervision to touch assistance including verbal cues for tub or shower transfers; -The resident required substantial to maximal assistance to shower or bath him/herself. Review of the resident's Care Plan, located in the resident's EMR under the Care Plan tab, showed the following: -Initiated [DATE], ADL self-care performance deficit related to weakness; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Initiated [DATE], the resident required max assistance by 1 staff with bathing/showering 2x a week (Tues/Friday) and as necessary. -Initiated [DATE], the resident was independent with toilet transfers due to grab bar and required supervision assisting with all other transfers. Review of the resident's Care Plan Item/Task Listing Report, dated [DATE], showed the facility scheduled the resident to receive bathing as hi/her care plan stated each Tuesday, Friday, and as needed. During an interview on [DATE], at 10:17 A.M., the resident said he/she got bathed once a week, which was not okay. He/she liked to be bathed two times a week. The resident said he/she had spoken to a social worker about his/her bathing preference. Review of the resident's monthly Documentation Surveyor Report V2, dated [DATE] to [DATE], showed the following: -On [DATE], the resident refused a bath; -On [DATE], the resident refused a bath; -On [DATE], the resident received a shower; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident refused a bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a shower; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident received a shower; -On [DATE], the resident received a bed bath; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident received a shower; -On [DATE], the resident received a shower; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE], the resident received a bed bath; -On [DATE], the resident refused a bath; -On [DATE], the resident received a shower; -On [DATE], the resident did not received a scheduled bath; -On [DATE], the resident received a bed bath; -Staff did not document the resident was offered an opportunity to receive a bath or shower when the resident refused or missed their regularly scheduled bathing day. During an interview on [DATE], at 3:35 P.M., the DON reviewed the resident's records and the monthly Documentation Surveyor Report V2 report for the resident's no-bathing days. The DON said there was no documentation that bathing was reoffered every day before the next scheduled bathing day. The DON said that if a resident refuses to bathe, the staff should re-offer and document it. 6. Review of Resident #6'sAdmission Record, undated, located in the resident's EMR under the Profile tab, showed an admitted [DATE]. Review of the resident's quarterly MDS, with an ARD of [DATE] and located in the resident's EMR under the MDS tab, showed the following: -The facility assessed the resident as cognitively intact; -The resident did not exhibit behavioral symptoms including rejecting care; -The resident used a wheelchair and required partial to moderate assistance for tub or shower transfer and substantial to maximal assistance for shower or bath. Review of the resident's Care Plan, located in the resident's EMR under the Care Plan tab, showed the following: -Initiated [DATE], ADL self-care performance deficit due to hereditary ataxia (a group of inherited neurological disorders characterized by progressive incoordination and loss of balance); -Initiated [DATE], provide sponge bath when a full bath or shower cannot be tolerated; -Initiated [DATE], resident was max assistance of 1 staff with bathing/showering 2 times a week Mon/Thursday and as needed. Review of the resident's Care Plan Item/Task Listing Report, dated [DATE], showed the facility scheduled the resident to receive bathing as his/her care plan stated each Monday, Thursday, and as needed. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE], at 1:39 P.M., the resident said he/she only received one bath a week instead of two times a week. The resident also said each Monday and Thursday were his/her scheduled shower days and that his/her last bath was last Thursday ([DATE]), which was the only bath of that week. Review of the resident's monthly Documentation Surveyor Report V2, dated [DATE] to [DATE], showed the following: -On [DATE], the resident received a shower; -On [DATE], the resident did not receive scheduled shower; -On [DATE], the resident received a shower; -On [DATE], the resident received a shower; -On [DATE], the resident refused a bath; -On [DATE], the resident received a shower; -On [DATE], the resident received a bed bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident received a shower; -Staff did not document the resident was offered an opportunity to receive a bath or shower when the resident refused or missed their regularly scheduled bathing day. During an interview on [DATE], at 3:35 PM, the reviewed the resident's records, including the monthly Documentation Surveyor Report V2 report for the residents' no-bathing days. The DON said there was no documentation that bathing was reoffered every day before the next scheduled bathing day. The DON said that if a resident refused to bathe, the staff should re-offer and document it. 7. During an interview on [DATE],5 at 8:59 A.M., Certified Nurse Aide (CNA) 1 said his/her primary job was being a shower aide. Residents were supposed to get two showers a week unless they refuse. They wouldn't get a shower though if he/she was pulled to the floor because they were short staffed. The CNA said he/she gets pulled to the floor on average two days a week. During an interview on [DATE], at 1:34 PM, Registered Nurse (RN) 1 said the shower aides will let him/her know if a resident refuses their shower. Staff will still try to give them a second shower on the make-up days. Wednesday and Sundays are make-up shower days. If a resident repeatedly refuses, then staff will let their power of attorney know. There are not any resident who regularly refuses showers. All the residents have scheduled shower days, but sometimes staffing affects it. At times they do have to pull the shower aide to help out on the floor as an aide. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE], at 12:17 PM, the DON said anytime a resident wants a shower on another day, the staff will accommodate them. The same goes if the shower aide gets pulled to the floor, staff will still give them a shower another day. During an interview on [DATE], at 2:05 PM, the Assistant Director of Nursing (ADON) said residents have two scheduled showers a week. He/she didn't know of any residents that were refusing showers. The shower aide was supposed to let the ADON know when a resident refused a shower.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 22411 Based on interview and record review, the facility failed to provide documented evidence the facility documented residents' and/or their representatives grievances and provided grievance decisions/resolutions after grievances were voiced for two residents (Resident #60 and #91) of 34 sampled residents. Review of the facility's policy titled, Grievances and Complaints Policy and Procedure, revised 12/2016, showed the following: -The facility had adopted an internal grievance procedure providing for prompt and equitable resolution of complaints/grievances of all types, including but not limited to, those alleging any discriminatory action prohibited by or in violation of patient rights, applicable state and/or federal law, internal policies, rules, enactments, guidelines, codes, regulations, or initiatives issued or enacted by any and all entities holding jurisdiction over this facility; -Depending on the nature of the complaint/grievance, there may or may not be an official form that should be completed in accordance with applicable regulations. Regardless, all complaints should be in writing, containing the name of the person filing the complaint/grievance, the address and other contact information for the person filing, the name of the patient, a description of the act/actions/problem prompting the complaint/grievance, and the remedy or relief sought; -All complaints/grievances should be filed with the facility Grievance Official immediately upon discovery of the offense and no longer than 30 days following discovery; -The Grievance Officer will investigate the complaint, and forward to governing entities as required. The investigation will afford all interested persons and their representatives an opportunity to submit evidence relevant to the complaint/grievance. The investigator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and share them only with those who have a need to know; -The Grievance Officer is responsible for all of the following with relation to filed grievances: receiving and tracking, leading and investigating, maintaining confidentiality, issuing official decisions and regulations, coordinating with state and federal agencies, preventing further violations while investigating, documenting findings; and adhering to all applicable state and federal laws and regulations. -The person making the complaint/grievance will be notified by the Grievance Officer of the findings and the resolution of the complaint/grievance. Review of the facility's Grievance Form, revised 12/2016, showed at the bottom of the form boxes to be checked by the facility or the Grievance Officer that included the following: -Grievance recorded on Grievance Log. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Decision/Investigation outcome discussed with person filing grievance on [DATE] by [initials of person who discussed outcome]; -Grievance resolved/no further action to be taken, or unable to resolve. 1. During an interview on 02/10/25, at 10:11 A.M., Family Member (FM) 2 was in Resident #60's room. FM 2 indicated one of the biggest concerns was the door coming into the unit was always buzzing and going off. FM 2 said about 90% of the time it malfunctioned and the alarm goes off. At times, it has alarmed for up to 15 minutes. The lengthy time the alarm went off was because no one could get to it right away. FM 2 indicated filing a grievance over a year ago and nothing had happened. The Social Service Director (SSD) told him/her it was brought up in a meeting, but nothing has happened to fix it. Observation on 02/11/25, at 12:45 P.M., in the memory care unit, showed an ongoing issue with the door alarm. During lunchtime, the door alarm was repeatedly sounding, and staff members were actively managing the alarm by turning it off and on to stop the noise. During an interview on 02/11/25, at 12:47 P.M., License Practical Nurse (LPN) 1 confirmed he/she was aware of the door's buzzing problem. The LPN explained the issue could be managed by being careful about how the door was closed. During an interview on 02/12/25, at 3:08 P.M., the Maintenance Man discussed the dementia unit door issue. He explained the door's magnet sometimes shifted and turned sideways. To prevent problems, staff members were instructed not to slam the door, but instead to close it gently. The Maintenance Man indicated this had been a long-standing practice at the facility, stating, I was told it has been that way, and this is what we do. He also mentioned that he had not received any complaints about noise from the door. During an interview on 02/13/25, at 10:19 A.M., the Administrator discussed concerns about a door alarm system. According to the Administrator, people sometimes caused the door alarm to malfunction by allowing the door to slam, which created a gap that prevented the alarm from triggering. The Administrator stated during his time at the facility, they had adjusted the door multiple times. The door alarm was designed to sound when the door was not closed securely. If the door closed too slowly, it might trigger the alarm. The Administrator stated he knew who complained about the door and he has had multiple conversations about the issue. When asked to review any grievances and written resolutions, the Administrator denied the survey team their request. 2. Review of the facility's policy titled, Personal Property, revised September 2012 showed the resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. Review of Resident #91's Admission Record, located in the resident's electronic medical record (EMR) under the Profile tab showed the resident was admitted to the facility on [DATE]. Review of the resident's quarterly Minimum Data Assessment (MDS), with an assessment reference date (ARD) of 12/04/24 and located in the resident's EMR under the MDS tab, showed the resident was not a candidate for a brief interview for mental status (BIMS) interview. The resident had short- and long-term memory problems. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of of the resident's Inventory Sheet, dated 06/17/24 and located in the resident's EMR under the Misc [miscellaneous] tab, showed personal items inventoried upon admission. During an interview on 02/10/25, at 1:48 P.M., Family Member (FM) 3 said the resident had several pieces of missing clothes. The facility was responsible for doing the resident's laundry. FM 3 talked to nurses, case workers, and the Administrator about missing clothes. The resident had a dozen pants now down to four pants, no socks, fleece jacket, two blankets, and a gray hoodless jacket. FM 3 said she brought clothes for the resident and the facility was to label and add them to the rest of the resident's belongings. FM 3 said he/she had completed several grievances, and most of the grievances she never received anything back after filing them. During an interview on 02/12/25, at 4:02 P.M., the Social Services Assistant (SSA) said housekeeping labeled the clothes with a label maker. For the residents who resided on the short-term hall, at times he/she marked items with a marker. He/she said he/she did not know the process exactly to label personal items that are brought in from home. The facility would turn missing items into grievance if the items were not found. The forms the facility had were internal forms only and the person filing a grievance does not get a copy of the form. During an interview on 02/12/25, at 4:19 PM, the Social Service Director (SSD) stated the resident had a care plan meeting, and the family mentioned a fleece sweater, socks, and a couple pair of pants were missing. The family was not provided or offered to file a grievance. During an interview on 02/13/25, at 10:19 A.M., the Administrator denied the survey team the access to the grievances and/or documented resolutions.

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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 - Some	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** 43353 Based on observation, interview, and record review, the facility failed to ensure residents received their scheduled showers for six resident nts (Resident (R) R6, R7, R10, R30, R39, and R66) reviewed for showers out of 34 sampled residents This failure could lead to decreased quality of life and dignity. Review of the facility's policy titled, Bath, Shower/Tub, revised February 2018, showed the following: -Purposes of the procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin; -Staff to document each bathing and notify the supervisor if any resident refuses the shower/tub bath; -The bathing documentation requirement included the the date and time the shower/tub bath was performed and if the resident refused the shower/tub bath, the reason; -Notify the supervisor if the resident refuses the shower/tub bath. Review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, revised ,d+[DATE], showed the followng: -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene; -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene. 1. Review of Resident #10's Admission Record, undated, located in the resident's electronic medical record (EMR) under the Profile tab, showed the an admitted [DATE]. Review of of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of [DATE] and located in the EMR under the MDS tab, showed the following: -The facility assessed the resident as moderately cognitively impaired; -The resident was dependent on staff to completion of the shower task. Review of the residen'ts Point of Care (POC) documentation showed the resident did not receive a scheduled shower or bed bath on the following dates: -On [DATE]; (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE]; -On [DATE]; -On [DATE]; -On [DATE]; -Staff did not document any resident refusals of their showers or bed baths. During an interview on [DATE], at 9:57 A.M., the resident said he/she gets one shower a week and he/she would like to get two showers a week. He/she only gets one on Monday and not the Thursday shower. The shower aide gets pulled to work on the floor instead. 2. Review of Resident #30'sAdmission Record, undated, located in the resident's EMR under the Profile tab, showed an admitted [DATE]. Review of R30's quarterly MDS, with an ARD of [DATE] and located in the resident's EMR under the MDS tab, showed the following: -The facility assessed the resident as cognitively intact; -The resident was being dependent on staff to complete showers. Review of of the resident's POC documentation showed the resident did not receive a scheduled shower or bed bath on the following dates: -On [DATE], -On [DATE]; -On [DATE]; -On [DATE]; -On [DATE]; -Staff did not document any resident refusals of their showers or bed baths. During an interview on [DATE], at 10:29 A.M., the resident said he/she had been at the facility about 13 months. He/she only got one shower a week and would like to get more than one shower. The facility does not two showers due to the shower aide being needed out on the floor instead. 3. Review of Resident #66's Admission Record, undated and located in the resident's EMR under the Profile tab of the EMR, showed an admitted [DATE]. Review of the resident's significant change in status MDS, with an ARD of [DATE] and located in the resident's EMR under the MDS tab, showed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility assessed the resident was cognitively intact; -The resident was dependent on staff to complete showers. Review of the resident's POC showed the resident did not receive a scheduled shower or bed bath on the following dates: -On [DATE] -On [DATE]; -On [DATE]; -On [DATE]; -On [DATE]; -Staff did not document any resident refusals of their showers or bed baths. During an interview on [DATE], at 10:17 A.M., the resident said he/she doesn't get his/her showers. There was one week he/she did not get a bath for one week. He/she would like to get two showers a week, but there's not enough staff to help out. One time they gave him/her a little shower. They took hium/her in there and put him/her under the water, let the water fall on him/her, and then took him/her out as quick as they took him/her in. They did not wash him/her and called that a shower. 4. Review of Resident #39's Admission Record, undated, located in the resident's EMR under the Profile tab, showed an admitted [DATE]. Review of the resident's annual MDS, with an ARD of [DATE] and located in the resident's EMR under the MDS tab, showed the following: -The facility assessed as cognitively intact. -The resident to used a wheelchair and was dependent on staff for tub or shower transfers and to shower or bath him/herself. Review of the resident's Care Plan, located in the resident's EMR under the Care Plan tab, showed the following: -Initiated [DATE], ADL self-care performance deficit with limited mobility related to cerebrovascular accident (CVA - stroke) with hemiplegia (one-sided muscle paralysis or weakness); -Initiated [DATE], resident required dependent assistance by x 2 staff with bathing; -Initiatiated [DATE], resident prefers to have a whirlpool once a week and a sponge bath for his/her 2x week Tuesday/Friday. He/she prefers to have them after lunch with no set days. He/she agreed to have 2 whirlpools a week until his skin is healed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Care Plan Item/Task Listing Report, dated [DATE], showed the facility scheduled the resident to receive bathing as his care plan stated each Tuesday, Friday, and as needed. During the interview on [DATE], at 11:28 A.M., the resident said his/her last shower was about two weeks ago, with no bathing in between. He/she placed a bath request to the bath aides about two weeks ago, but no staff ever gave him/her one. Review of the resident's monthly Documentation Surveyor Report V2, dated [DATE] to [DATE], showed the following: -On [DATE], the resident received a bed bath; -On [DATE], the reesident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a whirlpool bath; -On [DATE], the resident refused a bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident did nto receive a scheduled bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident received a bed bath; -On [DATE], the rsident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a bed bath; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE], the resident did not receive a scheduled bath; -On [DATE], the resident refused a bath; -On [DATE], the residet received a bath. -Staff did not document the resident was offered an opportunity to receive a bath or shower when the resident refused or missed their regularly scheduled bathing day. During the interview on [DATE], at 3:35 P.M., the DON reviewed the resident's records and the monthly Documentation Surveyor Report V2 report for the resident's no-bathing days. The DON said there was no documentation that bathing was reoffered every day before the next scheduled bathing day. The DON stated that if a resident refuses to bathe, the staff should re-offer and document it. 5. Review of Resident #7's Admission Record, undated, located in the resident's EMR under the Profile tab, showed an admitted [DATE]. Revive of the resident's quarterly MDS, with an ARD of [DATE], and located in the resident's EMR under the MDS tab, showed the following: -The facility assessed was cognitively intact; -The resident did not exhibit behavioral symptoms including rejecting care; -The resident used a wheelchair and required staff's supervision to touch assistance including verbal cues for tub or shower transfers; -The resident required substantial to maximal assistance to shower or bath him/herself. Review of the resident's Care Plan, located in the resident's EMR under the Care Plan tab, showed the following: -Initiated [DATE], ADL self-care performance deficit related to weakness; -Initiated [DATE], the resident required max assistance by 1 staff with bathing/showering 2x a week (Tues/Friday) and as necessary. -Initiated [DATE], the resident was independent with toilet transfers due to grab bar and required supervision assisting with all other transfers. Review of the resident's Care Plan Item/Task Listing Report, dated [DATE], showed the facility scheduled the resident to receive bathing as hi/her care plan stated each Tuesday, Friday, and as needed. During an interview on [DATE], at 10:17 A.M., the resident said he/she got bathed once a week, which was not okay. He/she liked to be bathed two times a week. The resident said he/she had spoken to a social worker about his/her bathing preference. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's monthly Documentation Surveyor Report V2, dated [DATE] to [DATE], showed the following: -On [DATE], the resident refused a bath; -On [DATE], the resident refused a bath; -On [DATE], the resident received a shower; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident did not recieve a scheduled shower; -On [DATE], the resident refused a bath; -On [DATE], the resident received a bed bath; -On [DATE], the resident received a shower; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident received a shower; -On [DATE], the resident received a bed bath; -On [DATE], the resident did not receive a scheduled shower; -On [DATE], the resident did not recieve a scheduled shower; -On [DATE], the resident received a shower; -On [DATE], the resident received a shower; -On [DATE], the resident received a bed bath; -On [DATE], the residetn refused a bath; -On [DATE], the resident received a shower; -On [DATE], the resident did not received a scheduled bath; -On [DATE], the resident received a bed bath; -Staff did not document the resident was offered an opportunity to receive a bath or shower when the resident refused or missed their regularly scheduled bathing day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE], at 3:35 P.M., the DON reviewed the resident's records and the monthly Documentation Surveyor Report V2 report for the resident's no-bathing days. The DON said there was no documentation that bathing was reoffered every day before the next scheduled bathing day. The DON said that if a resident refuses to bathe, the staff should re-offer and document it. 6. Review of Resident #6'sAdmission Record, undated, located in the resident's EMR under the Profile tab, showed an admitted [DATE]. Review of the resident's quarterly MDS, with an ARD of [DATE] and located in the resident's EMR under the MDS tab, showed the following: -The facility assessed the resident as cognitively intact; -The resident did not exhibit behavioral symptoms including rejecting care; -The resident used a wheelchair and required partial to moderate assistance for tub or shower transfer and substantial to maximal assistance for shower or bath. Review of the resident's Care Plan, located in the resident's EMR under the Care Plan tab, showed the following: -Initiated [DATE], ADL self-care performance deficit due to hereditary ataxia (a group of inherited neurological disorders characterized by progressive incoordination and loss of balance); -Initiated [DATE], provide sponge bath when a full bath or shower cannot be tolerated; -Initiated [DATE], resident was max assistance of 1 staff with bathing/showering 2 times a week Mon/Thursday and as needed. Review of the resident's Care Plan Item/Task Listing Report, dated [DATE], showed the facility scheduled the resident to receive bathing as his/her care plan stated each Monday, Thursday, and as needed. During an interview on [DATE], at 1:39 P.M., the resident said he/she only received one bath a week instead of two times a week. The resident also said each Monday and Thursday were his/her scheduled shower days and that his/her last bath was last Thursday ([DATE]), which was the only bath of that week. Review of the resident's monthly Documentation Surveyor Report V2, dated [DATE] to [DATE], showed the following: -On [DATE], the resident received a shower; -On [DATE], the resident did not receive scheduled shower; -On [DATE], the resident received a shower; -On [DATE], the resident received a shower; (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE], the resident refused a bath; -On [DATE], the reisdent received a shower; -On [DATE], the resident received a bed bath; -On [DATE], the resident did nto receive a scheduled bath; -On [DATE], the resdient recieved a shower; -Staff did not document the resident was offered an opportunity to receive a bath or shower when the resident refused or missed their regularly scheduled bathing day. During an interview on [DATE], at 3:35 PM, the reviewed the resident's records, including the monthly Documentation Surveyor Report V2 report for the residents' no-bathing days. The DON said there was no documentation that bathing was reoffered every day before the next scheduled bathing day. The DON said that if a resident refused to bathe, the staff should re-offer and document it. 7. During an interview on [DATE],5 at 8:59 A.M., Certified Nurse Aide (CNA) 1 said his/her primary job was being a shower aide. Residents were supposed to get two showers a week unless they refuse. They wouldn't get a shower though if he/she was pulled to the floor because they were short staffed. The CNA said he/she gets pulled to the floor on average two days a week. During an interview on [DATE], at 1:34 PM, Registered Nurse (RN) 1 said the shower aides will let him/her know if a resident refuses their shower. Staff will still try to give them a second shower on the make-up days. Wednesday and Sundays are make-up shower days. If a resident repeatedly refuses, then staff will let their power of attorney know. There are not any resideent who regularly refuses showers. All the residents have scheduled shower days, but sometimes staffing affects it. At times they do have to pull the shower aide to help out on the floor as an aide. During an interview on [DATE], at 12:17 PM, the DON said anytime a resident wants a shower on another day, the staff will accommodate them. The same goes if the shower aide gets pulled to the floor, staff will still give them a shower another day. During an interview on [DATE], at 2:05 PM, the Assistant Director of Nursing (ADON) said residents have two scheduled showers a week. He/she didn't know of any residents that were refusing showers. The shower aide was supposed to let the ADON know when a resident refused a shower.

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F 0757

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident’s drug regimen must be free from unnecessary drugs.

33865

Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications when on one resident (Resident #54), of five residents reviewed for unnecessary medication use, receive opioid pain medication without assessment of the proper pain level, without documention of non-pharmalogical interventions attempted first, and without documented monitoring for side effects.

Review of the facility's policy for Medication Therapy, revised April 2007, showed the following:

-Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks;

-Upon or shortly after admission, and periodically thereafter the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen to identify whether there is a clear indication for treating that individual with the medication; the dosage is appropriate; the frequency of administration and duration of use are appropriate; and potential or suspected side effects are present.

Review of the National Library of Medicine's website, accessed on 02/16/25, under the Bookshelf tab in book selection, State Pearls for Hydrocodone page, last update 01/29/24, showed the following:

-Hydrocodone is primarily used to treat severe chronic pain that requires opioid analgesia and is not effectively treated by non-opioid alternatives;

-Clinicians should vigilantly monitor patients for pain relief, constipation, respiratory depression, and other potential adverse effects;

-The most common adverse effects of hydrocodone included frequent constipation and nausea;

-Additional adverse effects of hydrocodone included the severe respiratory depression, shortness of breath, respiratory tract infection, hypotension (low blood pressure), bradycardia (fast heart beat), and peripheral edema (swelling), headache, chills, anxiety, sedation, insomnia, dizziness, drowsiness, fatigue, pruritus (itching), diaphoresis (excessive sweating), rash, vomiting, dyspepsia (discomfort or pain in the upper abdomen, often after eating or drinking), gastroenteritis (an inflammation of the lining of the stomach and intestines), constipation, abdominal pain, urinary tract infection, urinary retention associated with prostatic hypertrophy (a non-cancerous enlargement of the prostate gland, which is located below the bladder in men), tinnitus (a condition where a person perceives ringing, buzzing, hissing, or other noises in their ears or head, even when there is no external source of sound), sensorineural hearing loss, and secondary adrenal insufficiency.

1. Review of Resident #54's Admission Record, dated 02/11/25, located in the resident's electronic medical record (EMR) under the Profile tab showed revealed the facility admitted the resident on 01/04/21 with diagnoses including chronic pain syndrome.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) with an assessment reference date (ARD) of 01/11/25, showed the facility assessed the resident had frequent pain, which occasionally affected his/her sleep. The resident received scheduled and as needed pain medication including an opioid. Review of the resident's Care Plan for chronic pain due to limited mobility, myopathy (a group of disorders that affect the muscles, causing weakness and other symptom), and polyneuropathies (disorders that affect multiple peripheral nerves, causing damage and dysfunction), initiated on 04/13/21, showed following interventions: -Administer medications as ordered by physician and monitor/document side effects and effectiveness each shift; -Assess pain on scale of 1 to 10 every shift; -Hydrocodone/APA had a black box warning of addiction, abuse, misuse, and life-threatening respiratory depression. Review of the resident's Administration Report, for order range 12/01/24 to 02/28/25, dated 02/12/25, showed the resident received Norco Tablet 10-325 milligrams (mg) (hydrocodone-acetaminophen), one tablet by mouth every 4 hours as needed for pain. The report showed the resident had received Norco when experiencing no pain and mild to moderate pain (scale 0 to 4) as follows: -From 12/01/24 to 12/31/24: 53 times. -From 01/01/25 to 01/31/25: 22 times. -From 02/01/25 to 02/11/25: 11 times. Review of of the resident's record showed there was no documentation that the staff offered nonpharmacological interventions for pain prior to administering Norco when the resident indicated mild to moderate pain. Staff did not document about whether the staff had been monitoring the opioid's adverse effects. During an interview on 02/11/25, at 3:42 P.M., the Director of Nursing (DON) reviewed the resident's record and said there was no documentation the opioid adverse effects were being monitored and the nonpharmacological interventions for pain were offered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43353 Based on observations, interviews, and record review, the facility failed ensure storage of medication per standards of practice and in a manner that prevented possible of expired medications/supplies when staff failed to remove expired medications/supplies from one of two medication storage rooms and two of four medication carts. Review of the facility's policy titled, Medication Labeling and Storage, dated 2001, showed the following: -The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. -If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Observation on 02/13/25, at 9:07 A.M., with Licensed Practical Nurse (LPN) 4 of the medication cart at the nurses' station on Hall 400 showed one open box and one unopened box of Assure Prism blood glucose control solution with the expiration date of 12/07/24 were found in the first drawer of medication cart. LPN4 confirmed they were expired and removed them from the medication cart. Observation on 02/13/25, at 9:40 A.M., with LPN5 of the medication cart at the nurses' station on Hall 300 showed one open box of Assure Prism blood glucose control solution with the expiration date of 12/07/24 was found in the first drawer of the medication cart. LPN5 confirmed it was expired and removed it from the medication cart. Observation on 02/13/25, at 9:43 A.M., of the medication room at the nurses' station on Hall 300 was showed one open bottle of Docusate Sodium Liquid [stool softener laxative] that was not labeled with an open date and had an expiration date of 06/2024 was found on a shelf in the cabinet. LPN5 confirmed it was expired and removed it from the medication cart. During an interview on 02/13/25, at 9:43 A.M., LPN5 said he/she didn't know how long it had been up there, but staff don't use it. It's everyone's job to check for expired meds. Staff also have a monthly audit done when the pharmacy comes in the building. During an interview on 02/13/25, at 12:05 P.M., the Director of Nursing (DON) stated all the certified medication techs (CMT) and nurses are responsible for checking expiration dates. Our pharmacy comes in monthly and audits all the medication carts and medication rooms and removes all the expired meds too.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33865 Based on observations, interviews, and record review, the facility failed to ensure food items were stored in accordance with professional standards of practice for food service safety when expired foods were found in kitchen storage areas. Review of the facility's policy titled, Food Receiving and Storage, revised ,d+[DATE], showed foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). 1. Observation and interview on [DATE], at 9:01 A.M., alongside the Certified Director of Food Service (CDFS), showed a refrigerator in the main kitchen had an opened five-pound container of cottage cheese with a best by date of [DATE]. The CDFS confirmed this food item was expired. Observation and interview on [DATE], at 9:02 A.M., alongside the CDFS, showed the dry storage room of the main kitchen had 15, 12-ounce cans of evaporated milk with best by dates of [DATE]. The CDFS confirmed the items were expired. Observation and interview on [DATE], at 10:18 A.M., alongside the CDFS, showed the walk-in refrigerator in the main kitchen had unsliced ham stored in a clear plastic bag with a use-by date of [DATE]. The CDFS confirmed the food item was expired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Pointe Health and Rehabilitation	3705 S Jefferson Ave Springfield, MO 65807

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on observation, interview, and record review, the facility failed to ensure an effective infection control and prevention program was maintained for six residents (Resident #101, #211, #212, #215, #359, and #54) of 25 residents reviewed for infection control when the facility failed to clean and disinfect patient care equipment in between resident use. Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 09/2022, showed the following: -Resident-care equipment, including reusable items and durable medical equipment, will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Association (OSHA) Bloodborne Pathogens Standard. -Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment); -Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions. 1. Review of Resident #101's Admission Record, undated, located in the resident's electronic medical record (EMR) under the Profile tab showed the resident was admitted to the facility on [DATE]. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) with an Assessment Reference Date (ARD) of 01/25/25 and located in the EMR under the MDS tab, showed the facility assessed the resident as cognitively intact. During an observation on 02/11/25, at 9:16 A.M., in the resident's room, Certified Medication Technician (CMT) 1 obtained the resident's blood pressure using a wrist cuff on the resident's right wrist. CMT1 obtained the resident's oxygen saturation (O2) using a pulse oximeter checking multiple fingers. CMT1 administered the resident's medications and left the resident's room. CMT1 set the unclean wrist cuff and pulse oximeter on top of medication cart without a barrier and moved his/her med cart to doorway of of Resident #211's room. 2. Review of Resident #211's Admission Record, undated, located in the resident's EMR under the Profile tab showed the resident was admitted to the facility on [DATE]. Review of of the resident's admission MDS, with an ARD of 01/08/25, and located in the resident's EMR under the MDS tab, showed the facility assessed the resident to have a moderately cognitively impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/11/25, at 9:24 A.M., CMT 1 picked up the unclean wrist cuff from the top of the medication cart and entered the resident's room. CMT1 obtained the resident's blood pressure using the wrist cuff on the resident's right wrist. CMT1 then obtained the resident's O2 reading using the pulse oximeter on his/her finger. CMT1 set the unclean wrist cuff and pulse oximeter on top of medication cart without a barrier and moved his/her medication cart to the doorway of Resident #212's room. 3. Review of Resident #212's Admission Record, undated, located in the resident's EMR under the Profile tab revealed of the resident was admitted to the facility on [DATE]. Review of the resident's admission MDS, with an ARD of 01/28/25 and located in the resident's EMR under the MDS tab, showed the facility assessed the resident to be moderately cognitively impaired. During an observation on 02/11/25, at 9:43 A.M., CMT1 picked up the unclean wrist cuff from the top of medication cart and entered the resident's room. CMT1 obtained the resident's blood pressure using a wrist cuff on the resident's right wrist. CMT1 attempted to obtain the resident's O2 reading using the pulse oximeter on multiple fingers. CMT1 administered the resident's medications to him/her and left the resident's room. CMT1 then set the unclean wrist cuff and pulse oximeter on top of med cart without a barrier and moved her med cart to doorway of next resident's room to take vitals and administer meds too. 4. During an interview on 02/11/25, at 9:50 A.M., CMT1 said staff receive training once a month and get reminders all the time on infection control. He/she will wipe down the patient care equipment after using it on 5 to 6 residents. He/she didn't clean the wrist cuff or pulse oximeter before or after those three residents, but would have if they were on isolation or precautions. 5. During an observation on 02/13/25, at 9:07 A.M., CMT5 picked up a wrist cuff from top of the med cart and entered the Resident #212's room. CMT5 then obtained the resident's blood pressure using wrist cuff on his/her right wrist and obtained his O2 reading with the pulse oximeter he/she pulled out of his/her pocket. CMT5 administered the resident's medications to him/her, left the resident's room, set the now unclean wrist cuff and pulse oximeter on top of medication cart without a barrier, and moved the medication cart to doorway of the next resident's room to take vitals and to administer medications. 6. Review of Resident #215's Admission Record, undated, located in the resident's EMR under the Profile tab showed the following: -admitted [DATE]; -Diagnoses included sepsis due to methicillin susceptible staphylococcus aureus (MRSA) and severe sepsis with septic shock. Review of the resident's admission MDS, with an ARD of 01/27/25 and located in the resident's EMR under the MDS tab, showed staff assessed the resident as cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/13/25, at 9:18 A.M., CMT5 donned PPE from the isolation cart outside he resident's doorway. The resident's door had signage of Contact Precautions posted to. The CMT stated, I don't know why he is on contact precautions. I believe it has something to do with his medical condition and why he is here at this facility. CMT5 picked up the wrist cuff and pulse oximeter from top of medication cart and entered the resident's room, leaving his door partially open. CMT5 obtained the resident's blood pressure using the wrist cuff on his/her right wrist and obtained his/her O2 reading with the pulse oximeter. CMT5 administered there resident's medications to him, doffed his/her PPE, set the wrist cuff on top of the medication cart without a barrier, put the pulse oximeter that he/she was holding into his/her pocket, washed his/her hands, exited the room, and closed the door. CMT5 moved the med cart to the doorway of next resident's room to take vitals and to administer medications. 7. Review of Resident #359's Admission Record, undated, located in the resident's EMR under the Profile tab showed the resident was admitted to the facility on [DATE]. During an observation on 02/13/25, at 9:25 A.M., CMT5 picked up the unclean wrist cuff from the top of the medication cart and entered the resident's room. CMT5 obtained the resident's blood pressure using the wrist cuff on his/her right wrist and obtained his/her O2 reading with the pulse oximeter he/she pulled out of his/her pocket. CMT5 administered the resident's medications to him, left the resident's room, set unclean wrist cuff and pulse oximeter on top of the medication cart without a barrier, and moved her medication cart to the doorway of next resident's room to take vitals and to administer medications. 8. During an interview on 02/13/25, at 9:35 AM, CMT5 said staff are supposed to clean patient care equipment before, after, and in between each use. He/she forgot and didn't clean them between the three residents. 9. During an interview on 02/11/25, at 1:34 P.M., Registered Nurse (RN) 1 said he/she used to be the CNA program trainer and he/she always taught them to clean any type of patient care equipment with the disinfecting Sani-cloths after every use. During an interview on 02/12/25, at 10:54 A.M., the Infection Preventionist (IP) said patient care equipment should be cleaned between residents or whenever equipment is taken into a resident room. They are all trained to clean them that way and to use the cleaning wipes from the container with purple top. We have racks hanging on the walls on a couple of halls that have the cleaning wipes so they're easily accessible to staff to clean with. During an interview on 02/12/25, at 10:40 AM, the Director of Nursing (DON) said my expectation was that staff are all responsible for infection control. Staff are to use standard practice of cleaning for all patient care equipment before and after use on a resident. We task the infection control training with the IP, but staff always constantly giving everyone reminders.