STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265881	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Dardenne Prairie	7275 State Highway N Dardenne Prairie, MO 63368

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed physician orders for two residents (Resident #4 and #5) of ten sampled residents. Staff failed to follow physician orders for dressing changes to intravenous (IV) sites and wounds and failed to follow physician orders to secure an indwelling catheter. The facility census was 29.The facility provided no policy for following physician orders upon request.Review of the facility policy Wound Treatment Management with a revision date of 4/2025 showed the following:-To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders;-The facility will follow specific physician orders for providing wound care.Review of the facility policy Skin Assessment with a revision date of 4/2025 showed the following:-It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management;-A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and at least weekly thereafter. 1. Review of Resident #4's face sheet showed the following:-admitted to the facility on [DATE];-Diagnoses including osteomyelitis (infection of the bone) of vertebra, sacral and sacrococcygeal region (lower back and tailbone region of the spine), multiple sclerosis (an autoimmune disease that damages nerves). Review of the resident's care plan for infection dated 10/28/25 showed the resident had osteomyelitis of the sacrum. Staff should provide antibiotics and wound care as prescribed.Review of the resident's care plan for altercation to skin integrity dated 10/28/25 directed staff to weekly skin checks per facility schedule. Review of the resident's care plan for Stage 4 Pressure Ulcer (PU a full-thickness tissue loss where skin, fat, and muscle have been destroyed, exposing underlying bone, tendon, or muscle) dated 10/28/25 directed staff to complete treatments to the resident's pressure ulcer as prescribed.Review of the resident's Physician Orders (POS) dated October 2025 showed the following:-Complete weekly skin checks on Wednesday with an order date of 10/30/25;-PICC (Peripherally Inserted Central Catheter - (a long, thin tube inserted into a vein in the arm and threaded to a large vein near the heart. It is used for long-term intravenous (IV) treatments). Dressing change weekly and as needed with an order dated of 10/28/25;-Urinary catheter (a tube inserted in the bladder to drain urine) anchor and change every Sunday;-Urinary catheter care every shift;-Cleanse under both breasts with soap and water BID (two times a day) and apply antifungal powder;-Admit wound care standing orders: coccyx (tailbone), cleanse with wound cleanser, pat dry, apply cover dressing and notify wound care provider for further directions with a start date of 10/28/25. Review of the resident's Medication Administration Record/Treatment Administration Record (MAR/TAR) dated October 2025 on 11/5/25 showed the following:-Coccyx wound: sterile saline, skin prep, pack with Opticell AG (a type of silver antibacterial gelling fiber wound dressing), apply four by four dressing every 72 hours with a start date of 10/28/25;-There was no documentation staff completed this dressing change on 10/28/25;- Admit wound care standing orders: coccyx, cleanse with wound cleanser, pat dry, apply cover dressing and notify wound care provider for further directions BID (day and night) with a start date of 10/28/25; the day shift on 10/29/25 was blank with no documentation staff completed the ordered dressing change and blank on the night shift on 10/28/25, 10/29/25 and 10/30/25;-Cleanse under breasts with soap and water BID and apply antifungal powder documented was blank on 10/30/25 at 7:00 P.M. with no documentation staff completed the treatment; -Urinary catheter care was not included on the MAR/TAR for staff to document completion;-Urinary catheter anchor change every Sunday was not on the MAR/TAR for staff to document completion. Review of the resident's MAR/TAR dated November 2025 on 11/5/25 showed the following:-PICC line dressing change documented as completed on 11/3/25;-Cleanse under breast with soap and water BID and antifungal powder BID;- There was nothing documented on 11/1/25 at 7:00 A.M. or 7:00 P.M. showing staff completed the ordered treatment and no documentation on 11/2/25 at 7:00 P.M. that staff completed the treatment; -No documentation staff completed urinary catheter care;- Urinary catheter anchor change every Sunday was not part of the MAR/TAR for staff to document completion. Observation and interview on 11/5/25 at 10:20 A.M. showed the following:-Resident #4 lay in the bed with a dressing to the left upper arm where the PICC line was inserted. The dressing on the PICC line was dated 10/22/25;-An indwelling catheter bag hung on the side of the bed with yellow urine;-Resident #4 said that staff has not changed or cleaned the PICC line site since he/she admitted to the facility and staff had not performed any catheter care. His/her treatment to the wound on

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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 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. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to secure indwelling catheter drainage tubing and bags for two residents (Resident 4, and #5), in a review of ten residents with indwelling catheters. These failures increased the residents' risk for urinary tract infections. The facility census was 29. Review of the facility policy for Catheter Care with a revision date of 4/2025 showed the following:-It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use;-Catheter care will be performed every shift and as needed by nursing personnel;-Privacy bags will be available and catheter drainage bags will be covered at all times while in use;-Catheter drainage bags will be positioned below bladder level, clear from floor, and will not be level with the resident while the resident is in bed;-Ensure the drainage bag is located below the level of the bladder to discourage backflow of urine. 1. Review of Resident #4's face sheet showed the following:-admitted to the facility on [DATE] with diagnoses of osteomyelitis (infection of the bone);- Multiple sclerosis (an autoimmune disease of the nervous system). Review of the admission assessment dated [DATE] showed the resident was alert and oriented, able to make needs known. Able to make self-understood and able to understand others. Review of the resident's care plan for Indwelling Catheter dated 10/28/25 showed the following:-The resident required an indwelling catheter at this time secondary to neurogenic bladder (a condition where nerve damage prevents the brain and bladder from communicating properly, leading to a loss of bladder control);-Interventions: catheter care every shift and as needed, ensure drainage bag has a dignity cover, keep the drain bag below the level of the bladder. Review of the resident's Physician Orders (POS) dated October 2025 showed the following:-Urinary catheter (a tube inserted in the bladder to drain urine) anchor change every Sunday;-Urinary catheter care every shift. Observation and interview on 11/5/25 at 10:20 A.M. showed the following:-The resident had an indwelling catheter with yellow urine, there was no drainage bag cover over the drainage bag;-The resident said he/she was supposed to have catheter care every shift, but this was not done. It had been several days since his/her catheter has been cleaned. Observation on 11/5/25 at 3:00 P.M. with the Assisted Director of Nursing (ADON) and Registered Nurse (RN) A showed the following:-The resident lay in bed;- The ADON provided wound care;-The resident's urinary catheter did not have an anchor on the resident's leg to secure the catheter tubing;-The urinary catheter drained yellow urine and the urinary drainage bag that was positioned on the side of the bed that was closest to the door opening to the hallway was not covered with a dignity bag. 2. Review of Resident #5's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of urinary tract infection, urinary retention and chronic kidney disease. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 8/27/25, showed the following:-Alert and oriented and able to make needs known;-Able to understand others and able to make self understood;-Requires assistance with Activates of Daily Living (ADL's);- Indwelling urinary catheter. Review of the resident's care plan for Indwelling Catheter dated 8/26/25 showed the following:-The resident required an indwelling catheter due to wounds and urinary retention;-Catheter care every shift and as needed, change catheter as needed, monitor for signs and symptoms of a UTI. Review of the resident's POS dated November 2025 showed the following:-Urinary catheter care every shift and as needed;-Urinary catheter anchor, change every Sunday. Observation on 11/5/25 at 10:28 A.M. showed Resident #5 sat in a wheelchair with an indwelling urinary catheter. The catheter tubing hung down and touched the floor; there was sediment in the tubing. The catheter bag did not have a dignity cover, the drainage bag was visible from the door. Observation on 11/5/25 at 2:35 P.M. with the ADON and RN A showed the following:-The resident sat in a wheelchair with an indwelling urinary catheter. The catheter tubing hung down and touched the floor; there was sediment in the tubing;-The ADON offered the resident catheter care, the resident said he/she had not had catheter care in several days;-The ADON and RN helped the resident come to a standing position and the ADON performed catheter care. There was no anchor securing the tubing to the resident's leg and the tubing pulled as the resident stood. The resident said he/she felt the catheter tube pulling down;-RN A said that the catheter tubing should not be on the floor, and he/she was going to call the physician about the sediment in the tubing. During an interview on 11/5/25 at 9:30 A.M. the Director of Nursing said the following:-Catheter care should be done every shift;-The indwelling catheter tubing should be anchored to the resident's leg to prevent the tubing from pulling and should be changed weekly and dated when

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow current infection control standards for four residents (Resident #1, #3, #7 and #10), in a review of ten sampled residents when staff failed to perform proper hand hygiene and change gloves to prevent infection during personal care for Resident #1, #3, #7 and #10, and failed to properly handle soiled linens during personal care for Resident #10. The facility census was 29.Review of the facility policy for Hand Hygiene with a revision date of 4/2025 showed the following:-All staff will perform proper hand hygiene procedures to prevent the spread of infection to tother personnel, residents and visitors. This applies to all staff working in all locations within the facility;-Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice;-Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Hands hygiene is done when hands are visibly dirty, visibly soiled with blood or other body fluids, between resident contacts, after handling contaminated objects, before performing invasive procedures, before applying and after removing personal protective equipment (PPE), including gloves, before and after handling clean or soiled dressings, linens, before performing resident care procedures, before and after providing care to residents in isolation, after handling items potentially contaminated with blood, body fluids, secretions, or excretions, when, during resident care, moving from a contaminated body site to a clean body site, when in doubt;-The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (putting on) gloves, and immediately after removing gloves. Review of the facility policy for Handling Soiled Linen with a revision date of 4/2025 showed the following:-It is the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. This policy pertains to soiled linen;-All used linen should be handled using standard precautions (i.e. gloves) and treated as potentially contaminated;-Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces and persons;-Used or soiled linen shall be collected at the bedside (or point of use, such as dining room) and placed in a [NAME] bag or designated linen receptacle;-Wash hands after contact with soiled linen. 1. Review of Resident #1's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of spinal stenosis (the narrowing of the spinal canal that puts pressure on the nerves and spinal cord like pain, numbness), urinary tract infection, diabetes, and end stage renal disease with dialysis (the final stage of kidney failure where the kidneys permanently stop working, requiring dialysis). Review of the resident's Minimum Data Set (MDS) a federally mandated assessment instrument completed by staff, dated 8/29/25 showed the following:-Alert and oriented and able to make decisions;-Able to make self-understood and able to understand others;-Dependent upon staff for personal hygiene;-Indwelling catheter. Review of the resident's care plan for indwelling catheter dated 8/29/25 directed staff to complete catheter care each shift. Observation and interview on 10/31/25 at 9:55 A.M. showed the following:-Resident #1 lay in bed with an indwelling catheter, the tubing of the catheter was whitish colored with thick sediment in the tubing;-The resident said he/she went to dialysis three times a week, his/her last appointment was yesterday. The physician at the dialysis clinic said the catheter needed to be changed;-He/She had been incontinent of feces and needed to be changed. The resident turned on the call light. Observation on 10/31/25 at 10:33 A.M. showed the following:-Certified Nurse Aide (CNA) D answered the resident's call light; the resident told CNA D he/she needed to be changed;-CNA D put on a gown and took a pair of gloves out of a box. Without washing his/her hands CNA D applied the gloves, went into the resident's bathroom, put several washcloths in warm water and placed the wet washcloths on the sheet on the resident's bed;-CNA D then rolled the resident over and removed the resident's brief. With a wet washcloth he/she removed dried feces from the anal area then placed the soiled washcloth on the sheet. Without performing hand hygiene and changing gloves, CNA D opened the top drawer of the nightstand cabinet and retrieved a tube of protective, placed some of the ointment on his/her soiled gloves, and applied the ointment to the residents' buttocks. Without changing gloves and performing hand hygiene, CNA D then took a clean brief from the resident's nightstand, put the clean brief on the resident and without changing the sheet, covered the resident with blankets; -CNA D went into the resident's bathroom, placed the soiled washcloth and the soiled brief in a trash bag, removed his/her gown and gloves, and without washing his/her hands exited the resident's room. 2. Review of Resident #3's face sheet showed the resident admitted to the