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	01/15/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed follow discharge process per facility policy. Staff failed to provide a copy of bed hold policy and written notice of transfer to the resident and/or the resident's representative when four residents (Residents #42, #34, #9 and #47), in a review of 15 sampled residents, were transferred/discharged from the facility. The facility census was 32. Review of the facility's policy for transfer/discharge notices, last revised April 2025, showed the following:-The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and way they can understand. The notice will include all the following at the time it is provided: -The specific reason and basis for transfer or discharge; -The effective date of transfer or discharge; -The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged ;-Emergency Transfers to Acute Care;-Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. Review of the facility's policy, Bed Hold Prior to Discharge, last revised April 2025, showed the following:-The facility will have a process in place to ensure residents and/or their representatives are made aware of the facility's bed-hold and reserve bed payment policy well in advance of being transferred to the hospital;-The facility will provide written information about these policies to residents and/or resident representatives prior to and upon transfer for such absences;-The written information given to the resident and/or resident representative will include the following: -The duration of the state bed-hold, if any, during which the resident is permitted to return and resume residence in the nursing facility; -The reserve bed payment policy in the state plan, if any; -The facility policies regarding bed-hold periods to include permitting residents to return to the next available bed; -Conditions upon which the resident would return to the facility. 1. Review of Resident #42's face sheet showed the resident was his/her own responsible party. Review of the Prospective Payment System (PPS), dated 12/22/25, which uses the MDS assessment to determine Medicare payments, showed the resident was cognitively intact. Review of the resident's progress notes, dated 12/28/25 at 9:19 A.M., showed staff documented the resident was sent to the hospital for increased cough and dyspnea (shortness of breath). There was no documentation to show that anyone was notified of the transfer or staff provided bed hold information. Review of the resident's medical record showed no evidence staff provided the resident with a written notice of transfer or bed hold when the resident was transferred to the hospital on [DATE]. Review of the resident's progress notes dated 01/05/26 at 5:47 P.M., the resident returned from the hospital. During an interview on 01/15/26 at 9:25 A.M., the resident said the following:-The facility did not explain or give a written copy of the transfer/discharge and bed hold process on 12/28/25 when he/she was sent to the hospital;-The facility staff told him/her he/she needed to go to the hospital due to his/her cough and dyspnea and transferred him/her. 2. Review of Resident #34's face sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 01/03/26 at 1:43 P.M., showed the resident was sent to hospital for low blood sugar and lethargy. Review of the resident's progress note, dated 01/06/26 at 3:52 P.M., (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265881	A. Building B. Wing	01/15/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed the resident returned from the hospital. Review of the resident's medical record showed no evidence staff provided the resident's representative with a written notice of transfer when the resident was transferred to the hospital on [DATE]. 3. Review of Resident #9's face sheet showed the resident was his/her own responsible party. Review of the resident's progress notes, dated 01/05/26 at 10:30 P.M., showed staff documented the resident was sent to the hospital for unsafe behaviors. There was no documentation to show anyone was notified of the transfer or staff provided bed hold information. Review of the resident's Comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, completed on 01/07/26, showed the resident had severe cognitive impairment. Review of the resident's medical record showed no evidence staff provided the resident or the resident's representative with a written notice of transfer or bed hold when the resident transferred to the hospital on [DATE]. 4. Review of Resident #47's face sheet showed the resident was his/her own responsible party. Review of the resident's progress notes, dated 11/27/25 at 12:52 P.M., showed staff documented the resident was transferred to the hospital for aggressive behaviors/agitation. There was no documentation to show that anyone was notified of the transfer or staff provided bed hold information. Review of the resident's medical record showed no evidence staff provided the resident with a written notice of transfer/discharge or bed hold when the resident transferred to the hospital on [DATE]. 5. During an interview on 01/14/26 at 3:10 P.M., Registered Nurse (RN) Q said the following:-He/She was agency staff; -He/She had not been orientated to the discharge process;-The Director of Nursing (DON) or Assistant Director of Nursing (ADON) would do the paperwork if needed. During an interview on 01/14/26 at 2:35 P.M., the facility's regional nurse said the following: -Nursing staff were responsible for completing bed hold and transfer/discharge notices when a resident transferred to the hospital;-Nursing staff should provide the bed hold and transfer/discharge notices to the resident and/or resident representative upon transfer and should document and upload the notices in the resident's electronic medical record; -Upon investigation, she was unable to locate a transfer/discharge notice for Resident #34 or #47;-She noticed staff did not complete this consistently and notices were being missed. During an interview on 01/15/26 at 11:45 A.M., the administrator said she would expect the transfer/discharge and bed hold paperwork to be done per the policy.

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	01/15/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, facility staff failed to ensure one resident (Resident #34), in a review of 14 residents and two additional residents (Resident # 100 and # 101) were free from significant medication errors. Staff failed to prime (remove the air) insulin (injectable medication to treat diabetes (inability to control the amount of sugar in the blood)) pens prior to administration of the physician ordered dose, as the facility policy and manufacturer's instructions directed, resulting in administration of less than the ordered dose of insulin. The facility census was 32. Review of the facility policy, Insulin Pen, revised 04/25, showed the following:-It is the policy of this facility to use insulin pens to improve the accuracy of insulin dosing, provide increased resident comfort and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge;-Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. Review of the Lispro Kwik Pen (prefilled pen of fast acting insulin where a dose is dialed on the pen and injected through a new sterile needle attached to the pen prior to each administration) package insert showed the following in part:-Prime: If you do not prime before each injection, you may get too much or too little insulin. Turn the dose knob to select two units, hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top, push the dose knob in until it stops and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. Repeat the priming procedure if you did not see insulin at the tip of the needle;-Turn the dose knob and select the number of units you need to inject and administer the medication. Review of the Lantus Solostar Pen (prefilled pen of long-acting insulin where a dose is dialed on the pen and injected through a new sterile needle attached to the pen prior to each administration) package insert showed the following in part:-Prime: If you do not prime before each injection, you may get too much or too little insulin. Turn the dose knob to select two units, hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top, push the dose knob in until it stops and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. Repeat the priming procedure if you did not see insulin at the tip of the needle;-Turn the dose knob and select the number of units you need to inject and administer the medication. Review of the Aspart Flex Pen (prefilled pen of fast acting insulin where a dose is dialed on the pen and injected through a new sterile needle attached to the pen prior to each administration) package insert showed the following in part:-Prime: If you do not prime before each injection, you may get too much or too little insulin. Turn the dose knob to select two units, hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top, push the dose knob in until it stops and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. Repeat the priming procedure if you did not see insulin at the tip of the needle;-Turn the dose knob and select the number of units you need to inject and administer the medication. 1. Review of Resident #100's January 2026 Physician Order Sheet (POS) showed the following:-Diagnosis of type II diabetes;-Lispro Kwik Pen insulin 100 units/milliliter (ml) subcutaneous (tissue just below the skin), inject three units daily with meals;-Lispro Kwik Pen insulin 100 units/ml subcutaneous with meals, inject as per sliding scale (an amount to be determined based on an Accu check (finger stick procedure to determine the amount of sugar in the blood)): if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 4 401 or greater give 12 units, notify the physician. Review of the resident's January 2026 Medication Administration Record (MAR) showed the following:-Lispro 100 units/ml insulin three units daily with meals, scheduled for 8:00 A.M.;-Lispro 100/ml insulin per sliding scale, scheduled for 8:00 A.M. Observation and interview on 01/13/26 at 9:25 A.M., showed the following:-The Assistant Director of Nursing (ADON) said she was helping the nurse by completing the Accu checks and insulin administrations for him/her;-The nurse was running late on doing the Accu checks and insulins; -She had checked all the Accu checks on the hall starting (continued on next page)

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	01/15/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 8:45 A.M.;-Resident #100's Accu check reading was 276 milligrams per deciliter (mg/dL) (measurement of the amount of glucose or sugar in the blood) this morning and she had determined the resident would need six units of Lispro sliding scale insulin;-The ADON obtained the resident's Lispro Kwik Pen from the top medication cart drawer, removed the pen cap, cleansed the tip of the insulin pen with an alcohol pad and attached a new sterile needle. The ADON did not prime the pen;-The ADON dialed up six units of Lispro insulin for the sliding scale and three units for the scheduled dose for a total of nine units and administered the medication in the resident's abdomen. 2. Review of Resident #34's January 2026 POS showed the following:-Diagnosis of type II diabetes with hypoglycemia (low blood sugar);-Lantus Solostar insulin pen, 100 units/ml, inject 14 units subcutaneous daily;-Lispro Kwik Pen insulin 100 units/ml subcutaneous with meals, inject as per sliding scale: if 70-130= 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 400 notify the physician. Review of the resident's January 2026 MAR showed the following:-Lantus 100 units/ml insulin, 14 units daily, scheduled for 7:00 A.M.;-Lispro 100 units/ml insulin per sliding scale, scheduled for 8:00 A.M. Observation and interview on 01/13/26 at 9:28 A.M., showed the following:-The ADON said Resident #34's Accu check reading was 243 this morning and the resident should get six units of Lispro sliding scale insulin;-The ADON obtained the resident's Lispro Kwik Pen from the top medication cart drawer, removed the pen cap, cleansed the tip of the insulin pen with an alcohol pad and attached a new sterile needle. The ADON did not prime the pen;-The ADON dialed up six units of Lispro insulin and administered the medication in the resident's abdomen; -The ADON obtained the resident's Lantus Solostar pen from the top medication cart drawer, removed the pen cap, cleansed the tip of the insulin pen with an alcohol pad and attached a new sterile needle. The ADON did not prime the pen;-The ADON dialed up 14 units of Lantus insulin and administered the medication in the resident's abdomen. During an interview on 01/13/26 at 3:05 P.M., the ADON said insulin pens were to be primed with two units when the pen was first opened and used, not with each injection. 4. Review of the Resident #101's January 2026 POS showed the following:-Diagnosis of type II diabetes with hyperglycemia and diabetic polyneuropathy (nerve damage from diabetes);-Aspart (also known as Novolog) insulin pen, 100 units/ml subcutaneous with meals, inject as per sliding scale: if 0- 150 = 1 unit; 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units. Max 30 units per day;-Lantus Solostar insulin pen, 100 units/ml, inject 47 unit subcutaneously one time a day. Review of the resident's January 2026 MAR showed the following:-Lantus insulin 100 units/ml, 47 units daily, scheduled for 7:00 A.M.;-Aspart insulin 100 units/ml, per sliding scale, scheduled for 7:30 A.M. Observation on 01/15/26 at 8:55 A.M. showed the following:-Licensed Practical Nurse (LPN) E obtained the resident's Accu check with results of 111 mg/dL and determined Aspart insulin sliding scale dose was to be one unit;-LPN E obtained the resident's Aspart insulin pen from the medication cart, cleaned the tip of the insulin pen with an alcohol pad and attached a new sterile needle;-LPN E did not prime the insulin pen;-LPN E dialed up one unit of Aspart insulin and administered the medication in the resident's left arm;-LPN E obtained the resident's Lantus pen from the medication cart, cleaned the tip of the insulin pen with an alcohol pad and attached a new sterile needle;-LPN E did not prime the insulin pen;-LPN E dialed up 47 units of Lantus insulin and administered the medication in the resident's left arm. During an interview on 01/15/26 at 9:05 A.M. LPN E said insulin pens were primed at the end of each injection, so it was ready for the next injection; During an interview on 01/15/26 at 11:45 A.M., the Director of Nursing (DON) said she would expect the insulin pens to be primed with two units prior to every injection.

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	01/15/2026

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 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** Based on observation, interview and record review, the facility failed to follow current infection control standards for five residents (Resident #4, #40, #41, #56 and #57), in a review of 15 sampled residents, when staff failed to perform proper hand hygiene, change gloves, properly handle contaminated linens and follow enhanced barrier precautions (EBP) by wearing personal protective equipment (PPE) to prevent infection while providing personal care. The facility census was 32. Review of the facility policy, Hand Hygiene, revised 04/2025, showed the following:-All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility;-Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR);-Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice;-Alcohol-based hand rub with 60% to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom;-The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Review of the facility policy, Personal Protective Equipment, revised April 2025, showed the following:-This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff;-Personal protective equipment, or PPE, refers to a variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with pathogens. It includes gloves, gowns, face protection (facemasks, goggles, and face shields), and respiratory protection (respirators);-All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely;-PPE will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status;-Multiple factors determine the appropriate selection of PPE for a particular task: -The type of exposure anticipated (e.g., splash/spray versus touch); -The volume of fluid or tissue to which there is a potential exposure; -The likelihood of exposure; -The probable route of exposure (e.g., direct contact versus inhalation); -The need for transmission-based precautions;-Wear gloves when direct contact with blood, body fluids, mucous membranes, non-intactskin, or potentially contaminated surfaces or equipment is anticipated;-Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene;-Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn; -Wear gowns to protect arms, exposed body areas, and clothing from contamination with blood, body fluids, and other potentially infectious material;-Staff will receive training on the why, what, and how of PPE upon hire, annually, when new products are introduced, and as needed. Review of the facility policy, Enhanced Barrier Precautions, revised April 2025, showed the following:-Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms;- Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities;-All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions;All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions;-Initiation of Enhanced Barrier Precautions:-An order for enhanced barrier precautions will be obtained for residents with any of the following: -Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding (continued on next page)

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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.)-Implementation of Enhanced Barrier Precautions:-High-contact resident care activities include: -Dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, wound care (any skin opening requiring a dressing), and device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters);-Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Review of the facility policy, Handling Soiled Linen, last revised 04/25 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;-Linens can become contaminated with pathogens from contact with intact skin, body substances, or from environmental containments;-Transmission of pathogens can occur through direct contact with linens or aerosols generated from sorting and handling contaminated linen;-All used linens should be handled using standard precautions (gloves) and treated as potentially contaminated;-Linens 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 linens shall be collected at the bedside and placed in a linen bag or designated linen receptacle;-When the task is complete, the bag shall be closed securely and placed in the soiled utility room;-Soiled linens shall not be kept in the resident's room or bathroom. 1. Review of Resident #4's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 10/28/25, showed the following:-He/She was dependent on staff for toilet hygiene;-He/She had an indwelling urinary catheter (tube inserted into the bladder to drain urine);-He/She was always incontinent of bowel. Review of the resident's Care Plan, last revised on 11/07/25, showed the following:-He/She had a urinary catheter;-The resident required enhanced barrier precautions;-He/She had osteomyelitis (an infection in the bone) to the sacrum (triangular bone in the lower back);-Encourage and assist with proper perineal care;-He/She had a stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) to the coccyx/sacrum;-He/She required assistance with toileting;-Staff were instructed to provide incontinence care after each incontinent episode. Review of the resident's physician's orders, dated January 2026, showed the following:-Diagnoses included osteomyelitis of vertebra, neuromuscular dysfunction of bladder (injury or disease interrupts the electrical signals between your nervous system and bladder function);-Indwelling urinary catheter;-The resident had a wound. Ensure enhanced barrier precautions are maintained every shift;-Cleanse wound with wound cleanser or normal saline, lightly pack with collagen particles (used to promote wound healing) and calcium alginate with silver (a natural, highly absorbent material from brown seaweed, used primarily in advanced wound dressings to create a moist healing environment and absorb exudate, forming a gel that promotes healing and reduces infection risk, while also functioning as a food stabilizer and in tissue engineering), cover with foam dressing every day and as needed for wound saturation or dressing comes off. Observation on 01/13/26 at 11:00 A.M. showed a sign posted outside of the resident's room showing the resident was on enhanced barrier precautions and directed staff to use gowns and gloves when directly assisting the resident with care needs. Gowns and gloves were present in a storage container in the hallway outside the resident's room. During an interview on 01/13/26 at 11:00 A.M., the resident said staff did not wear gowns when they provided his/her care. Observation on 01/13/26 at 11:15 A.M. showed the following:-Certified Nurse Assistant (CNA) A and CNA B were in the resident's room to provide incontinence care. Both staff wore gloves and gowns; -The resident had a urinary catheter and was incontinent of bowel; -With gloved hands, CNA A cleaned (continued on next page)

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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's perineal area, including around the resident's urinary catheter, with a soapy washcloth; -Without removing his/her gloves and/or performing hand hygiene, CNA A removed a pillow from between the resident's legs, removed the catheter drainage bag from the resident's bed frame and placed it on top of the resident's legs, obtained clean wet wash clothes, and assisted the resident to roll onto his/her right side; -With gloved hands, CNA B cleaned feces from the resident's rectal area with a disposable wipe.-Wearing the same soiled gloves, he/she grabbed another wipe from the package with the same hand he/she used to clean the resident's rectal area, cleaned more feces from the resident's rectal area, removed the resident's soiled incontinence brief, positioned a clean brief under the resident, and moved the package of wipes to the bedside table; -CNA A removed the gloves he/she wore when cleaning the resident's perineal area, and without performing hand hygiene, opened the door and exited the resident's room;-While wearing the same gloves he/she wore when providing incontinence care, CNA B sat in the chair in the resident's room and rested his/her gloved hands on the arm rests as he/she waited for CNA A to return to the room; -CNA A returned to the room, did not perform hand hygiene, and put on gloves and a gown;-The Assistant Director of Nursing (ADON) entered the resident's room, put on gloves and a gown;-As the ADON changed the resident's dressing, CNA B held the resident's legs. CNA B wore the same gloves he/she wore to provide incontinence care to the resident; -The ADON exited the room, and CNA A and CNA B put an incontinence brief on the resident and positioned the resident in the bed. Observation on 01/13/26 at 2:30 P.M. showed the following:-CNA A and CNA B entered the resident's room. -CNA A and CNA B put on gloves, but neither staff put on a gown;-CNA A and CNA B pulled the resident up in bed and repositioned him/her in the bed. During an interview on 01/13/26 at 2:30 P.M., CNA B said the following:-He/She did not always put on a gown when providing care to residents who had EBP instructions and PPE outside of the door;-He/She followed what the other staff did. If other staff did not wear PPE, he/she did not wear PPE;-He/She could read the sign on the door and knew he/she was supposed to wear PPE, but he/she just did not wear it;-He/She was not supposed to touch any clean items with contaminated gloves/hands;-He/She should perform hand hygiene after he/she removed his/her gloves. He/She did not realize he/she did not complete hand hygiene. 2. Review of Resident #40's admission MDS, dated [DATE], showed the following:-He/She was dependent on staff with toilet hygiene;-He/She had an indwelling catheter;-He/She had an ostomy (opening in the abdomen, rerouting waste such as urine or stool from the digestive or urinary tract to exit the body into a collection pouch). Review of the resident's care plan, last revised on 11/09/25, showed the following:-He/She had osteomyelitis of the sacrum;-He/She had a stage IV sacral wound;-He/She had a colostomy (an opening (stoma) in the abdomen, redirecting part of the colon to the outside of the body, allowing stool and gas to exit into an external pouch instead of the anus);-He/She had a urinary catheter;-Staff were to assist with proper peri-care, catheter care and ostomy care;-Staff were to follow enhanced barrier precautions when providing care. Review of the resident's physician's orders, dated January 2026, showed the following:-Diagnoses included osteomyelitis and colostomy;-Enhanced barrier precautions;-Urinary catheter with catheter cares every shift and as needed. Observation on 01/14/26 at 8:30 A.M. showed a sign located outside the resident's room which identified the resident was on EBP and directed staff to use gloves and gowns when providing care. There was a cart, stocked with gowns and gloves, outside the resident's room. Observation on 01/14/26 at 8:30 A.M. showed the following:-CNA D entered resident's rooms and put on gloves. CNA D did not put on a gown;-CNA D removed the resident's gown;-The resident had a urinary catheter and a colostomy that was full of feces;-The resident had a wound vac system connected to a wound dressing on the resident's sacral area;-CNA D used wipes to clean the resident's perineal area, assisted the resident to his/her side, and cleaned between the resident's buttocks;-CNA D removed his/her gloves and without performing hand hygiene, put on new gloves. CNA D put a second glove over the glove on his/her right hand, applied barrier cream to his/her right hand, wiped the barrier cream on the resident's groin and perineal areas, and removed the outer glove on the right hand;-CNA D obtained a clean incontinence brief and placed (continued on next page)

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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it under the resident, assisted the resident onto the side of bed, put a gait belt around the resident, placed a walker in front of the resident, assisted the resident to dress, adjusted the resident's wound vac tubing, and pulled the urinary catheter tubing through the resident's pants;-CNA D removed his/her gloves and without performing hand hygiene, exited the room; -CNA D returned to the room, did not perform hand hygiene, did not put on a gown, and put on gloves. He/She lifted the resident's shirt, opened the colostomy bag, and removed feces from the bag by squeezing the feces from the bag and rinsing the bag with water. He/She then used disposable wipe to clean feces from the colostomy bag; -He/She reattached the colostomy bag, removed his/her gloves, picked up the bags containing soiled trash, did not perform hand hygiene, and put on new gloves;-He/She pushed the resident in the wheelchair to the bathroom, assisted the resident to stand, pulled down the resident's pants, assisted the resident back into wheelchair, drained cloudy yellow urine from the catheter drainage bag, detached the catheter drainage bag and applied a leg drainage bag system, removed his/her gloves, and without performing hand hygiene, exited the room;-CNA D returned to the room, and without performing hand hygiene and putting on a gown, put on gloves and attached the leg bag to the resident's leg. During an interview on 01/14/26 at 9:30 A.M., CNA D said the following:-He/She was supposed to wash his/her hands every time he/she changed his/her gloves and when he/she was in contact with any bodily fluids;-He/She was not supposed to touch any clean items with contaminated gloves/hands;-He/She was agency staff and did not know he/she needed to wear a gown when providing care to the resident;-He/She knew what the EBP sign meant but thought he/she only had to wear a gown if he/she wanted. 3. Review Resident #56's admission MDS, dated [DATE], showed the following:-He/She had a urinary catheter;-He/She had one or more unhealed pressure ulcers/injuries;-He/She had three unstageable pressure ulcers/injuries (wound bed covered by slough and eschar);-He/She had a urinary tract infection (UTI) within the last 30 days. Review of the resident's Care Plan, revised on 01/07/26, showed the following:-Actual skin impairment to left heel, right heel, left ankle, buttocks, and left hip;-At risk for infection secondary to suprapubic catheter, recent hospitalization, weakness, and debility;-Enhanced barrier precautions; Review of the resident's physician orders, dated 01/13/26, showed the following:-Right hip surgical incision: Cleanse with wound cleanser, pat dry; and apply cover dressing every shift for wound care;-Catheter: Ensure enhanced barrier precautions (EBP) are in place every shift;-Left lateral heel: Cleanse with wound cleanser or normal saline; pat dry; apply betadine moist gauze, cover with ABD, wrap with Kerlix every day shift;-Left plantar foot: Cleanse with wound cleanser or normal saline; pat dry; apply betadine moist gauze, cover with ABD, wrap with Kerlix every day shift;-Right heel: Cleanse with wound cleanser or normal saline; pat dry; apply betadine moist gauze, cover with ABD, wrap with Kerlix every day shift;-Wound: EBP related to wound every shift for precautions. Observation on 01/13/26 at 12:30 P.M. showed the following:-Registered Nurse (RN) N entered the resident's room wearing a gown and gloves, cleaned the wound on the resident's left lateral heel/ankle with wound cleanser, patted dry, covered with betadine gauze, covered with ABD, and wrapped the wound with Kerlix. He/She doffed his/her gloves, and without performing hand hygiene, donned a new pair of gloves;-RN N removed the soiled bandages from the resident's left plantar foot, cleaned the wound with wound cleanser, patted dry, applied betadine moist gauze, covered with ABD, and wrapped with Kerlix;-RN N doffed his/her gloves, washed his/her hands, and donned new gloves;-RN N removed the soiled bandages from the resident's right heel and placed the soiled bandages into the trash;-While wearing the same gloves, RN N cleaned the wound with wound cleanser, patted dry, applied betadine moist gauze, covered with ABD, and wrapped with Kerlix; -Wearing the same gloves he/she wore to provide wound care to the resident's right heel, RN N removed the soiled dressing from the resident's right hip, cleaned the wound with wound cleanser, patted dry, cut the new bandages with scissors to fit the area, and covered the wound with the new bandage;-While wearing the same gloves he/she wore to clean the wound on the resident's right hip, RN N held the bed controller and lowered the resident's bed;-RN N doffed his/her gloves and gown;-Without performing hand hygiene or wearing a (continued on next page)

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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown or gloves, RN N moved the resident's catheter bag from the bed and attached it to the left side of the resident's bed, put the call light in the resident's hand, moved the trash can near the resident's door, and then washed his/her hands. RN N placed a pillow under the resident's left leg and placed podus boots (orthotic device designed to immobilize, support, and protect the foot and ankle) on the resident's feet. During an interview on 1/13/26 at 1:30 P.M., RN N said the following:-He/She normally changed his/her gloves and washed his/her hands between dirty and clean tasks;-He/She should wear a gown and gloves when he/she provided any cares or when he/she touched the resident. 4. Review of Resident #57's physician order sheet, dated January 2026, showed the resident had t a peripherally inserted central catheter (PICC) line (a long thin flexible tube inserted into a small arm vein and threaded to a large vein near the heart, used for long-term intravenous (IV) (in the vein) fluids and medications); ensure enhanced barrier precautions are maintained every shift. Review of the resident's Care Plan, dated 01/05/26, showed the following:-He/She was incontinent secondary to decreased mobility;-Staff were to assist with toileting and incontinence care after each incontinence episode;-He/She had alterations in ADL function secondary to decreased mobility;-Staff were to assist in completing ADL tasks each day;-He/She was at risk for infection secondary to recent hospitalization and surgery;-Staff were to use universal precautions (the care plan did not address the physician order for EBP precautions). Observation of the resident's room on 01/13/26 at 9:33 A.M. showed the resident had a sign outside of the room showing he/she required enhanced barrier precautions and directed staff to use gowns and gloves when coming into direct contact with the resident. There was a storage container outside the room with gowns and gloves. Observation on 01/13/26 at 9:35 A.M. showed the following:-CNA A and CNA B were in the resident's room, giving the resident a bed bath from a basin of soapy bath water;-The resident had a bandage on the right upper arm covering a PICC line insertion site with two lumens (small tubes to administer fluids, medication, nutrition or blood products) on the outside of the bandage;-CNA A and CNA B wore gloves, but no gowns;-CNA B removed the resident's gown and covered the resident with a dry towel;-CNA B rolled the resident to his/her left side; CNA B removed a urine soaked incontinent brief from the resident and then rolled the resident to his/her back and covered him/her back up with the towel; - CNA B touched the resident's skin and towel with the same gloved hands he/she had touched the urine soaked brief with;-CNA B wet a washcloth and washed the resident's face and wet another washcloth with soap and water and washed the resident's right axilla, right arm and right hand; -CNA A washed the resident's left axilla, left arm and left hand; -CNA B wet a clean washcloth and washed the resident's chest, chest, abdomen and front perineal area, then turned the resident to his/her left side, touching the resident's right hip and shoulder and washed the resident's back and buttocks and rolled the resident to his/her back; -CNA A removed gloves, and without performing hand hygiene left the resident's room;-CNA B touched the bed remote and used it to elevate the foot of the bed for the resident;-CNA B dumped the basin of soapy bath water out in the bathroom and filled the basin up with clean warm water;-CNA B got a clean washcloth and rinsed soap off the resident's arms, chest and front perineal area and then washed the resident's hair;-He/She placed wet (urine soiled) linens in a laundry bag and dumped the soapy water from the basin and added clean water in the basin;-CNA B used a clean washcloth to rinse soap out of the resident's hair, still wearing the gloves he/she had used from the beginning of the bed bath when he/she had removed a urine soiled brief and washed the resident's peri area; -CNA B had touched the resident and personal use items with the soiled gloves;-CNA B removed his/her gloves and dried the resident's hair with a towel;-Without performing hand hygiene, CNA B donned new gloves, turned the resident to his/her left side and dried the resident's buttocks with a towel;-CNA B placed a new incontinence brief under the resident, rolled the resident to his/her back and pulled the brief between the resident's legs, rolled the resident to his/her right side and pulled the incontinence brief the rest of the way under the resident, assisted putting pants on the resident and a mechanical lift sling (a comfortable, supportive fabric sling used with a mechanical resident lift) under the resident;-Licensed Practical Nurse (LPN) E entered the room, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265881	A. Building B. Wing	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	donned gloves, and assisted CNA B to transfer the resident to his/her wheelchair; LPN E did not wear a gown. 5. Review of Resident #41's admission MDS, dated [DATE], showed the following:-He/She had moderate cognitive impairment;-He/She was dependent on staff for toilet hygiene and lower body dressing;-He/She required substantial/maximal assistance of staff for bathing and upper body dressing;-He/She was frequently incontinent of bowel and bladder. Review of the resident's care plan, last revised 12/02/25, showed the following:-He/She was incontinent secondary to inability to feel the need to void;-Staff were to apply moisture barrier to skin;-He/She had alterations in activities of daily living (ADL) function secondary to recent hip surgery with decreased mobility;-He/She required assistance completing ADL tasks each day;-He/She was at risk for alteration to skin integrity secondary to decreased mobility;-Staff were to provide skin and incontinence care assistance as needed;-He/She was at risk for infection secondary to recent hospitalization and incontinence;-Staff were to use universal precautions. Observation on 01/13/26 at 10:50 A.M. showed the following:-CNA A entered the resident's room to provide incontinence care;-With gloves on, CNA A rolled the resident to his/her left side, held the resident over with his/her gloved left hand, and with his/her gloved right hand, removed incontinence wipes from a package and cleaned feces from the resident's buttocks; with the right gloved hand, he/she removed another incontinence wipe from the package and finished cleaning the buttocks;-CNA A removed soiled linens from the bed and placed them on the floor, without putting them in a bag;-Wearing the same soiled gloves, CNA A put a clean incontinence brief under the resident, touched the resident with his/her gloved right hand and pulled on the resident's left thigh to roll him/her over to pull the incontinence brief through to the other side, assisted the resident to his/her back and fastened the incontinence brief;-CNA A removed his/her soiled gloves, and without performing hand hygiene, including washing hands with soap and water or using hand sanitizer, donned new gloves;-CNA A put the resident's sweat pants and socks on, rolled him/her to the left side, pulled his/her pants up, rolled the resident to his/her right side and finished pulling up the resident's pants;-CNA A picked the dirty linens up off the floor and carried them to the bathroom and put them on the floor in the bathroom; -CNA A removed gloves, and without performing hand hygiene, donned new gloves and put the resident's shoes on, lowered the bed and assisted the resident to sit on the edge of the bed, applied a gait belt on the resident, removed his/her gloves and left the room, leaving the resident sitting on the side of the bed, to go get a walker;-CNA A returned to the room with a walker, donned new gloves and assisted the resident to stand with the walker and transferred him/her to a wheelchair;-CNA A removed the resident's shirt, which had food particles on the front and was urine soaked in the back and put a clean shirt on the resident and removed his/her gloves without performing hand hygiene;-CNA A gave the resident a wet washcloth to wash his face, combed the resident's hair, put foot pedals on the chair and took the resident to therapy;-Staff did not clean the floor in the resident's room where staff placed dirty linens; the linens remained on the floor in the bathroom. During an interview on 01/13/26 at 2:50 P.M. CNA A said the following;-He/She should have changed gloves when going from dirty to clean;-He/She should have performed hand hygiene by washing hands with soap and water or using hand sanitizer when changing gloves;-He/She should not have put dirty linens on the floor; he/she should have placed the linens in a linen bag but there was no linen bag available;-He/She had not yet picked the linens up off the bathroom floor. 6. During an interview on 01/14/26 at 11:00 A.M., the Director of Nursing (DON) said the following:-No laundry should be placed on the floor for any reason;-She expected staff to wash hands when entering a resident room, between glove changes, and before exiting a room;-Staff should not touch any clean items with contaminated gloves and/or hands;-Staff should wear gowns and gloves every time they entered a room where a resident was on EBP; -Staff were to change their PPE if they exited and had to re-enter a resident's room; -Residents with wounds and catheters were on EBP. During an interview on 01/15/26 at 11:45 A.M., the administrator said the following:-Staff should be following facility policies;-Staff should change gloves and perform hand washing when going from dirty to clean or entering or leaving a resident's room;-EBP should be worn for the specified resident's when performing direct resident care;-Linens should never be on the floor, even if in laundry bags.