STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265887	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Homes of Adrian	402 W 1st Street Adrian, MO 64720

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review of nurse aides at least once every 12 months and provide regular in-service education for three Certified Nursing Assistants (CNA) (CNA C, CNA D, and CNA E) out of five sampled CNAs. The facility census was 28 residents. Review of the facility's In-Service Training, Nurse Aide policy, undated, showed:-All personnel were required to participate in regular in-service education.-Annual in-services included:--Continued competence of nurse aides.--Training that addressed the care of residents with cognitive impairment.-Supervised practical training was defined as training in a setting in which instruction and oversight were provided by a person who had relevant education and/or experience specific to the subject of the training being provided.-Training methods included: in-person instruction, webinars, supervised practical training, computer-based training, self-directed learning, mentoring and/or coaching.-Nurse aide participation in training was documented by the Director or Nursing (DON) or designee.-Documentation included: date and time training, topic of training, method of training, summary/description of the material presented, and hours of training completed.1. Review of CNA C's training record showed:-He/She was hired 9/26/24.-No performance review was on file or available.2. Review of CNA D's training record showed:-He/She was hired on 5/8/24-No performance review was on file or available.3. Review of CNA E's training record showed:-He/She was hired on 9/26/24.-No performance review was on file or available.During an interview on 9/30/25 at 3:29 P.M., CNA A said:-Most of his/her training was on a computer program.-He/She had not attended any in person in-services. -Staff were responsible for getting their training done.-He/She had not a performance review.During an interview on 9/30/25 at 3:55 P.M., CNA B said:-He/She used the computer program for training.-He/She was unsure of an in-person in-services being offered. -He/She should be having an annual evaluation next month.During an interview on 10/2/25 at 12:54 P.M., Licensed Practical Nurse (LPN) A said:-There have been no skills fairs (a group training with stations where CNAs perform job related tasks to measure competence and performance) in the last year.-There are clipboards with information on it, and we read it and signed it. -There was not any consistent training offered at this facility. During an interview on 10/02/2025 at 1:38 P.M., the DON said:-He/She was unaware of how many training hours were required each year for CNAs. -There was no system in place for ensuring training hours and performance reviews were completed.-It was up to each staff person to make sure training was getting done.-There have been no skills fairs presented lately.-He/She used skill check off sheets but has been more than a year since they were used.-The CNA Training was done but not documented.During an interview on 10/2/25 at 2:54 P.M., the Business Office Manager (BOM) said:-He/She did not track training; the DON did that.-CNA D was PRN (staff who worked on an as needed basis and was not part of the regular schedule) and was not present when training was offered. -PRN staff should be held to the same training regulations as full-time staff.

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
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR) was completed monthly by the contracted pharmacist and then reviewed and responded to by the facility physician(s) for three sampled residents (Resident #5, Resident #21 and Resident #28) out of five residents sampled for MRR's. The facility census was 28 residents. Review of the facility's Medication Regimen Review policy, undated, showed:-The purpose of the policy was to ensure MMRs were conducted in accordance with professional standards of practice.-The facility had MRR's completed monthly in accordance with professional standards.-The licensed pharmacist completed drug regimen reviews on al facility residents monthly and a full report was provided to the facility that included any recommendations.-The Director of Nursing (DON) or designee was responsible to review the MRR and prepare MRR recommendation sheets to send to the facility physician.-The DON reviewed and signed the MRR recommendation sheets, took off orders and documented physician response or new orders in the Electronic Health Record (EHR).-MRR recommendations were signed, completed and uploaded to the HER within 14 days of monthly pharmacy report receipt.1. Review of Resident #5's initial Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 7/15/25, showed:-The resident was admitted to the facility on [DATE].-The resident was severely cognitively impaired.-The resident was diagnosed with:--Thyroid disorder (a health disorder that affects the thyroid gland which produced hormones that regulate metabolism, growth, and other bodily functions).--Seizure disorder (a health condition causing a sudden burst of electrical activity in the brain).--Anxiety (a mental health condition causing feelings of fear, dread and uneasiness).Review of the resident's Physician Oder Summary, dated October 2025, showed the resident was ordered:-Levothyroxine Sodium (medication used to regulate thyroid hormones) Oral Tablet 25 mcg (micrograms-a unit of measure), one tablet by mouth every day for thyroid disorder.-Keppra (medication used to treat seizure disorders) Oral Tablet 500 mg (milligrams-a unit of measure), three tablets by mouth two time a day for seizures.-Lacosamide (medication used to treat seizure disorders) Oral Tablet 200 mg, one table by mouth two times a day for seizures.-Lorazepam (medication used to treat anxiety) Oral Tablet 0.5 mg, one tablet by mouth two times a day for anxiety.Review of the facility's Pharmacy Medication Regimen Review summary showed the resident did not have an MRR completed in July, August or September 2025.2. Review of Resident #21's quarterly MDS, dated [DATE], showed:-The resident was admitted to the facility on [DATE].-The resident was moderately cognitively impaired.-The resident was diagnosed with:--Thyroid disorder.--Anxiety.--High blood pressure.Review of the resident's Physician Order Summary, dated October 2025, showed the resident was ordered:-Levothyroxine Sodium Oral Tablet 150 mcg daily.-Diltiazem HCl (a medication used to treat high blood pressure).-Trazodone (a medication used to treat insomnia (a sleep disorder) for people with anxiety).Review of the facility's Pharmacy Medication Regimen Review summary showed the resident did not have an MRR completed in July, August or September 2025.3. Review of Resident #28's comprehensive MDS, dated [DATE], showed:-The resident was admitted to the facility on [DATE].-The resident was moderately cognitively impaired.-The resident was diagnosed with:--Generalized anxiety disorder.--Major depressive disorder.--Deep vein thrombosis (a condition where a blood clot formed in one or more of the deep veins, typically in the legs).Review of the resident's Physician Order Summary, dated October 2025, showed:-Buspirone HCL (a medication used to treat anxiety) Tablet, 15 mg, one tablet my mouth three times a day for anxiety.-Eliquis Oral (a medication used to treat thrombosis) Tablet 2.5 mg by mouth two times a day.-Sertraline HCL (a medication used to treat depression) 100 mg by mouth on time a day for depression.Review of the resident's Pharmacy Reviews showed no MRR's were completed for the resident in June, July and August 2025.4. During an interview on 10/1/2025 at (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:32 A.M., the Director of Nursing (DON) said:-He/She started the DON position the end of May 2025.-He/She started tracking the pharmacy MRR's in June 2025.-Prior to May he/she noted an issue with the MRR's getting completed.-He/She discussed it with the pharmacist who reported he/she was unable to locate the reviews for the facility.-There was a Performance Improvement Plan (PIP) developed to improve the process.-The PIP was completed but there was no record of it.-The previous DON was responsible and when he/she left the position no one could find the MRR's.-The DON was responsible for preparing and tracking the MRR's to make sure they were making the appropriate changes according to the pharmacist recommendations and physician responses.-The Medical Director's corporate office was not tracking the responses for June, July and August 2025.-The DON was responsible for tracking the MRR's and physician responses. -The MRR's were completed, but there wasn't any documentation showing it.During an interview on 10/1/25 at 11:00 A.M., the Administrator said:-It was his/her understanding the MRR's had issues in June, July and August.-There was PIP developed but the previous DON was responsible for it, and no one has been able to locate it since he/she left.-The DON was responsible for ensuring the MRR's get completed, documented and provided to the physician to respond to.-He/She expected the MRR's to be completed monthly and tracked appropriately.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure safe food handling and storage by not properly labeling opened food containers with the date it was opened; storing outdated, expired or not properly sealed food; and not refrigerating opened food. This practice had the potential to affect all residents who consume food from the kitchen. The facility census was 28 residents.Review of the facility's Food Receiving and Storage Policy, dated October 2017, showed:-Foods shall be received and stored in a manner that complied with safe food handling practices.-Non-refrigerated foods were stored in the dry storage unit.-Dry foods stored in bins were removed from original packaging, labeled and dated with a use by date. 1.Observation of the dry storage unit on 9/29/2025 at 9:25 A.M., showed:-A clear plastic container/bin with blue lid containing elbow macaroni had no date.-A large clear plastic container/bin of spiral pasta had a label indicating a date of 2/8 with no year or any other identifiers.-A large clear plastic container with penne pasta did not have a label indicating a date opened and the lid was not securely fastened.-An opened box of Cream of Wheat was inside of a gallon sized Ziplock bag with no date indicating when it was opened. -A bottle of pure honey was opened with no label indicating a date when it was opened. -An opened bag of generic fruit loops with no date indicating when it was opened with a manufacturer expiration date of 6/2025.-An opened bottle of Orange Chicken sauce with no label indicating the date it was opened and manufacturer label showing to refrigerate after opening. -An opened, unsealed bag of corn flakes inside an opened box marked corn flakes with no label indicating the date it was opened. During an interview on 10/01/2025 at 8:09 A.M., [NAME] A said:-When he/she opened food containers he/she put a sticker on the opened container showing the date he/she opened it.-It was discarded after seven days.-He/She looked for manufacturer expiration dates before serving the item.-If it wasn't labeled, he/she threw it away and did not serve it to the residents. During an interview on 10/01/2025 at 8:31 A.M., the Dietary Manager said:-He/She expected all foods to be labeled with a date opened sticker.-He/She expected dietary staff to put those stickers on packages they open.-He/She expected dietary staff to check the labels for dates prior to serving that food.-He/She threw away food that was not labeled.-He/She expected staff to pay attention to manufacturer's directions regarding refrigeration after opening and expiration dates.-He/She expected foods to be refrigerated after opening if indicated on the label.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff was adhering to infection control practices while preforming wound care for one sampled resident (Resident # 7) and failed to put into place Enhanced Barrier Precautions (EBP- an infection control strategy that uses gloves and gowns during high-contact resident care to reduce the spread of multidrug-resistant organisms (MDRO) for two sampled residents (Resident #7 and Resident #13) who had wounds out of 13 sampled residents. Based on interview and record review, the facility failed to properly screen new employees for tuberculosis (TB-a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) for eight out of ten sampled new employees prior to hire. The facility census was 28 residents.Review of 19 Code of State Regulations 20-20.100 TB testing for residents and workers in long-term care facilities, paragraph three, showed:-All new long-term care facility employees who work ten or more hours per week should have the first of two TB skin tests (TST) within one month prior to starting employment in the facility.-The results of TST should be read 48-72 hours from administration.-If the initial TST result is zero to nine millimeters (mm) in duration, the second test should be administered as soon as possible within three weeks after employment begins, unless documentation is provided indicating a two-step TST was completed in the past and at least one subsequent annual test within the past year. Review of The Centers for Disease Control (CDC- a government agency with the main goal is the protection of public health and safety through the control and prevention of disease) guidelines, as of 10/29/25, showed: -The TB skin test results should be read between 48-72 hours after it was administered. -The second TST should be completed one to three weeks after the first TST. Review of the facility's Tuberculosis, Employee Screening Policy, dated March 2021, showed:-All employees were screened for latent tuberculosis infection (LTBI) and active TB disease, using the TST or interferon gamma release assay (IGRA-a blood test that measured the body's immune response to TB and symptom screening prior to beginning employment.-Each newly hired employee was screened for LTBI and active TB disease after an employment offer was made but prior to the employee's duty assignment.-Screening included a baseline test for LTBI using a TST or IGRA.-If the first baseline test was positive the individual must undergo symptom evaluation and chest x-ray to rule out active TB. 1. Employee B's employment record showed: -He/She was hired on 3/11/25 and started working with residents on 3/15/25.-The first step TB test was administered on 3/11/25 and read on 3/14/25 with a negative result.-The second step TB test was administered on 4/25/25 and read on 4/26/25 with a negative result. The second step was administered outside the recommended one to three weeks from the first step TB test and was read within 24 hours of administration. 2. Employee C's employment record showed:-He/She was hired on 6/30/25 and started working around residents on 7/2/25.-He/She had the first step TST administered on 6/30/25 and read on 7/3/25 with a negative result. The test was read after Employee C started working with residents. -The second step TB test was administered on 7/14/25 and read on 7/17/25 with a negative result. 3. Employee D's employment record showed:-He/She was hired on 3/20/24 and started working around residents on 3/22/24.-Employee D had the first TST administered on 7/28/24 and read on 7/31/24 with a negative result. The first step TB test was not administered until over four months after his/her hire date.-The second step TB test was administered on 8/31/24 and read on 8/16/24 with a negative result. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Employee F's employment record showed:-He/She was hired on 8/11/25 and started working around residents on 8/12/25.-He/She had the first step TST administered on 8/11/25 and was read on 8/14/25 with a negative result. The test was read after Employee F started working with residents. -The second step TB test was administered on 8/16/25 and read on 8/19/25 with a negative result. The second step was administered less than one week after the first test was administered and read. 5. Employee G's employment record showed:-He/She was hired on 7/30/25 and started working around residents on 8/2/25.-He/She had the first step TST administered on 7/30/25 and read on 8/3/25 with a negative result. The test was read after Employee G started working with residents.-The second step TB test was administered on 8/14/25 and read on 8/17/25 with a negative result 6. Employee H's employment record showed:-He/She was hired on 5/12/25 and started working around residents on 5/14/25.-He/She had the first step TST administered on 5/12/25 and read on 5/15/25 with a negative result. The test was read after Employee H started working with residents.-The second step TB test was administered on 5/24/25 and read on 5/27/25 with a negative result. 7. Employee J's employment record showed:-He/She was hired on 9/26/24 and started working around residents on 9/28/25.-He/She had the first step TST administered on 9/26/24 and read on 9/29/24 with a negative result. The test was read after Employee J started working with residents.-The second step TB test was administered on 10/8/24 and read on 10/11/24 with a negative result. 8. Employee K's employment record showed:-He/She was hired on 4/15/25 and started working around residents on 4/16/25.-He/She did not have a first or second TB skin test.-He/She had an x-ray on 5/6/25 with a negative result. The X-ray was not obtained or resulted prior to Employee K working with residents. During an interview on 10/02/2025 at 1:38 P.M., the Director of Nursing (DON) said:-The Business Office Manager (BOM) lets him/her know when they have new hires.-One of the nurses administers the TB to the employees.-Staff received their first TB before hire.-It was read two to three days after administered and documented on the staff TB form.-The second TB was given 14-21 days after the first one was read.-He/She was unsure if staff tests should be read before starting the floor.-He/She tracked the employee TB testing.-The first step TST's should be read before working with residents.-The second step TST's should be done one to three weeks after the first TST was read. During an interview on 10/2/25 at 2:02 P.M., the Administrator said:-Staff hire dates were based on when they started their training and on-boarding.-Training and on-boarding were completed prior to working with residents.-Employees hire dates were typically a couple of days before they worked on the floor with the residents.-He/She expected staff to have their TB testing read prior to working with residents. 9. Review of the facility's policy dated October 2018, Infection Control, showed all personnel would be trained on infection control policies and practices upon hire and periodically thereafter. Review of the facility's policy, dated August 2019, Monitoring Compliance with Infection Control, showed:-The infection preventionist or designee monitors the compliance and effectiveness of their infection prevention and control policies and practices.-Monitoring includes regular surveillance of adherence to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand hygiene practices and the availability of hand hygiene supplies, and the availability of personal protective equipment (PPE- equipment worn to minimize exposure to hazards that cause workplace illnesses) and its appropriate use. 10. Review of Resident #7's face sheet showed he/she was admitted to the facility with the following diagnoses:-Pulmonary Fibrosis (a chronic lung disease that occurs when lung tissue around the air sacs becomes damaged and scarred, making it harder to breath).-Sacrococcygeal disorder (conditions that affect the joint between the triangular bone at the base of the spine and the tailbone). Review of the resident's quarterly Minimum Data Set (MDS – a federally mandated assessment tool completed by the facility for care planning) dated 8/11/25 showed: -He/She was cognitively intact.-He/She had a skin tear.-He/She had nonsurgical dressings.-Cellulitis was not checked. Observation on 9/29/25 at 1:00 P.M. and on 10/2/25 at 9:00 A.M. showed:-No isolation cart within the vicinity of the resident's room.-There was no EBP sign on the door which would have shown what PPE staff/visitors should worn when interacting with the resident. -The Housekeeper went into the room without PPE on. Observation of wound care on 10/2/25 at 10:07 A.M. with Licensed Practical Nurse (LPN) A showed: -No isolation cart within the vicinity of the resident's room.-There was no EBP sign on the door which would have shown what PPE staff/visitors should worn when interacting with the resident.-He/She took a pair of scissors out of his/her pocket did not sanitize them prior to using the scissors.-He/She entered the room and put the wound supplies for the resident on the resident's nightstand without a barrier or cleansing it first.-He/She entered the resident's room without donning an isolation gown and was stopped by this surveyor. -He/She removed the old, soiled dressing from the resident's wound.-He/She took off the soiled gloves and changed into a clean pair of gloves without cleansing his/her hands.-He/She applied the wound cleanser and cut the dressing with the scissor without cleansing them. During an interview on 10/2/25 at 10:20 A.M. LPN A said:-He/She should have worn PPE (gown and gloves) but had forgotten. -There should have been an isolation cart outside the resident's room.-There should have been a sign on the door that indicated what PPE staff were to wear when interacting with the resident.-Previously staff had received education about EBP but it had been a while.-He/She should have used a bleach wipe to clean the scissors before using them the cut the resident's dressing.-He/She should have bleach wiped the night stand or put a barrier on it before laying down the dressing for the wound. 11. Review of Resident # 13's annual MDS dated [DATE] showed: -He/She had a surgical wound.-He/She had a skin tear. Observation on 9/29/25 at 10:07 A.M. showed Housekeeper A entered the resident's room to preform daily cleaning.-He/She was not wearing PPE.-There was no isolation cart within the vicinity of the resident's room.-There was no sign on the resident's door indicating staff was to use EBP. Observation on 10/2/25 at 9:00 A.M. showed:-There was no isolation cart within the vicinity of the resident's room.-There was no sign on the resident's door indicating staff was to use EBP. During an interview on 10/2/25 at 10:45 A.M. Certified Nursing Assistant (CNA) C said:-The resident had been at the facility for more than a month.-They had just started EBP with the resident today. During an interview on 10/2/25 at 11:00 A.M. Housekeeper A said:-The facility had not provided EBP training.-If there was an isolation sign on a resident's door he/she would wear what was on the sign when entering the room.-The resident had been in the facility for months and there had not been an EBP sign on the door nor an isolation cart by their door.-He/She had not worn PPE when going into the resident's room to clean. 12. During an interview on 10/2/25 at 11:30 A.M. LPN A said: -Staff should wash their hands before and after cares with the residents and after any glove changes.-Staff should have sanitized the surface before putting the dressing for wound care or provided a barrier.-Staff should have sanitized scissor before use.-The residents have had open wounds for a couple of months.-They were not doing EBP before survey.-The DON was ultimately responsible for Infection Control.-They should have done spot checks to ensure the residents were (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to provide the required 12 hours of nurse aide in-service training that included the topics of dementia (a progressive mental disorder causing confusion, and impairment of control, memory, judgement, and impulses), and Abuse, Neglect and Exploitation (ANE) for three out of five sampled Certified Nursing Assistants (CNA) (CNA C, CNA D, and CNA E) for October 2024 through September 2025. The facility census was 28 residents.Review of the facility's In-Service Training, Nurse Aide policy, undated, showed:-All personnel were required to participate in regular in-service education.-Annual in-services included:--Continued competence of nurse aides.--No less than 12 hours per employment year.--Training that addressed the care of residents with cognitive impairment.--Training in dementia management and resident abuse/neglect prevention.-Supervised practical training was defined as training in a setting in which instruction and oversight were provided by a person who had relevant education and/or experience specific to the subject of the training being provided.-Training methods included: in-person instruction, webinars, supervised practical training, computer-based training, self-directed learning, mentoring and/or coaching.-Nurse aide participation in training was documented by the Director or Nursing (DON) or designee.-Documentation included: date and time of training, topic of training, method of training, summary/description of the material presented, and hours of training completed. Review of the facility employee training records dated October 2024 through September 2025, showed:1. CNA C was hired on 9/26/24.-His/Her Relias Training Summary (a computer-based training program presented and tracked training topics and hours) had 9.5 hours of training for the dates shown above, which included:--About Alzheimer's Disease (a progressive and irreversible brain disorder that causes memory loss, confusion, and other cognitive impairments) and Dementia - 1 hour. --About Abuse, Neglect, and Exploitation (ANE) - 45 minutes.-He/She attended the in-service on the following dates: 1/24/25 and 7/28/25.-He/She did not have 12 hours of documented continuing educations. 2. Review of CNA D's Relias Training Hours Summary for 9/30/24 through 9/30/25, showed:-He/She was hired on 5/8/24.-He/She completed 0.0 hours of training for the dates shown above.-He/She did not attend any in-services on the dates above.-No documentation was available showing the required topics or number of hours were met. 3. Review of CNA E's Relias Training Hours Summary for October 2024 through 9/30/25, showed:-He/She was hired on 9/26/24-He/She completed 0.0 hours of training for the dates shown above.-No documentation was available showing the required topics of dementia. -He/She attended the in-service on the following dates: 1/24/25, 1/31/25, one in-service sign in sheet which was undated, and 7/28/25.-He/She did not have 12 hours of documented continuing educations. During an interview on 9/30/25 at 3:29 P.M., CNA A said:-Most of his/her training was on the training computer program.-He/She had not attended any in person in-services. -Staff were responsible for getting their training done.During an interview on 9/30/25 at 3:55 P.M., CNA B said:-He/She used the training computer program for training.-Relias sent out an email when a training was posted and when it was due. -He/She was unsure of any in-person in-services being offered. -He/She should have an annual evaluation next month.During an interview on 10/2/25 at 12:54 P.M., Licensed Practical Nurse (LPN) A said:-Prior to the current DON there was a skills fair scheduled but that DON left and the skills fair never happened.-Prior to current DON there were in-services on pay days.-Now there are clipboards with information on it, and we read it and signed it. -There is no consistent training offered at this facility. During an interview on 10/02/2025 at 1:38 P.M., the DON said:-He/She was unaware of how many training hours were required for CNAs. -There was no system in place for ensuring training hours were completed.-The training computer system sent staff email notifications of when training was due.-It was up to each staff person to make sure it was done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265887	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Homes of Adrian	402 W 1st Street Adrian, MO 64720

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be informed when one resident (Resident #2) out of 13 sampled residents, was not provided information demonstrating the risks and/or benefits of the of the medication Paxil (a medication to treat mental health conditions) when ordered by the facility's physician to treat for depression (a mental health condition creating persistent feelings of sadness, hopelessness, and loss of interest in activities). The facility census was 28 residents.Review of the facility's Resident Rights policy, undated, showed:-The resident has a right to be fully informed.-Residents will be informed in writing of services available and all matters related to them.-Residents have the right to be informed of all aspects of their care.1. Review of Resident #2's face sheet, undated, showed:-The resident was diagnosed with depression.-The resident was admitted to the facility on [DATE].Review of the residents initial Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 7/31/25, showed:-The resident was cognitively intact. Review of the resident's Physician Order Summary, dated October 2025, showed:-The resident was ordered Paxil Oral tablet, 20 milligrams (mg-a unit of measure), take one tablet my mouth one time a day for depression.Review of the resident's Electronic Health Record (EHR) showed no evidence the resident was informed of the risks and/or benefits of Paxil.During an interview on 9/29/25 at 1:47 P.M., the resident said:-He/She received his/her medications on time.-He/She knew he/she was taking a medication for depression but could not remember the name.-No one reviewed with him/her the risks involved with taking the medication.During an interview on 10/2/25 at 1:38 P.M., the Director of Nursing (DON) said:-He/She was aware of the resident's right to be informed.-He/She was unsure of where the documentation for informing about medications would be.-The physician or nursing staff were responsible for notifying the resident of the risks and benefits.-The resident was notified but it may have not been documented.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one sampled resident, (Resident #3) had appropriate and timely treatment for swollen feet/ankles out of 13 sampled residents. The facility census was 28 residents.Review of the facility's undated policy, Skin Integrity Policy/Procedure, showed:-The policy of the Baptist Home of [NAME] was intended to display practice guidelines for skin integrity monitoring and maintenance to reduce potential risk of skin breakdown where clinically appropriate.-Skin assessment would have been done routinely during personal cares.-Skin assessment would have been completed weekly for residents who were independent in personal cares.-Any issues with skin integrity would have been reported to the Charge Nurse.-The Charge Nurse would sign the skin assessment form and report newly identified issues to the Director of Nursing (DON) and Primary Care Physician for orders. Review of the facility's Performance Improvement Plan (PIP) dated 9/23/25 showed:-The purpose was to improve wound monitoring, treatment, documentation, and healing outcomes.-The goal was 100% skin assessment to be completed weekly.-100% wound/ulcer tracking, treatment and interventions and documentation to have been completed weekly.-Monitoring and reporting was to include:--Monitor weekly skin checks daily Monday through Friday.--Review wounds in weekly risk meeting.--Discuss wounds in daily (Inner Disciplinary Team) IDT meeting Monday through Friday.--Review and report wound tracking/documentation progress monthly. 1. Review of Resident # 3's Face sheet showed the following diagnoses:-High blood pressure.-Hyperlipidemia (a condition characterized by high levels of lipids (fats) in the blood, a major risk factor for cardiovascular diseases such as heart attack).-Age related physical disability. Resident skin checks were requested and not provided. Review of the resident's Care Plan dated 8/13/25 showed:-He/She had Hyperlipdemia.-He/She had hypertension (high blood pressure).-Staff was to monitor for and document any edema (swelling).-Staff was to notify the physician, dated 5/1/24. Observation on 9/29/25 at 10:50 A.M. showed the resident was sitting in his/her chair with 3+ edema (a swelling of the tissues caused by an accumulation of excess fluid) bilaterally (in both) in his/her ankles.During an interview on 9/29/25 at 10:55 A.M. the resident said:-His/Her feet and ankles had been swollen like this for a few days.-The swelling was kind of painful.-The staff had helped him/her with cares and told him/her to keep his/her feet elevated.-He/She did not know if staff had said anything to the nurse. Observation on 9/29/25 at 1:10 P.M. showed:-The resident was asleep in his/her recliner with his/her feet elevated.-His/Her feet had 3+ edema bilaterally. Observation on 9/30/25 at 10:53 A.M. showed:-The resident was sitting in his/her recliner with his/her feet elevated.-His/Her ankles and feet had 3+ edema and were reddened. -Licensed Practical Nurse (LPN) A was notified of the resident's swollen feet and ankles. During an interview on 10/1/25 at 9:30 A.M. LPN A said:-He/She had not known about the resident's swollen ankles.-The resident's feet and ankles were indeed very swollen.-He/She would need to notify the physician. During an interview on 10/1/25 at 10:30 A.M. Certified Nursing Assistant (CNA) A said:-He/She had helped the resident with cares.-He/She had not noticed the resident's ankles were swollen.-If He/She had seen that the resident's ankles were swollen and that was a change from the normal for that resident he/she would have told the nurse.-He/She had not received any education lately about reporting skin issues. Review of the resident's Nurses' Notes dated 10/2/2025 showed:-The resident was noted to have edema in his/her bilateral lower extremities (BLE) on 10/1/25.-The Nurse Practitioner was at the facility to assess the resident.-New orders were received for:--Lasix (a powerful water reducing pill) 20 milligram (mg) one pill to be given by mouth for five days.--Potassium Extended Release (ER) (a supplement commonly given to offset Lasix) 10 milliequivalents (meq) one pill daily for five days.--Chest x ray.--Brain Natriuretic Peptide (BNP a test used to assess heart failure).Review of the resident's Physician's Order Sheet dated October 2025 showed the following orders:-Two view chest x ray due to increased edema.-BNP due to new edema (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in BLE.-Lasix 20 mg tablet one tablet by mouth one time a day for edema for five days.-Potassium ER 10 meq one tablet by mouth one time a day for supplement for five days. Review of the resident's results of the tests ordered on 10/1/25 showed:-The BNP was normal.-The Chest x ray showed Thoracic (chest) degenerative changes.-Impression was chronic chest findings were present.-The resident's Physician was notified of test results. During an interview on 10/2/25 at 1:30 P.M. the Director of Nursing said:-Staff should have seen the resident had swollen ankles.-Staff should have informed the nurse so he/she could call the physician.-They have had some issues and had started a PIP about skin observations.-He/She was ultimately responsible for ensuring the residents received the treatments they needed.-This was missed.