STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265638	A. Building B. Wing	03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Homes, Tri-County	601 North Galloway Road Vandalia, MO 63382

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to provide care in a manner that enhanced resident dignity for three residents (Residents #43, #28, and #41), in a review of 19 sampled residents. Facility staff also failed to cover two residents' (Resident #2 and #30) urinary catheter (tube leading from the urinary bladder to the outside to drain urine) drainage bags with a dignity/privacy cover. The facility census was 55. Review of the undated facility policy, Residents Rights Policy, showed the following: -These resident rights ensure that at least, each resident admitted to this facility is/has: -Fully informed, as evidenced by the resident's written acknowledgement, prior to or at this time of admission and during stay, of these rights and of all rules and regulations governing residents conduct and responsibilities; -Treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and care for his/her personal needs; -The right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Review of the facility policy, Dignity, revised February 2021, showed the following: -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem; -Residents are treated with dignity and respect at all times; -Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures; -Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example; a. Addressing the underlying motives or root causes for behavior; and (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Not challenging or contradicting the resident's beliefs or statements. 1. Review of Resident #43's face sheet showed the following: -Diagnosis of: Major depressive disorder, severe with psychotic symptoms, muscle spasm and chronic pain. Review of the resident's care plan, dated 7/11/19, showed the following: -Frequently incontinent of bladder; -Goal to remain clean, dry, and odor free; -Determine times when usually required toileting, assist to the bathroom at these times; -Provide privacy with toileting; -Toilet in advance of need. Review of the resident's care plan, updated 3/30/21, directed staff to transfer the resident to the wheelchair with a mechanical lift and two staff assist. Review of the resident's quarterly Minimum Data Set (MDS), a federally required assessment instrument completed by facility staff, dated 12/24/21, showed the following: -Severe cognitive impairment; -Makes self understood and understands others; -Mild depression; -Required extensive physical assistance of two or more staff members for bed mobility; -Dependent on staff for transfers and toilet use. Observation on 2/16/22 at 7:41 A.M. to 8:25 A.M., in the resident's room showed the following: -The resident yelled I gotta go! Help Me! Please; -Licensed Practical Nurse (LPN) A told the resident, I'll be right there; -The resident continued to yell, and said, Oh my stomach is killing me! Please help me! I've got to go now; -LPN A told the resident, I'll be right back, I promise and went into another resident's room; -Certified Medication Technician (CMT) R walked past the resident's room. The resident yelled Help me! I've gotta go poop! I've gotta go now; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Social Service Director walked down the hallway, heard the resident, walked into the resident's room and said, Do you have your call light on? There, I pushed it for you. No one wants to sit in their own poo! and walked back out of the room; -The resident yelled even louder Help! Please help me! Hurry; -Maintenance O stopped to ask the resident what he/she needed and then went and told LPN A; -LPN A came out of another resident's room and asked CMT R if he/she could help lay the resident down and told him/her that he/she would need someone else to assist with the resident; -CMT R went into the other resident's room and took him/her to breakfast; -The administrator came down the hallway and asked CNA K to go in the resident's room and turn the call light off and said, I know who it is - could you just go and turn the light off, it's red; -LPN A and CNA K went into the resident's room and transferred the resident to his/her bed via Hoyer lift (assistive device using a sling to transfer resident between wheelchair and with electrical or hydraulic power) and removed the resident's clothes; -The resident was incontinent of bowel and bladder; -CNA K placed two trash bags at the end of the bed and went to the sink and washed his/her hands. He/She removed the resident's soiled gown and incontinence brief and the resident said It's cold in here, with no clothes on it's real cold; -CNA K left the resident laying fully exposed while he/she went over to the sink to wash his/her hands and get more wet cloths; - CNA K performed peri care, applied barrier ointment to resident's perineal area, placed a clean gown on the resident and then covered the resident. 2. Review of Resident #28's Face Sheet showed the resident admitted to the facility on [DATE]. Review of the resident's Care Plan, dated 3/4/21, showed the following: -Impaired level of cognitive function due to Alzheimer's disease; -At risk for episodes of agitation or fear due to confusion; -Reassure the resident when confused or upset; -Anticipate resident's needs; -Provide privacy; -Dress appropriately according to season and time of day; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provide grooming, hygiene needs. Review of the resident's significant change in condition MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis of heart failure, Alzheimer's disease, anxiety disorder, depression; -Required extensive physical assistance of two or more staff members for bed mobility; -Dependent on staff for transfers, eating, toilet use, and hygiene. Observation on 2/16/22 at 6:40 A.M., showed the following: -Resident in his/her room in bed and visible to anyone in the hallway; -Resident yelled for help; -Unidentified staff walked by and did not respond to the resident. Observation on 2/16/22 at 6:59 A.M.-7:33 A.M. (Continual observation), showed the following: -Resident in his/her room in bed; -At 6:59 A.M. the resident yelled for help, was moving his/her legs and covers. Activity Director/CNA and CNA K walked by the resident's room, but did not respond to the resident; -At 7:05 A.M. the resident continued to yell for help, pulled his/her covers up to his/her chest exposing bare skin from the abdomen to mid calf. The resident was only wearing socks, his/her private area was exposed and visible from the hall. Three staff walked by, but did not respond to the resident yelling for help; -At 7:06 A.M. the Transportation/Floor maintenance staff walked by the resident's room and did not respond to calls for help; -At 7:10 A.M. Licensed Practical Nurse (LPN) D walked by the resident's room while the resident was yelling help, but did not respond to the resident; -At 7:20 A.M. the resident continued to be exposed, now yelling hey; -At 7:24 A.M. Housekeeper FF walked by and did not respond to the resident calling out; -At 7:25 A.M. Certified Medication Technician (CMT) R propelled a resident to his/her room past the resident's room, walked back by the resident who continued to yell for help but did not respond; -At 7:26 A.M. Transportation/Floor maintenance staff, the Activity Director, and another unidentified staff member walked by the resident's room, the resident yelled out for help and did staff not respond to the resident; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 7:28 A.M. the resident continued to be exposed, the Maintenance Director walked into the resident's room while the resident called out for help to deliver incontinence products and told the resident someone would be there in a minute and walked out of the room without covering the resident, pulling the curtain, or closing the door; -At 7:30 A.M. CMT R propelled another resident to his/her room, walking by the resident's room as Resident #28 called out for help. CMT R did not respond to Resident #28; -At 7:31 A.M. CNA K walked past the resident's room while the resident called out for help and did not respond to the resident; -At 7:33 A.M. LPN A responded to the resident, covered the resident with a blanket and the resident stopped yelling out. During an interview on 2/16/22 at 8:20 A.M., CNA K said the following: -Staff tried to respond to residents that yell out; -There are so many residents that yell out on the hall and they get to them as fast as they can; -Sometimes there are four residents continually yelling out at the same time. During an interview on 2/16/22 at 9:30 A.M., CMT R said staff should respond to residents when they call out for help. He/She did not because he/she was focused on getting the residents from the dining room. During an interview on 2/23/22 at 10:10 A.M., LPN D said all staff should acknowledge the residents any time they call out for help; 3. Review of Resident #41's face sheet showed the following: -The resident's diagnoses included posterior reversible encephalopathy syndrome (a condition that can cause headaches, seizures and visual disturbances; blurred vision to blindness), neuromyelitis optica (a condition that can cause blindness in one or both eyes, weakness or paralysis in the legs or arms, painful spasms, loss of sensation and bladder or bowel dysfunction), ischemic optic neuropathy (when blood does not flow properly to your eye's optic nerve, eventually causing lasting damage to this nerve and you suddenly lose your vision in one or both of your eyes). Review of the resident's care plan, dated 11/18/21, showed the following: -The resident required total assistance with all activities of daily living (ADL) task performance, anticipate resident's needs. Provide morning and evening care and provide privacy; -No evidence of a care plan focus to address the resident's visual deficit. Review of the resident's quarterly MDS, dated [DATE], showed the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's vision was severely impaired; no vision, sees only light, colors or shapes. Eyes do not appear to follow objects; -The resident did not reject care; -The resident was totally dependent on two or more staff for bed mobility, eating, dressing, bathing, transfers, personal hygiene, toileting and locomotion on the unit; -The resident had impairment on both sides of his/her upper extremities (shoulders, elbows, wrists, and hands) and lower extremities (hips, knees, ankles and feet); -The resident was always incontinent of bladder and bowel. Observation on 2/15/22 at 9:48 A.M. showed the following: -CNA K and Nurse Aide (NA) W transferred the resident to his/her bed from his/her wheelchair; -The two staff members removed the resident's pants and incontinence brief; -CNA K continued with peri care and cleaned the resident's groin and buttock with the window blind open to a staff parking lot; -CNA K stepped away from the bed, washed his/her hands while NA W stood beside the bed. CNA K retrieved more clean washcloths to continue cleaning the resident. During this time the resident lay in bed without clothes on from the waist down and the staff did not cover him/her with a blanket; -After CNA K and NA W finished changing and cleaning up the resident NA W pulled the blind closed. During an interview on 2/22/22 at 10:00 A.M., the resident said he/she would not want the blinds left open when the staff were changing him/her and leaving him/her naked for everyone outside to see him/her. The resident said that would be embarrassing and he/she did not know the staff had done that to him/her. During an interview on 2/23/22 at 12:15 P.M., CNA K said the following: -Residents should have privacy when staff provide care (change incontinence briefs, give a bed bath); -He/She forgot to close the blinds when providing care for the resident on 2/15/22; -Residents' bodies should be covered as much as possible during care or covered completely if he/she stepped away from the bed. 4. Review of Resident #2's face sheet showed the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's diagnoses included acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood), history of urinary tract infection (an infection in any part of the urinary system, the kidneys, bladder, or urethra), Alzheimer's disease with late onset (a progressive disease that destroys memory and other important mental functions), diabetes mellitus (a group of diseases that result in too much sugar in the blood), and hypertension (high blood pressure). Review of the resident's significant change MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Extensive assistance of one staff member for hygiene and dressing; -Extensive assistance of two staff members for transfers, walking, and toileting; -Urinary catheter (a tube inserted into the bladder to drain urine) present. Review of the resident's care plan, last revised on 2/15/22, showed the following: -Resident required assistance with ADLs; -Change urinary catheter leg bag once weekly on Tuesday. During an observation on 2/14/22 at 12:18 P.M., the resident sat at the dining room table with his/her urinary drainage bag attached to the frame of his/her wheelchair without a dignity cover over the bag. Yellow urine was visible in the drainage bag. During an interview on 2/14/22 at 1:15 P.M., CNA I said he/she was not sure why the resident did not have a dignity cover over the urinary drainage bag. It was typical that the bags are covered. 5. Review of Resident #30's face sheet showed the following: -The resident's diagnoses include dementia, retention of urine, traumatic brain injury, history of falling, and artificial openings of urinary tract. Review of the resident's care plan, dated 3/15/16, showed the following: The resident had moderately impaired cognitive skills for daily decision making; -The resident required assistance with ADLs; -The supra pubic catheter (tube leading from the urinary bladder and the skin to the outside to drain urine) will remain patent and free from infections; -Apply leg bag in the morning and to dependent drainage bag at bedtime. Record review of the quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Extensive assistance needed in activities of daily living; -Substantial/maximal assistance needed with self-care; -The resident has an indwelling catheter. Observation on 2/14/22 at 11:40 A.M., showed the resident sat in dining area in a recliner with his/her eyes closed. Other residents also sat in the dining area. The resident's urinary drainage bag, attached to the recliner, had visible urine in the bag and no privacy cover. Observation on 2/14/22 at 2:40 P.M., showed the resident lay in bed with his/her eyes closed. His/Her urinary drainage bag was attached to his/her bed with visible urine in the bag and no privacy cover. Observation on 2/14/22 at 2:45 P.M., showed the resident lay in bed with his/her eyes closed. His/her urinary drainage bag with urine visible in the bag, was attached to his/her bed and was without a privacy cover. During an interview on 2/14/22 at 3:00 P.M., CMT F said he/she not sure why the resident did not have a dignity cover over the urinary drainage bag. Observation on 2/15/22 at 10:00 A.M., showed following: -The resident lay in bed with his/her eyes closed; -The resident's urinary drainage bag was in an open lower bedside table drawer and contained dark urine; -There was no privacy cover and the drainage bag was visible from the doorway. 6. During an interview on 2/25/22 at 8:30 A.M., the Director of Nursing (DON) said the following: -She would expect staff to go in a resident's room and see what they need if they are calling out; -She would not expect a staff member to walk by a resident's room and not acknowledge the resident if they are calling out for help; -She would not expect staff to ignore the residents; -It was not acceptable for a resident to be lying naked in their room and to be exposed to people in the hallway; -Catheter bags should be covered to maintain residents' dignity; -When providing resident care the window blinds and privacy curtain should be pulled to provide privacy for the resident; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When leaving the resident's room cover the resident to ensure he/she is not exposed to people walking in or by the room. During an interview on 2/25/22 at 8:30 A.M., the administrator said the following: -Staff are expected to maintain a resident's dignity; -It was not acceptable to walk past the room of a resident that is calling out; -She would expect staff to go into the resident's room and see what they needed; -Many times a resident will call out and not know what they need, and the resident needs to be answered by staff to see if they can provide help. 42594 44687 45563

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to provide a clean, comfortable and odor free environment by failing to ensure flooring and walls in resident rooms, furnishings, hallways, ceiling vents, and common areas were clean and in good repair. The facility census was 55. Review of the facility policy, Homelike Environment, revised February 2021, showed the following: -Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible; -The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. The characteristics include: a. clean, sanitary, and orderly environment; b. inviting colors and decor; c. personalized furniture and room arrangements; d. clean bed and bath linens that are in good condition; e. pleasant, neutral scents. 1. Observation on 02/14/22 between 10:05 A.M. and 4:45 P.M., during the life safety code tour of the facility, showed the following: -In the back dining area, a 12 inch by 12 inch ceiling vent was covered in a thick layer of dust; -In the beauty shop, a 12 inch by 12 inch ceiling vent was covered with a thick layer of dust; -In the back nurse's station, two 12 inch by 12 inch ceiling vents were covered with a thick layer of dust; -In the back bathroom by the nurse's station, a 4 inch by 4 inch ceiling vent was covered with a thick layer of dust; -In resident room [ROOM NUMBER], a 4 inch by 6 inch ceiling vent was covered with a thick layer of dust; -In resident room [ROOM NUMBER], a 4 inch by 6 inch ceiling vent was covered with a thick layer of dust; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the front bathroom by the nurse's station, a 4 inch by 4 inch ceiling vent was covered with a thick layer of dust; -In the 200 hallway, an 18 inch by 18 inch ceiling vent was covered with a thick layer of dust; -In the special care unit shower, a 12 inch by 12 inch ceiling vent was covered with a thick layer of dust; -In the special care nurse's station, a 12 inch by 12 inch ceiling vent was covered with a thick layer of dust; -In the 100 hallway, three 12 inch by 12 inch ceiling vents were covered with a thick layer of dust; -In the hallway by the kitchen and laundry area, an 18 inch by 18 inch and two 12 inch by 12 inch ceiling vents were covered with a thick layer of dust. Observation in the kitchen area on 02/15/22 between 8:15 A.M. and 11:10 A.M., during the life safety code tour of the facility, showed 4 inch by 6 inch and a 4 inch by 4 inch ceiling vents were covered with a thick layer of dust. Observation on 2/14/22 to 2/16/22 showed the following: -room [ROOM NUMBER]- multiple areas on the door frame with paint missing as well as scuffs with paint missing on the bottom of the entry door; -room [ROOM NUMBER]- multiple scuffs with paint missing on the door, multiple areas of scuffed paint on the wall near the floor throughout the room, entry door frame scuffed up and missing paint; -room [ROOM NUMBER]- multiple paint scuffs on bathroom door and bedroom door with paint missing, wall behind door missing a chunk of the wall exposing the drywall, large amounts of paint gone above the trim by bathroom door, wall scarred by heater, heater scraped up and missing paint, dresser missing stain and scuffed around edges, doorframe scuffed with paint missing; -room [ROOM NUMBER]- bathroom and entry doors scuffed with paint missing, areas on wall missing paint behind the beds, both door frames scuffed up with missing paint; -room [ROOM NUMBER]- telephone wire running down wall with no cover on the phone box, wall scuffed up near the floor throughout the room, bathroom door scuffed and missing paint, entry door frame scuffed up and missing paint, bed 1 and 2 dresser scuffed exposing wood beneath the finish, white baseboard trim scuffed up throughout the room; -room [ROOM NUMBER]- door frame scuffed with paint missing, and the entry door with scratches; -room [ROOM NUMBER]- door frame scuffed with paint missing, and the entry door with scratches. Observation on 2/14/22 at 3:15 P.M., of the special care unit (SCU) showed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER]- the sink countertop edge with chipped laminate exposing wood layer. The resident's door handle was loose and rubbed area on door exposing wood layer. Dark gray debris build up along the corners, floor and baseboards; -room [ROOM NUMBER]- floor tiles with dull finish. Dark streaked scuff marks, paint missing and exposing drywall on the walls. Cabinetry with worn finish. Privacy curtain with brown stain. Bathroom door jamb with chipped paint exposing the metal. Sink with broken stopper. Matted dark gray debris build up along the corners, floor, and baseboards; -room [ROOM NUMBER]- cabinetry with worn finish, drawers did not track or close. Dark gray debris build up along the corners, floor and baseboards; -room [ROOM NUMBER]- the sink countertop edge with chipped laminate exposing wood layer. Floor tiles with dull finish. Matted dark gray debris build up along the corners, floor, and baseboards. The walls with dark streaked scuff marks and paint missing exposing drywall. Cabinetry with worn finish, drawers did not track or close. Privacy curtain with brown stain. Ventilation cover not covering hole in wall and exposing drywall; -room [ROOM NUMBER]- floor tiles with dull finish. Matted dark gray debris build up along the corners, floor and baseboards. Scuffed marks on the walls; -room [ROOM NUMBER]- the sink countertop edge with chipped laminate exposing wood layer. Floor tiles with dull finish. Matted dark gray debris build up along the corners, floor, and baseboards. Dark streaked scuff marks on the walls. The toilet bowl was stained, missing screw cover where the safety hand rails attach to toilet. Ventilation cover not covering hole in the wall and exposed the drywall; -room [ROOM NUMBER]- the sink countertop edge with chipped laminate exposing wood layer. Matted dark gray debris build up along the corners, floor, and baseboards; -room [ROOM NUMBER]- floor tiles with dull finish. Matted dark gray debris build up along the corners, floor, and baseboards. Dark scuffed marks on the walls. Cabinetry with worn finish. Privacy curtain with brown stain; -room [ROOM NUMBER]- the sink countertop edge with chipped laminate exposing wood layer. Floor tiles with dull finish. Matted dark gray debris build up along the corners, floor, and baseboards. Dark streaked scuff marks on the walls. Ventilation cover did not cover a hole in the wall that exposed drywall. The room was occupied by a resident and had a strong urine odor; -room [ROOM NUMBER]- floor tiles with dull finish. Matted dark gray debris build up along the corners, floor, and baseboards. Dark streaked scuff on the walls; -The door frames to the resident rooms had missing paint and dark streaked scuff marks. Observation on 2/14/22 at 11:45 A.M. showed the brown recliner in the dining room/common area had a worn finish on both armrests, exposing the padding under the fabric covering. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/14/22 at 11:55 A.M. of occupied resident room [ROOM NUMBER] showed a strong urine odor. room [ROOM NUMBER] was located immediately to the right of the SCU entrance doors. Observation on 2/15/22 at 11:46 A.M., showed the floor outside room [ROOM NUMBER] had drag marks from the fire doors on the hallway floor. Observation on 2/16/22 at 5:25 A.M., of the SCU showed a strong urine odor throughout the unit. Observation on 2/22/22 at 10:10 A.M., of the SCU showed a strong urine odor throughout the unit. During an interview on 3/2/22 at 11:09 A.M., CMT R said the following: - SCU resident rooms are supposed to be cleaned every day, but with call-ins housekeeping does the best they can - Nursing staff mop floors and tidy rooms as needed, especially for the resident in room [ROOM NUMBER] who frequently urinates in the trash can. During an interview on 3/22/22 at 9:17 A.M., the Accounts Payable Staff said the following: -The maintenance staff were aware of work orders for SCU; -The maintenance supervisor was working on repairs in SCU; -The administrator or accounts payable staff order supplies needed for repairs or the maintenance staff can pick up supplies at the local hardware store. During an interview on 3/2/22 at 11:13 A.M., the Housekeeping/Dietary/Laundry Supervisor said the following: - She would expect housekeeping staff to clean SCU resident rooms daily; - She would expect privacy curtains to be washed when soiled During an interview on 3/2/22 at 2:10 P.M., Floor Maintenance Staff said the following: -The floors currently need to be stripped and waxed; -The facility had a floor machine, but it does not do a good job; -The facility did not have it in the budget to purchase wax for the floors. During interviews on 2/15/22 at 3:50 P.M. and on 3/15/22 at 12:20 P.M., the Maintenance Supervisor said the following: -Maintenance staff was responsible for cleaning the ceiling vents. He was not aware of the ones found during the inspection. The ceiling vents are not on a monitoring schedule. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Repairs needed are filled out on a maintenance request form and placed in maintenance mailbox; -The needed repairs are then triaged and get completed typically within three days; -A repair could take longer if supplies are not available, but then completed within three days after supplies available; -The entire building gets painted two times a year and as the need arises; -Scuffed door frames, doors, residents walls, and base boards can be painted more often than twice a year when they are aware of the need. During interviews on 2/15/22 at 4:15 P.M. and on 3/15/22 at 11:33 A.M., the administrator said the following: -She expected the ceiling vents to be clean and dust free; -She would expect repairs to be completed within three days, as long as supplies are available. If supplies were unavailable within three days she expected the repair to be completed as soon as supplies were available; -She would expect maintenance to check the resident rooms monthly for painting and repair as needed and completed within a couple of weeks; -She would expect maintenance to check the units monthly for painting and repair as needed and complete within a couple of weeks; -She would expect maintenance to do a monthly walk through of the entire facility to assess needed repairs and repairs complete within a couple of weeks; -She would expect a monthly walk through of the entire facility to assess needed cleaning/painting and scuffed areas on the door frames/doors/walls and repairs complete within a couple of weeks; -She would expect the baseboards and corners of floors deep cleaned weekly by housekeeping to remove build-up of dirt and cleaned daily; -She would expect hallway floors swept and mopped twice daily by housekeeping and buffed with the buffer weekly by maintenance; -She would expect the resident rooms swept and mopped daily by housekeeping and the floors buffed by maintenance when a resident was not in the room, and when a room turned over and deep cleaned; -She would expect housekeeping or nursing (if no housekeeping) take out the trash at least three times a day to managing odors on the SCU; -She would expect housekeeping to clean the SCU if there is a strong smell of urine; if housekeeping is unavailable the charge nurse can access the cleaning supplies and nursing staff can clean and try to make the smell better; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She would expect housekeeping to clean the SCU three times a day; -She would expect SCU nursing staff to tidy up resident rooms and spot mop the floors. MO00170735 MO00171180 MO00172908

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to ensure facility staff provided bathing and hygiene needs for six residents (Residents #6, #28, #37, #41, #43, #44), in a review of 19 sampled residents who were unable to perform their own activities of daily living (ADL's). The facility census was 55. Review of the undated facility policy, Routine Resident Care/ADL's, showed the following: -Routine care rendered by all nursing staff includes attention to physical, emotional, social, spiritual, and life style preferences according to individual job descriptions; -Residents are given routine daily care by a certified nursing assistant (CNA) under the supervision of a licensed nurse; -Routine care by a nursing assistant includes the following: a. Assisting resident in personal care, bathing, dressing, eating, and encouraging participation in physical, social, and recreational activities; c. Observing and recording all aspects of personal care including bathing, food intake, ambulation activities, elimination and vital signs in the resident care charting record and resident food/group intake record in the resident's medical record. Review of the undated facility policy, Showers and Nail Care, showed the following: -Each resident will be showered or tub bathed two times a week and as needed; -Bed baths are given on days residents do not received a shower or tub bath; -A resident has the right to refuse a shower or tub bath, and be given a bed bath; -Nursing will document on shower/tub bath refusals; -Resident's nail (fingers and toes) will be cleaned after their shower or tub bath; -A CNA will trim nails unless the resident is diabetic or on anticoagulant therapy; -Residents that are diabetic or on anticoagulant therapy will be trimmed by the nurse. 1. Review of Resident #43's face sheet showed diagnosis of major depressive disorder, severe with psychotic symptoms, muscle spasm and chronic pain. Review of the resident's admission MDS, dated [DATE], showed the following: -Moderate cognitive impairment; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required extensive physical assistance of two or more staff members for bed mobility, transfers, hygiene, bathing, and toilet use. Review of the resident's Care Plan, updated 7/11/19, showed the following: -ADL's - resident requires assistance with all ADL tasks with one to two assist for bed mobility, transfer, toileting, grooming, bathing, and dressing. Review of the resident's shower/bath record, dated December 2021, showed the resident received a shower on 12/2/21 and 12/30/21, and no other dates for the month of December. There was no documentation the resident refused showers/bathing. The resident missed seven scheduled showers. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Requires extensive physical assistance of two or more staff members for bed mobility, and hygiene; -Dependent on staff for transfers, bathing and toilet use; -Limited range of motion in both lower extremities. Review of the resident's shower/bath record, dated January 2022, showed the resident received a shower/bath on 1/4/22, 1/11/22 and 1/18/22 and no other dates for the month of January. There was no documentation the resident refused shower/bathing. The resident missed five scheduled showers. Observation on 2/14/22 at 11:57 A.M., showed the following: -The resident in his/her wheelchair in his/her room; -His/her hair was greasy, dry skin on legs and arms, and the resident's fingernails were long with brown debris under the nails. During an interview on 2/14/22 at 11:57 A.M., the resident said the following: -He/She was lucky to get one bath a week; -He/She would like more baths, at least two a week; -When he/she goes too long without a bath he/she feels itchy. Review of the resident's shower/bath record, dated 2/1/22-2/22/22, showed staff documented the resident received a shower/bath on 2/14/22 and 2/18/22 and no other dates during the month of February. There was no documentation the resident refused showers/bathing. The resident missed four scheduled showers. 2. Review of Resident #44's annual MDS, dated [DATE], showed the following: -He/She had severely impaired cognition; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not reject cares; -He/She had total dependence of two or more staff members for bed mobility, toilet use, personal hygiene, bathing and transfers; -He/She was always incontinent of bladder and bowel. Review of the resident's ADL care plan, last updated on 3/30/21, showed the following: -He/She required extensive to total assist with bathing, dressing and personal hygiene; -He/She will be kept clean, dry and well-groomed daily; -He/She to receive showers two times a week; -His/Her hair to be shampooed two times a week; -Partial bath to be given on days not showered at bedtime and after incontinence episodes; -Provide oral care two times a day and as needed; -No documentation to show the resident refused oral care or showers. Review of the resident's December 1, 2021 through February 18, 2022 shower logs showed the following: -December 2021 showers given on 12/2, 12/6, 12/13, 12/20, 12/23, and 12/27; -January 2022 showers given on 1/5 and 1/12; -February 2022 showers given on 2/2 and 2/16. The documentation showed the resident had 10 showers in 80 days and should have had 24 showers. Review of the resident's progress notes, dated December 1, 2021 through February 18, 2022, showed no evidence the resident refused baths or showers. Observation on 2/16/22 at 5:50 A.M., showed they resident lay in bed with dry, peeling lips and teeth with a white thick buildup in between and on his/her teeth. Observation on 2/16/22 at 7:54 A.M., showed the following: -Certified Nurse Aide (CNA) K and the activity director changed the resident's brief and transferred the resident to his/her wheelchair; -Staff took the resident to the dining room for breakfast; -Staff did not provide oral care or wash the resident's face or hands. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/22/22 at 10:50 A.M., the resident sat in his/her room in a wheelchair and said the following: -When asked if the resident had his/her teeth brushed on that day he/she shook his/her head no; -When asked if he/she had his/her teeth brushed in the last few days the resident shook his/her head no. During an interview on 2/23/22 at 12:15 P.M. CNA K said the following: -The Certified Medication Technician (CMT) was suppose to provide oral care for the resident; -The resident refused oral care by some staff, but will sometimes allow him/her to provide oral care; -He/She was probably in a hurry and that was why he/she did not provide oral care for the resident on 2/16/22. During an interview on 3/21/22 at 11:42 A.M. CMT R said the following: -The resident refused oral care most of the time, every once in a while he/she will allow the CMT to provide oral care; -LPN A can get the resident to let him/her provide oral care. During an interview on 3/21/22 at 11:48 A.M., LPN A said the following: -The resident will allow the LPN to provide oral care most of the time; -The resident will only allow a few staff to provide oral care for him/her. 3. Review of Resident #28's Face Sheet showed the resident admitted to the facility on [DATE]. Review of the resident's Care Plan, dated 7/9/21, showed the following: -ADL: All Tasks required limited to extensive assistance of staff; -Anticipate resident's needs; provide care morning and evening; -Provide grooming and hygiene needs. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis of heart failure and Alzheimer's disease; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required extensive physical assistance of two or more staff members for bed mobility, transfers, toilet use, and bathing; -Dependent on staff for hygiene; -Indwelling urinary catheter, frequently incontinent of bowel. Review of the resident's shower/bath record, dated December 2021, showed no evidence staff gave the resident a shower or bath. There was no documentation the resident refused showers/bathing. Review of the resident's shower/bath record, dated January 2022, showed the resident received two showers/baths for the month of January one on 1/12/22 and another 1/19/22. There was no documentation the resident refused showers/bathing. The resident missed seven scheduled showers. Review of the resident's shower/bath record, dated 2/1/22-2/22/22, showed staff documented one shower/bath on 2/1/22. Review showed documentation of refusals. The resident missed five scheduled showers. Observation on 2/14/22 at 12:04 P.M., showed the following: -Resident up in his/her room in his/her recliner; -His/her hair was long and greasy; -His/her facial hair was long and unkempt; -His/her finger nails were long with brown debris under the nails. 4. Review of Resident #6's face sheet showed the following: -The resident's diagnoses hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (muscle weakness or partial paralysis on one side of the body), dementia with behavioral disturbance (a group of thinking and social symptoms that interferes with daily functioning). Review of the resident's quarterly MDS, dated [DATE], showed the following: -No behavior symptoms or rejection of care; -Total dependence of two staff for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. Review of the resident's care plan, revised on 2/13/22, showed the following: -He/She was a total assist for activities of daily living (ADL's); -He/She will be free from oral irritation/dry mucus membrane/oral infection daily; -Swab mouth and tongue with strong hot tea, cooled, every shift to prevent tongue from coating; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provide grooming/hygiene needs. Review of the resident's February 2022 physician order sheet showed the following: -Biotene moisturizing mouth mucosal spray, 2 sprays three times a day, ordered 10/7/21; -Swab mouth and tongue with strong hot tea, cooled, every shift to prevent tongue from coating, ordered 10/7/21. Review of the resident's February 2022 ancillary administration orders showed the following: -Biotene moisturizing mouth mucosal spray, 2 sprays by mucous membrane, three times a day - completed each shift; -Swab mouth and tongue with strong hot tea, cooled, every shift to prevent tongue from coating - completed each shift. Observation on 2/14/22 at 10:46 A.M., showed the resident lay in bed with his/her eyes closed. The resident's mouth was dry with brown crusty buildup on his/her lips and tongue. Observation on 2/15/22 at 10:12 A.M. showed the resident lay in bed. The resident's mouth was dry with brown crusty buildup on his/her lips and tongue. Observation on 2/15/22 at 1:37 P.M. showed LPN A performing oral care with brewed tea and oral swabs. Observation on 2/16/22 at 6:27 A.M. showed the resident lay in bed. The resident's mouth was dry with brown crusty buildup on his/her lips and tongue. Observation on 2/22/22 at 9:48 A.M. showed the resident lay in bed with his/her eyes closed. The resident's mouth was dry with brown crusty buildup on his/her lips and tongue. During an interview on 2/16/22, at 6:13 A.M., CNA N said oral care should be performed every day in the morning and before bed. During an interview on 2/16/22, at 2:22 P.M., Licensed Practical Nurse (LPN) A said the following: -Oral care should be performed morning and night on each resident; -The resident had an order to provide oral care every shift with strong brewed, cool tea; -Resident #6's oral care was performed by nursing staff. During an interview on 2/16/22 at 3:12 P.M., LPN D said the following: -Oral care should be performed at least two times a day by the CNA's; -Nursing was supposed to do oral care for Resident #6. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42594 5. Review of Resident #41's undated face sheet showed the following: -The resident's diagnoses included posterior reversible encephalopathy syndrome (a condition that can cause headaches, seizures and visual disturbances; blurred vision to blindness), neuromyelitis optica (a condition that can cause blindness in one or both eyes, weakness or paralysis in the legs or arms, painful spasms, loss of sensation and bladder or bowel dysfunction), muscle weakness, unspecified lack of coordination, difficulty in walking, abnormalities of gait and mobility and mild cognitive impairment. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident was totally dependent on two or more staff for bed mobility, eating, dressing, bathing, transfers, personal hygiene, toileting and locomotion on the unit; -The resident had impairment on both sides of his/her upper extremities (shoulders, elbows, wrists, and hands) and lower extremities (hips, knees, ankles and feet); -The resident was always incontinent of bladder and bowel. Review of the resident's care plan, updated 11/18/21, showed the the resident required total assistance with all ADL's, anticipate resident's needs, provide morning and evening care, grooming and hygiene needs; Review of the resident's shower logs, dated 12/1/21 through 2/18/22, showed the following: -December 2021 showers given on: 12/3, 12/7, 12/14 and 12/31; -January 2022 showers given on: 1/4, 1/18, and 1/25; -February 2022 showers given on: 2/2; -The resident received eight showers in three months, (December 2021- February 2/18/22) and should have received 24 showers. Review of the resident's progress notes showed no evidence the resident refused showers/bathing. During an interview on 2/14/22 at 1:15 P.M., the resident said the following: -He/She doesn't get as many showers as he/she would like; -He/She doesn't know if he/she had a designated shower day; -Sometimes staff will clean him/her up in bed; -He/She does not always feel clean. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #37's care plan, dated 10/6/21, showed the following: - Resident requires assistance with ADL task performance as follows: supervision, set-up, cues at mealtime; one assist for bed mobility; one assist for transfer, ambulation, toileting, grooming, bathing and dressing; - Resident will remain clean, neat, dressed appropriately for the season and free of body odor daily. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -No rejection of care; -Physical help needed in part of bathing activity. Review of resident's January 2022 shower log showed the following: -Showers received on 1/3/22, 1/10/22, 1/21/22, and 1/23/22; -The resident received four showers during the month of January. The resident missed four scheduled showers. Review of resident's February 2022 shower log showed the following: -Showers received on 2/9/22, 2/14/22, 2/18/22, and 2/21/22; -The resident received four showers during the month of February. The resident missed four scheduled showers. During interview on 2/14/22 at 11:16 AM, the resident said he/she will sometimes go a couple of weeks without getting a shower. 7. During an interview on 2/16/22, at 8:20 A.M. and 2/23/22 at 12:15 P.M., CNA K said the following: -Residents are scheduled to get two showers a week; -Sometimes only two aides work and cover all of the 200/300 hall and that is not enough staff to meet the residents' needs; -Residents don't always get two showers a week. During an interview on 2/16/2 at 2:22 P.M., LPN A said the following: -Showers should be given two times a week unless the resident refuses; (continued on next page)

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Baptist Homes, Tri-County	601 North Galloway Road Vandalia, MO 63382

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Oral care should be performed morning and night on each resident. During an interview on 2/16/22 at 3:12 P.M., LPN D said the following: -Showers are given two times a week to residents; -Oral care should be performed at least two times a day by the CNA's. During an interview on 2/25/22 at 8:30 A.M., the administrator said the following: -Residents should receive a minimum of two showers a week; -It should be documented on the shower papers, or in the nurses notes if a resident refused his/her shower/ bath; -She leaves it up to the charge nurses to make sure residents get two baths a week; -She did not know the showers were not getting done. MO00172908 MO00174210 MO00174442 MO00190937 45563

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on interview and record review, facility staff failed to implement their policy and failed to initiate cardiopulmonary resuscitation (CPR) (process of providing rescue ventilation and chest compressions to maintain circulation of blood) and call 911 for two residents (Resident #105 and #106) identified as having full code status (CPR required in the event of cardiac or respiratory arrest), when staff found the residents unresponsive and without a pulse. The facility census was 55. The administrator was notified on [DATE] at 2:30 P.M. of the Immediate Jeopardy (IJ), which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Review of the undated facility policy CPR showed the following: Standard: -Residents who have Full Code status will be given CPR in the absence of vital signs; Policy: -Resident code status will be determined/reviewed on admission and yearly; -Resident's attending physician will order Full Code or DNR (Do Not Resuscitate) as resident chooses (or durable power of attorney (DPOA)/guardian, if in effect); Procedure: 1. Physician order is received by licensed nurse for Full Code or DNR from physician; 2. Social Service Designee (SSD) or person designated by SSD, discusses code status with resident and has resident (or DPOA/guardian, if in effect) sign DNR form, if DNR is chosen; 3. If Full Code is chosen, licensed nurse/medical records designates this with a green full code sticker on the resident's chart, if not places a red sticker on chart, also places a red DNR or green full code sticker/circle on door/door frame. Lists of Full Code residents are placed at each nurse's desk, activity hall, therapy room and in vehicle for transport purposes; 4. If a resident designated Full Code is found to be without a pulse, CPR should be initiated immediately in the absence of vital signs regardless of color or body temperature and regardless of the length of time that vital signs may have been absent. CPR will be initiated immediately by the first person who is CPR certified; 6. CPR will be continued until the ambulance personnel arrive and the staff shall assist emergency medical personnel in continuing CPR until physician or coroner arrives or until resident is transferred by ambulance; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Family and physician should be called as soon as possible after 911. 1. Review of Resident #105's physician's order sheet (POS), dated [DATE], showed an order for full CPR. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed the following: -Moderately impaired cognition; -Diagnoses of pneumonia, diabetes, and anxiety. Review of the undated resident code list at the nurses' station showed the resident was a full code. Review of the resident's progress notes, dated [DATE] at 5:33 A.M., showed the following: -Upon helping to change resident found him/her warm to the touch temperature checked 100.4 F (normal adult temperature 97.5 to 98.9) temporal (a handheld thermometer that measures the temperature of a branch of the superficial temporal artery by pointing an infrared scanner directly at the forehead or lightly passing the scanner across the skin of the forehead); -Tylenol (pain reliever/fever reducer) crushed and given through feeding tube. Review of the resident's progress notes, dated [DATE] at 6:30 A.M., showed the following: -Upon entering the room, resident was found with no vital signs of life; -Family was called and did not wish for facility staff to start CPR. During interview on [DATE] at 5:12 P.M., Licensed Practical Nurse (LPN) Z said the following: -He/She was the charge nurse the night before the resident passed away; -He/She administered the resident's medications and tube feeding around 5:00 A.M. and noticed the resident felt hot when he/she assisted the resident to turn in bed; -He/She administered Tylenol for the elevated temperature; -The resident acted normal that shift, other than feeling hot to touch, and the resident did not fight him/her when he/she gave the resident's medication and tube feeding; -He/She reported to the oncoming nurse during report that the resident would need his/her temperature rechecked. During interview on [DATE] at 10:34 A.M. Certified Medication Technician (CMT) U said the following: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she was CPR certified; -He/she entered the resident's room shortly after 6:00 A.M. on [DATE] to check the resident's temperature because the resident had a fever during the night; -The resident was breathing when he/she was in the room; -The resident responded to his/her touch when he/she checked his/her temperature; -The resident's temperature was 97.7 degrees Fahrenheit. During interview on [DATE] at 10:00 A.M., Certified Nurse Aide (CNA) K said the following: -There was a list of resident code status at the nurses' stations; -The resident was a full code, he/she had a green dot on his/her door; -A green dot means go, do CPR; -A red dot means stop, don't do CPR; -When LPN C went to the resident's room to check on him/her, he/she was already gone; -He/She did post mortem care (care of the body after death) on the resident; -The resident's body was still warm and his/her extremities were still flexible, he/she hadn't been gone long. During interview on [DATE] at 2:10 P.M., LPN C said the following: -The night nurse had given the resident Tylenol around 5:00 A.M., because the resident had a fever; -He/She went down the hall at 6:30 A.M. and checked on the resident; -The resident had no pulse or respirations; -The resident's skin was cool and he/she had already turned a greenish color, he/she was already mottled; -He/She sent one of the aides to go get the other nurse (LPN T); -LPN T called the family and the family said they didn't want staff to do CPR; -He/She didn't see the resident go down (stop breathing); -His/Her impression was that if he/she saw the resident stop breathing, he/she should do CPR; -He/She was CPR certified; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She did not do CPR or call 911. During interview on [DATE] at 12:47 P.M., LPN T said the following: -The resident was alert, but not always verbal; -The resident was a full code; -He/She was called into the room by LPN C; -LPN C was assessing the resident; -The resident's color was purple, his/her skin was still warm, he/she was not cold to touch; -The resident was deceased , he/she had no vital signs; -He/She and LPN C did not perform CPR; -He/She was following LPN C's lead; -He/She called the resident's family member who said no, don't do anything; -He/She did not do CPR on the resident, because he/she did not know how long the resident had not been breathing and he/she was not his/her resident. During interview on [DATE] at 12:10 P.M., the SSD said the following: -She did advance directive paperwork with the resident on admission; -The resident requested to be a full code. 2. Review of Resident #106's care plan, dated [DATE], showed the following: -Advanced directives: Full Code status; -Will be kept safe and comfortable and will receive artificial resuscitation if needed. Review of the resident's physician's orders, dated [DATE], showed an order for full CPR. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnoses of urinary tract infection (UTI), dementia, Parkinson's disease (a long-term degenerative disorder of the central nervous system that mainly affects the motor system), malnutrition and depression. Review of the resident's progress notes, dated [DATE] at 4:22 P.M., showed the following: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 3:00 P.M. the resident was seen by this nurse and the other nurse on the floor as resident was complaining of anxiety, oxygen saturation at that time was 94% (normal range) and temperature was 97.7 Fahrenheit temporal. Had resident deep breathe and he/she calmed down. No more complaints voiced at that time; -At 4:12 P.M. went into resident's room and noted the resident did not appear to be breathing, no heartbeat detected, and when touched the resident was cold to touch; -When noted cool skin of resident, physician notified of resident passing, and said to notify family that it's too late for CPR and okay to release body to funeral home. During interview on [DATE] at 12:20 P.M., Registered Nurse (RN) V said the following: -He/She was the charge nurse on [DATE]; -He/She was CPR certified; -The resident was fine, then complained of being anxious which was his/her normal behavior; -He/She found the resident cold, stiff and blue; -The resident wasn't rigor stiff (stiffening of joints and muscles of a body a few hours after death), but he/she was kind of stiff and his/her coloring looked bad; -He/She called for the other nurse, they both listened for a heartbeat, and assessed the resident; -Collectively, he/she and the other nurse decided to call the physician; -Due to the resident's coloring, being cold, and being a little stiff, he/she wanted the physician's opinion before doing CPR; -He/She tried to get hold of the resident's family as well to get their opinion as to whether or not to do CPR; -The resident was a full code, but he/she felt like since the resident had no blood, was cold and stiff, the last thing he/she wanted to do was CPR if the resident was already gone. 3. During interview on [DATE] at 12:25 P.M., the administrator said the following: -She posted a list at each nurses' station of residents' code status; -She updates the resident code status list monthly; -If a full code resident was found without pulse or respirations, she would expect staff to immediately start CPR; -It would not be appropriate for staff to call the family prior to starting CPR; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Family wishes would not supersede physician's order for full code status; -She would expect staff to start CPR and call 911 before doing anything else including calling the physician; -Licensed nurses can't pronounce a resident as deceased in the facility. NOTE: At the time of survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the level of the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO00190578

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to provide adequate supervision and oversight to prevent falls for one resident, Resident #27, in a review of 19 sampled residents. The facility staff failed to implement fall prevention interventions as indicated on the resident's care plan, failed to provide safe transfers as directed by the resident's plan of care. Resident #27 had multiple falls with injuries including a subdural hematoma (pool of blood between the brain and its outermost covering). The facility census was 55. Review of the undated facility policy, Fall Assessment policy and procedures, showed the following: Fall assessment is completed up on admission to identify residents, who are at high risk for falls order to implement interventions and reduce the incidence of falls. It is also completed quarterly to identify residents who are at a high risk for falls and precipitating events and patterns leading to falls in order to implement interventions and reduce the incidence of future falls; - The Fall Risk Assessment will be complete upon admission by a licensed nurse; - The Fall Risk Assessment will also be completed quarterly on each resident; - The resident will be reassessed after each incident to determine precipitating factors and methods of intervention; - Following each fall, each resident is assessed to determine patterns related to occurrence of falls; - Falls will be discussed weekly at the Interdisciplinary Team meetings; - Residents who present as a Fall Risk on admission or on quarterly review will be reported to the care plan coordinator by the nurse who completed the Fall Risk Assessment; -The Interdisciplinary team will then develop plan of care to prevent falls; -Nursing will implement interventions to decrease or prevent future falls; - Interventions will consider the following about each resident: 1. Time of day; 2. Area of incident; 3. Diagnosis medications and side effects; 4. Environmental hazards; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	5. Increasing staff supervision; 6. Verbal reminders; 7. Diversional activities; 8. Evaluation of pain; 9. Scheduled toileting; 10. Low bed; 11. Bolster mattress; 12. Pad on floor; 13. Motion alarm; 14. Physical therapy (PT) and/or occupational therapy (OT) evaluation. 1. Record review of Resident #27's undated face sheet showed the resident was admitted to the facility on [DATE] with diagnosis of fluid overload, cerebral infarction (stroke), and chronic peripheral venous insufficiency. Record review of the resident's admission progress notes, dated 02/08/2021 at 10:17 A.M., showed the following: - The resident's family member said he/she had a stroke a few years ago; - The resident had needed more care; - The resident was an increased fall risk; - Had stress incontinence and wears pull up brief; - Usually went to the bathroom right after meals; - Walked with a walker around his/her house on his/her own; - Had three falls in the past six months, two of those were in the past three months; - No skin issues aware of, does bruise very easy; - Plans are for long term stay. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/21/21, showed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- Cognitively intact; - Occasionally incontinent; - Independently toileting; - [NAME] used for mobility; - Independent in transfers, locomotion in room and unit; - Balance during transitions and walking steady at all times; - Fall history one month prior to admission. Record review of the resident's care plan, dated 2/23/21, showed the following: - Potential for injury related to falls due to history of multiple falls; - Cue, reorient and supervise resident as needed. Be aware of safety issues; - Keep bed to lowest position when not giving care; - Assess visual/hearing deficit to determine safety needs; - Verbal cues as needed for safety; - Assess cause, pattern or previous falls and act upon resolvable factors; - Promote proper use of handrails, hand grips in bathroom; - Assess cause, pattern of previous falls and act upon resolvable factors; - Environmental checks keep floor uncluttered and kept dry (notify housekeeping for cleanup of spills with ten minutes); - Check assistive devices daily for damage (Example: Commode legs not loose); - Check that all locks are working on wheels of bed, wheelchairs, walkers, commodes etc; - Adequate lighting; - The resident had impaired communication due to minimal hearing loss when environment noise; - Will remain able to communicate, have needs met within environment, and answer call light promptly. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the resident's admission fall risk assessment, dated 3/15/21, showed the resident had a history of two falls in the past three months, required use of assistive device (walker), unsteady gait/balance and predisposing disease. Staff scored the resident at five indicating the resident was a low risk for falls (a score of 10 or above indicated high risk). Record review of the resident's care plan notes, dated on 3/25/21, showed discharge from physical therapy and occupational therapy. Review of the resident's therapy notes, dated on 3/25/21, showed the resident plateaued, being moderately independent (supervision needed) with mobility, transfers and ambulation. Review of the resident's restorative therapy notes, dated 3/29/21, showed began ambulating the resident 15 minutes a day on 3/29/21 and ended 4/3/21. During interview on 2/23/22 at 11:30 A.M., the Secretary/Restorative Aide said the following: -The resident received restorative therapy when discharged from physical therapy; -The goal, to ambulate the resident personally three times a week for 15 minutes a day; -The Special Care Unit (SCU) staff ambulate the resident daily. During interview on 3/10/22 at 10:22 A.M., Therapy Coordinator said the following: - The resident evaluated for PT (physical therapy), OT (Occupational therapy), and ST (Speech Therapy) on 2/9/21; - The resident plateaued, being moderately independent with mobility, transfers and ambulation; - Restorative therapy began ambulating the resident 15 minutes a day; - Restorative therapy ended 4/3/21. Record review of the resident's progress notes, dated 4/24/21 at 10:32 A.M., showed the following: - Unwitnessed fall; - The resident was found on floor next to the bed; - The resident was trying to reach his/her shoes; - The resident had an eight centimeter (cm) skin tear on left forearm to elbow; - The resident had a black bruise to right index finger; - The resident's gait unsteady, one assist with gait belt; - New order to cover skin tear left forearm with Telfa and loosely wrap with Kling every day. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's care plan showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident's fall on 4/24/21. Review of the Communication Book on the SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident's fall on 4/24/21. Record review of the resident's progress notes, dated 07/09/21 at 07:08 P.M., showed the following: - Unwitnessed fall; - The resident's roommate reported that resident was on floor in his/her room; - Small cut to right fourth finger; - The resident said he/she was helping his/her roommate get something out of a drawer and went to turn around and fell to the floor on his/her knees. Review of the resident's care plan showed no documentation facility staff updated, determined precipitating factors, evaluated or implemented new interventions after the resident's fall on 7/9/21. Review of the Communication Book on the SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident's fall on 7/9/21. Record review of the resident's progress notes, dated 07/22/21 at 03:29 P.M., showed the following: - Unwitnessed fall; - The resident noted to have multiple bruises at different stages of healing all throughout body during shower this evening; - The resident said he/she had fallen, but did not tell anyone; - The resident noted to have a 3.5 centimeter (cm) x 5 cm round black bruise on his/her anterior left leg above the knee; - A 4.5 cm x 5 cm purple and black bruise on the anterior left leg below the knee; - Below that another 2 cm x 3 cm purple bruise; - Multiple other bruises on both legs; - On left arm resident has 8 cm X 7 cm bruise that wraps around anterior and posterior sides about wrist; - On right anterior arm resident has a 20 cm X 3.5 cm black bruise. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's care plan showed no documentation facility staff updated, determined precipitating factors, evaluated or implemented new interventions after the resident's fall on 7/22/21. Review of the Communication Book on the SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions to address falls. Record review of the resident's quarterly MDS, dated [DATE], showed the following: - Severely impaired cognition; - Independent toilet use and ambulation (completes activity by him/herself with no assistance); - Independent with transfers; - Balance during transitions and walking steady at all times; - The resident had one fall since admission causing injury such as skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains or any fall-related injury that causes the resident to complain of pain; (review of the resident's medical record showed the resident had three unwitnessed falls since admission on 4/24/21, 7/9/21, and 7/22/21). Record review the resident's progress notes, dated 08/31/21 at 05:03 P.M., showed the following: - Unwitnessed fall; - The resident was found in bathroom doorway by therapy at 3:15 P.M.; - The resident said, just fell ; - Noted bump to center of the back of head with slight bleeding; - The resident assisted to wheelchair by two staff members and told not to walk at this time; - The therapy department notified of the resident being weaker and confusion increased in the afternoon into the night; - Requested to see if therapy could work with the resident and therapy going to look into picking up (PT evaluated the resident on 8/31/21). During interview on 3/10/22 at 10:22 A.M., the Therapy Coordinator said the following: - PT evaluated the resident on 8/31/21; - The resident plateaued, being moderately independent (supervision needed) with mobility, transfers and ambulation; - PT therapy from 8/31/21 until discharged on [DATE]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the resident's assessments showed no documentation facility staff updated the resident's fall risk assessment per policy. Record review of the resident's progress notes, dated 9/5/21 at 02:56 A.M., showed the following: - Unwitnessed fall 9/4/21; - The resident discovered by nurse walking down hall; - Resident in a sitting position on the floor between the bed and the bathroom door; - The resident indicated he/she hit his/her head when he/she fell ; - The resident had blood from back of head, right elbow, and just above the right wrist; - Resident alert, but did not know if he/she was going to the bathroom or had already been to the bathroom; - Transferred at 11:40 P.M. to local hospital. Record review of the resident's hospital records, dated 9/4/21, showed the following: - Performed a CT (Computed tomography scan-reveals anatomic details of internal organs that cannot be seen in conventional X-rays) of the resident's head and cervical (neck) spine; - Showed a subdural hematoma (pool of blood between the brain and its outermost covering), present at the vertex (highest point) on the left frontal region 12 mm x 52 mm; - The resident fell at the facility tonight and struck the back of his/her head. This also occurred several days ago; - The back of the head was painful and there was a small amount of weeping blood; - The facility staff reported the resident fell three days ago; - Transferred to trauma center for further evaluation by neurology and neurosurgery on 9/5/21. Record review of the resident's progress notes, dated 09/08/21 at 05:39 P.M., showed the following: - Report received from trauma center, CT revealed left frontal subdural hematoma with no midline shift (blood buildup or swelling around the damaged brain tissues is powerful enough to push the entire brain off center). No treatment, just letting it resolve on its own; - The resident started on Keppra (medication to prevent seizures); - Provider to determine if Keppra can be discontinued; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Homes, Tri-County	601 North Galloway Road Vandalia, MO 63382

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- Alert and oriented to self and sometimes place, which was baseline; - The resident remains one assist. Record review of the resident's progress notes, dated 9/9/21 at 2:06 A.M., showed the resident was readmit after 9/8/21 fall. The resident had rested with eyes closed so far this shift, monitored closely. Record review of the resident's five-day scheduled assessment MDS on 9/15/21 showed the following: - The resident needs one assist in activities of daily living (ADL) including ambulation, transfers, toileting, and hygiene, - The resident needs assistance with balance with transitions and walking; - Supervision of one assist while walking; - Balance not steady, needs one assist for balance; - No fall since prior assessment. (Review of the resident's medical record showed the resident had two unwitnessed falls on 8/31/21 and 9/4/21). Record review of the resident's progress note, dated 11/26/21 at 02:49 A.M., showed the following: - Unwitnessed fall; - The resident found on floor in a sitting position at 2:15 A.M.; - Confused if going to or coming back from the bathroom; - The resident denied hitting his/her head; - The resident had multiple bruising from previous falls. Review of the resident's care plan showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented interventions to prevent falls following the resident's fall on 11/26/21. Review of the Communication Book on the SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident fell on [DATE]. Record review of the resident's progress note, dated 11/27/21 at 11:58 A.M., showed fall with skin tear to left forearm. Review of the resident's care plan showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented interventions after multiple falls including the fall on 11/27/21. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Communication Book on the SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident fell on [DATE]. Record review of the resident's progress notes, dated 11/29/21 at 09:22 P.M., showed the following: - Unwitnessed fall; - At approximately 9:00 P.M., Certified Nurse Aides (CNAs) reported the resident was on the floor beside his/her bed; - The resident reported he/she did not hit his/her head; - No complaints of pain or discomfort at this time; - The resident's scab on left elbow bumped and bled a small amount; - The resident out bed and to the nurse's station four to five times today. Review of the resident's care plan showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident's fall on 11/29/21. Review of the Communication Book on the SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident's fall on 11/29/21. Record review of the resident's care plan notes, dated 11/30/21, showed the following: - Directed to keep call light attached to his/her clothing; - Keep orienting the resident due to confusion. Record review of the resident's progress note, dated 12/1/21 at 5:07 P.M., showed the following: - Staff found the resident on the floor at 8:41 P.M.; - Unwitnessed fall; - The resident had a scrape on the left side of his/her back; - The resident's right eye was swollen. Review of the resident's care plan showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident's fall on 12/1/21. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Communication Book on SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident fell on [DATE]. Record review of the resident's progress note, dated 12/2/21 at 3:40 A.M., showed the following: -Staff found the resident on the floor; - Unwitnessed fall; - Blood on the floor; - The resident had a hematoma (bleeding under skin, bruise) and laceration to the head; - Transferred to the emergency room , laceration repaired with skin glue. Review of the resident's care plan showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented interventions after the resident's fall on 12/2/21. Record review of the resident's progress note, dated 12/20/21 at 1:20 P.M., showed the following: -The resident lay on the floor; - The resident fell to the floor onto his/her right side; - A 2.8 cm skin tear to his/her right arm near the elbow; - Hematoma right elbow; - The resident complained of right shoulder pain; - Physician order to X-Ray the right shoulder, negative for fracture. Review of the resident's care plan showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident's fall on 12/20/21. Review of the Communication Book on the SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions to address falls following the resident's fall on 12/20/21. Record review of the resident's progress note, dated 12/22/21 at 2:40 P.M., showed the following: - Staff found the resident on the floor on his/her side; - Unwitnessed fall; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- The resident had a 4.5 cm skin tear on his/her left arm, area approximated well and steri strips applied. Record review of the resident's progress note, dated 12/22/21 at 5:30 P.M., showed the following: - Unwitnessed fall; - Right forearm skin tear, exposing bone; - The resident was confused and did not understand what happened to his/her arm; - Transferred to the emergency room . Record review of the resident's progress note, dated 12/22/21 at 11:06 P.M., showed the following: - The resident fell twice today; - The resident was having loose stools; - The resident returned from the emergency room at 1:25 A.M.; - Pressure dressing to right forearm; - Two fingers of left hand bond together with a dressing. Review of the resident's care plan showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented new interventions after the resident's falls on 12/22/21. Record review of the Communication Book on the Special Care Unit (SCU), dated 12/28/21, showed the following: - Update sheet on the resident for 12/19/21 and 12/22/21 falls (no documentation in EMR for 12/19/21 fall); - Staff please make sure assist of one; - Use of walker; - No other update sheets in book for the resident from October 2021 to present. Record review of the resident's care plan notes on 1/3/22 showed the following: - Resident up with one assist and walker; - No documentation facility staff determined precipitating factors, evaluate or implemented further interventions after the falls on 12/19/21 and 12/22/21. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the resident's significant change MDS on 2/4/22 showed the following: - Severely impaired cognition; - The resident sometimes able to understand others; - The resident responds adequately to simple, direct communication only; - Balance not steady; - The resident has two falls since admission causing injury. (The progress notes show the resident with seven of eight falls unwitnessed since 9/15/21). Record review of the resident's progress notes, dated 2/7/22, showed the resident was transferred out to the local hospital by ambulance and report called to the emergency room . Record review of the resident's hospital record dated 2/7/22 at 9:50 A.M., showed the following: - The resident had severe dementia; - The resident fell out of bed this morning; - CT of cervical (neck) spine showed no fracture; - X-rays of right shoulder and arm showed no fracture; - Laceration of skin. Review of the resident's care plan showed no documentation facility staff determined precipitating factors, evaluated or implemented interventions after the resident's witnessed fall on 2/7/22. Review of the Communication Book on the SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented interventions after the resident's fall on 2/7/22. Observation on 02/14/22 at 2:25 P.M. to 2:35 P.M., in the dining room showed the following: - The resident sat in wheelchair with six other dependent residents; - The resident scooted from the table, one hand gripped the table and he/she attempted to get out of the wheelchair at 2:28 P.M.; - No staff were present in the dining room; - Other residents in the dining room told the resident not to get out of wheelchair and to sit down before he/she fell ; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- The resident continued to scoot away from table, one hand gripped the table and the resident attempted to get out of wheelchair; - CNA N came out of a resident room, returned to the dining room and redirected the resident to sit down at 2:35 P.M. Record review of the resident's progress notes on 2/15/22 at 6:50 A.M., showed the following: -Certified Medication Technician (CMT) F heard the housekeeper twice holler out the resident's name. Housekeeper reported the resident had fallen and he/she could not get to the resident in time; -The housekeeper witnessed the resident fall on his/her right side from a standing position and the resident hit his/her head on the floor. By the time this nurse got there he/she had rolled himself/herself onto her back; - Resident moving arms and legs but holding right elbow; - Noted lump to back of head; - Unsteady gait; - Sent to local hospital per ambulance for evaluation of head injury. Record review of the resident's local hospital record, dated 2/15/22 showed the following: - The resident fell again in facility; - The resident complained of neck tenderness; - Performed CT cervical spine and CT of the head; - The resident's diagnosis, posterior occipital hematoma (bruise under skin); - The resident returned to facility. Review of the resident's care plan showed no documentation facility staff determined precipitating factors, evaluated or implemented interventions after the resident's witnessed fall on 2/15/22. Review of the Communication Book on the SCU showed no documentation facility staff updated the care plan, determined precipitating factors, evaluated or implemented interventions to prevent falls after the resident's fall on 2/15/22. Observation on 2/22/22 at 10:10 A.M., of the resident in the SCU showed the resident sat in a wheelchair and wore fleece lined socks without grippers on the bottom of his/her socks. During interview on 3/10/22 at 10:22 A.M., the Therapy Coordinator said the following: -PT evaluated the resident for skilled services on 12/30/21; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-PT began gait training, increasing toe clearance and step length on 12/31/21 through 1/25/22; -The resident had confusion, poor insight, poor balance and needed one assist for activities; -The resident discharged on [DATE] due to transfer to the local hospital for fluid retention; -The resident moved to the SCU after hospitalization due to confusion and falls; -On 1/31/22 the resident ambulated five feet with moderate assistance (one assist) and on discharge of 2/11/22 the resident ambulated 75 feet with minimal assistance. During an interview on 2/16/22 at 4:50 P.M. and 2/23/22 at 4:30 P.M. CMT F said the following: - He/she did not know where to find fall interventions or updates on residents; - He/she did not know where to find a communication book and did not know there was a communication book; - He/she cannot access care plans on the electronic medical record (EMR); - Staff try to keep a close eye on the resident, offer toileting and ambulation; - Impossible for one staff member to keep up with checks and performing cares; - Report given on every resident to the next shift, may not get a full length report when starting the shift. During an interview on 2/22/22 at 10:40 A.M., Social Service staff member AA said the following: - He/she relieved staff for lunch and monitored residents in the dining room; - He/she did not know what care or interventions are required for the residents on the SCU. During an interview on 02/16/22 at 5:00 P.M. and 2/23/22 at 4:23 P.M., Licensed Practical Nurse (LPN) A said the following: -He/she was the charge nurse for the SCU; - Staff tried to keep a constant watch on the residents; - The resident is quick, didn't remember that he/she needs assistance when getting up and there isn't enough staff to prevent him/her from falling; - The resident started on west wing and had lots of falls; - The resident had therapy in the past and staff walks to dine; -The charge nurse was responsible for vital signs and assessing residents after a fall; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/she did not document the evaluation of each fall intervention in the progress note and does not evaluate the care plan; -He/she does not look at care plan after falls, he/she said the MDS/care plan coordinator will post intervention updates after fall meetings on Mondays and put in the communication book on SCU; - The MDS/Care Plan Coordinator prints the resident's care plan with intervention updates and places it in communication book for each unit (The communication book on the SCU showed last update for resident was on 12/28/21), only charge nurses could view the care plans on the EMR; - The MDS/Care plan coordinator responsible for care plan updates. During an interview on 2/22/22 at 10:00 A.M., charge nurse LPN D said the following: - On Mondays, the MDS/care plan coordinator will update the communication book on what staff need to do to prevent falls or what has changed on the care plan; - The resident's room direct in the line of sight of nurses station; - SCU staff offer toileting, in dining room with majority of staff/residents; -Electronic reporting by staff was sent to administrator and DON of any changes or updates in resident condition. During interview on 2/15/22 at 12:05 P.M., the MDS/care plan coordinator said the following: -Her responsibility to update the care plans after change in condition such as falls; -The administrator or nurse sends an alert through their electronic charting system, then he/she was responsible to update the care plan; -He/she did not attend the fall meetings, because she did not have enough time; -If the administrator or nurse fails to send information or updates, then the care plans are not updated. During an interview on 2/25/22 at 8:30 A.M., the administrator and DON said the following: - The licensed staff could not access to edit the care plan to update or change; - She thought staff could all look at care plans on the EMR; - All licensed staff couldn't see the resident's care plan on the EMR yesterday, but now they can; - Fall interventions should be re-evaluated in an ongoing process by staff; - If new interventions are put in place, the MDS/Care plan Coordinator prints out intervention updates and puts them in binder for the CNA's and staff; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- Care plans are re-evaluated after falls by the MDS/Care plan Coordinator; - She expects the MDS/Care Plan Coordinator attend the fall meeting every Monday for evaluating falls and updating interventions; -She would expect staff to follow the care plan, assist in residents' needs, provide a safe environment, call for assistance when needed and monitor closely to prevent falls for the resident. MO 00172908 MO 00176164 MO 00179843 44687 Surveyor: [NAME], [NAME] Surveyor: [NAME], [NAME] 45563

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff to meet residents' needs for two residents (Resident #28, and #43) in a review of 19 sampled residents and three additional residents (Resident #14, #21 and #54). Staff failed to provide routine showers to ensure good personal hygiene and prevent body odors and failed to respond timely to call lights. The facility census was 55. Review of the facility's undated policy, Staffing Plan, showed the following: -Consideration is given to the patients' and resident's needs when the composition of the nursing staff is determined; -Nursing services are provided 24 hours a day, seven days a week; -Sufficient personnel are assigned and on duty to assure safe, effective nursing care, including relief personnel during vacations, holidays, emergencies, and sick leaves; -Time schedules indicated the number of and classification of nursing personnel are developed; -These schedules are maintained and posted for each unit for every shift; -A staffing pattern is developed that considers the needs of the resident/patient populations; -When staffing falls below normal numbers, attempts will be made to call in help; -Nursing staff will be scheduled extended shifts and not be allowed to leave their unit until the proper personnel relief including: RN's, LPNs, Certified Medicine Technicians (CMTs), Certified Nurse Aide (CNAs) and Nurse Aide (NAs), unit helpers and feeding assistants; -Emergency Plan will be activated including use of ancillary staff to assist in necessary areas as training provides as needed; -All contracted nursing agencies will be notified; -If unavailable, nursing administration will be called to provide coverage and to assure safe levels of care and adherence to state requirements. Review of the facility policy, Policy and Procedure for Call Light System, updated January 2022, showed the following: -The facility will maintain a call light system in the facility for all residents and staff members to use for assistance and or emergencies; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All nursing staff will be educated and trained on constant checking of the monitors to ensure call lights are being answered timely and that each resident has their call light within reach of using; -The system will allow each charge nurse or Special Care Unit (SCU) supervisor to carry beepers with them while on duty during their shift; -The beepers will alert the charge nurse immediately when assistance is needed; -Computer monitors are also displayed at each nurse's station as well on the East and [NAME] halls for a visual alert for CNA's to see, in order to know which room has called for assistance; -The first initial green light call which will alert staff when a resident has called for assistance and will go directly to the charge nurse beepers; -If this call is not answered within three minutes a second call or yellow call will go to the charge nurse or SCU supervisor that this light has not been answered; -At five minutes a red call signal will alert the charge nurse or SCU supervisor, displaying a resident has had their call light on for at least a total of eight minutes; -These calls will also be displayed on the computer monitor according to color; -The Director of Nursing (DON) and/or administrator have the ability to run a report to monitor the time and effectiveness of the call light system for all units of the facility. Review of the undated facility policy, Routine Resident Care/ADLs, showed the following: -Routine care rendered by all nursing staff includes attention to physical, emotional, social, spiritual, and life style preferences according to individual job descriptions; -Residents are given routine daily care by a certified nursing assistant (CNA) under the supervision of a licensed nurse; -Routine care by a nursing assistant includes the following: a. Assisting resident in personal care, bathing, dressing, eating, and encouraging participation in physical, social, and recreational activities; b. Providing privacy and personal space for residents; c. Observing and recording all aspects of personal care including bathing, food intake, ambulation activities, elimination and vital signs in the resident care charting record and resident food/group intake record in the resident's medical record. Review of the undated facility policy, Showers and Nail Care, showed the following: -Each resident will be showered or tub bathed two times a week and as needed; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bed baths are given on days residents do not receive a shower or tub bath; -A resident has the right to refuse a shower or tub bath, and be given a bed bath; -Nursing will document on shower/tub bath refusals; -Residents' nails (fingers and toes) will be cleaned after their shower or tub bath; -A CNA will trim nails unless resident is diabetic or on anticoagulant therapy; -Residents that are diabetic or on anticoagulant therapy will be trimmed by the nurse. Review showed the facility assessment did not address how many staff the facility should have. 1. Review of Resident #14's shower sheets, dated December 2021 and January 2022, showed the following: -The resident received baths on 12/4/21, 12/6/21, 12/13/21, 12/18/21 and 12/20/21; -The resident received baths on 1/4/22, 1/6/22, 1/13/22, 1/18/22 and 1/20/22; -The resident missed three baths/showers in December; -The resident missed four baths/showers in January; -The resident was scheduled to get a bath/shower two times a week. Review of the resident's February 2022 shower sheets showed the residents received baths on 2/1/22, 2/8/22, 2/15/22 and 2/22/22. The resident missed three showers in February. Review of the resident's annual MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Minimal depression; -Decision making ability was left blank; -Extensive assistance by one staff member for personal hygiene, dressing, and bathing; -Extensive assistance by two staff members for toileting; -The resident is frequently incontinent of bowel and bladder. Review of the resident's call light log showed on 2/10/22 the resident activated his/her call light at 11:28 P.M. and it was answered at 00:17 A.M. (49 minutes). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/14/22 at 12:44 P.M., showed the resident's fingernails were approximately 1/4 inch long and had food debris under the fingernails and around the nail bed. During an interview on 2/14/22 at 12:44 P.M., the resident said the following: -Sometimes it takes a long time to get his/her call light answered; -He/She does not always get his/her bath; -He/She was supposed to get two baths a week; -He/She would like two baths a week; -His/Her fingernails were dirty and needed to be trimmed. 2. Review of Resident #21's face sheet showed the resident's diagnoses include cerebral infarction (damage to the tissues in the brain due to a loss of oxygen to the area), hypertension (high blood pressure), diabetes mellitus (a group of diseases that result in too much sugar in the blood), and major depressive disorder (a persistent feeling of sadness or loss of interest that can lead to behavioral or physical symptoms). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -No behavior symptoms or rejection of care; -Independent decision making ability; -Extensive assistance by one staff member for dressing, toileting, and bathing; -Limited assistance by one staff member for personal hygiene; -Occasionally incontinent of bladder. Review of the call light log printed on 6/22/22 showed the following: -On 2/12/22 the resident activated his/her call light at 6:30 A.M. and it was answered at 6:58 A.M. (28 minutes); -On 2/13/22 the resident activated his/her call light at 6:24 A.M. and it was answered at 6:53 A.M. (29 minutes); -On 2/14/22 the resident activated his/her call light at 6:48 A.M. and it was answered at 7:38 A.M. (50 minutes); -On 2/14/22 the resident activated his/her call light at 8:16 A.M. and it was answered at 8:40 A.M. (24 minutes); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 2/15/22 the resident activated his/her call light at 6:10 A.M. and it was answered at 6:25 A.M. (15 minutes); -On 2/15/22 the resident activated his/her call light at 6:42 A.M. and it was answered at 6:53 A.M. (11 minutes). During an interview on 2/15/22 at 9:28 A.M., the resident said the following: -His/Her call light does not get answered by CNA L, CNA L will come in and answer his/her roommate's call light but not his/hers; -Today he/she turned on his/her call light at 6:10 A.M. and it did not get answered by CNA L; -He/She [NAME] like there was not enough staff to meet the residents' needs; -The facility was short staffed on every shift; -Overnight shift only had one nurse and one CNA on the hall. 3. Review of Resident #54's face sheet showed the resident's diagnoses included congestive heart failure (a progressive condition that affects the pumping power of the heart muscle), essential hypertension (high blood pressure), chronic pain, generalized anxiety (severe, ongoing anxiety that interferes with daily activities), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Independent decision making; -Supervision only for completion of personal hygiene; -Limited assistance by one staff member for dressing and toileting; -Occasionally incontinent of bladder. During an interview on 2/15/22 at 10:00 A.M., the resident said that on the night shift it can take anywhere between 15 minutes to an hour for the call light to be answered. He/She did not feel like there was enough staff across the board to meet all of the residents' needs. Review of the call light log printed on 2/22/22 showed on 2/11/22 the resident activated his/her call light at 5:14 A.M. and it was answered at 6:01 A.M. (47 minutes). 4. Review of Resident #43's face sheet showed diagnoses of major depressive disorder, severe with psychotic symptoms, muscle spasm and chronic pain. Review of the resident's admission MDS, dated [DATE], showed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Moderate cognitive impairment; -Required extensive physical assistance of two or more staff members bed mobility, transfers, hygiene, bathing, and toilet use. Review of the resident's Care Plan, updated 7/11/19, showed ADL's - resident required assistance with all ADL tasks with one to two assist for bed mobility, transfer, toileting, grooming, bathing, and dressing. Review of the resident's shower/bath record, dated December 2021, showed the resident received a shower on 12/2/21 and 12/30/21, and no other dates for the month of December. There was no documentation the resident refused showers/bathing. The resident missed seven scheduled showers. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Required extensive physical assistance of two or more staff members for bed mobility, and hygiene; -Dependent on staff for transfers, bathing, and toilet use; -Limited range of motion in both lower extremities. Review of the resident's shower/bath record, dated January 2022, showed the resident received a shower/bath on 1/4/22, 1/11/22 and 1/18/22 and no other dates for the month of January. There was no documentation the resident refused shower/bathing. The resident missed five scheduled showers. Review of the resident's nurses notes, dated 12/1/21-2/22/22, showed no evidence of the resident receiving a bath or shower. Observation on 2/14/22 at 11:57 A.M., showed the following: -The resident sat in his/her wheelchair in his/her room; -His/her hair was greasy, there was dry skin on legs and arms, and the resident's fingernails were long with brown debris under the nails. During an interview on 2/14/22 at 11:57 A.M., the resident said the following: -He/She was lucky to get one bath a week; -He/She would like more baths, at least two a week; -When he/she goes too long without a bath he/she feels itchy. Review of the resident's shower/bath record, dated 2/1/22-2/22/22, showed staff documented the resident received a shower/bath on 2/14/22 and 2/18/22 and no other dates during the month of February. There was no documentation the resident refused showers/bathing. The resident missed four scheduled showers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #28's care plan, dated 7/9/21, showed the following: -ADL: All Tasks required limited to extensive assistance of staff; -Anticipate resident's needs; provide care morning and evening; -Provide grooming and hygiene needs. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis of heart failure and Alzheimer's disease; -Required extensive physical assistance of two or more staff members for bed mobility, transfers, toilet use, and bathing; -Dependent on staff for personal hygiene; -Indwelling urinary catheter, frequently incontinent of bowel. Review of the resident's shower/bath record, dated December 2021, showed no evidence staff gave the resident a shower or bath. There was no documentation the resident refused showers/bathing. Review of the resident's shower/bath record, dated January 2022, showed the resident received two showers/baths for the month of January on 1/12/22 and 1/19/22. There was no documentation the resident refused showers/bathing. The resident missed seven scheduled showers. Review of the resident's shower/bath record, dated 2/1/22-2/22/22, showed staff documented the resident received one shower/bath on 2/1/22. There was no documentation the resident refused showers/bathing. The resident missed five scheduled showers. Observation on 2/14/22 at 12:04 P.M., in the resident's room showed the following: -The resident sat in his/her recliner; -His/her hair was long and greasy; -His/her facial hair was long and unkempt; -His/her finger nails were long with brown debris under the nails. 6, During an interview on 2/16/22 at 8:20 A.M., and 2/23/22 at 12:15 P.M., CNA K said the following: -Residents are scheduled to get two showers a week; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She does not feel two aides on the 200 hall was enough staff to meet the needs of the residents; -Residents did not always get checked on or incontinent briefs changed every two hours; -Residents did not always get two showers a week; -Sometimes it takes a while to answer call lights; -Most all the residents on the 200 hall required total care and transfers with a Hoyer lift. During an interview on 2/16/22 at 2:22 P.M., LPN A said the following: -Residents are given a bath two times a week unless the resident refuses; -He/She does not feel like he/she has enough staff to meet the residents' needs; -Many times housekeeping and activities have to help with nursing tasks to make it through the day; -Call lights should be answered within a couple of minutes. During an interview on 2/16/22 at 3:12 P.M., LPN D said the following: -Call lights should be answered in less than three minutes; -If a call light goes off longer than a few minutes the color on the monitor changes to yellow and then to red if it continues to go off longer than 10 minutes. During an interview on 2/25/22 at 8:30 A.M., the DON said the following: -Residents should be checked at a minimum every two hours. -Minimum showers should be two times a week. During an interview on on 2/23/22 at 3:03 P.M. and on 2/25/22 at 8:30 A.M., the administrator said the following: -Adequate staffing had been identified as a problem and have a process improvement plan in Quality Assurance committee; -Residents should receive a minimum of two showers a week; -It should be documented on the shower papers, or in the nurses notes if a resident refused his/her shower/ bath; -It was left up to the charge nurses to make sure the residents are getting two baths a week; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She was unaware the residents were not receiving two baths a week; -She was unaware of the requirements for call lights. MO 00170735 MO 00171180 MO 00171181 MO 00172210 MO 00173431 MO 00174442 MO 00176039 MO 00176164 MO 00179843 45563

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview and record review, the facility failed to ensure three staff members (Feed Aide/Activity Aide BB, Feed Aide CC and Feed Aide DD) had successfully completed a State-approved training program for feeding assistants and failed to ensure these staff members were not providing feeding assistance to five residents (Residents #11, #18, #28, #44, and #48) in a sample of 19 residents with complicated feeding problems. The facility census was 55. Review of the undated facility policy, Paid Feeding Assistant, showed the following: -The regulation requires that paid feeding assistants must work under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), and they must call the supervisory nurse in case of emergency; -Therefore, a facility that has received a waiver and does not have either an RN or LPN available in the building cannot use paid feeding assistants during those times; Interdisciplinary Team (IDT) Assessment of Resident Eligibility for Feeding Assistance: -When determining whether a resident may be assisted by a paid feeding assistant, facility staff must base resident selection on the IDT's current assessment of the resident's condition and the resident's latest comprehensive assessment and plan of care; -Appropriateness should be reflected in the resident's comprehensive care plan; -Paid feeding assistants are only permitted to assist residents who have no complicated eating or drinking problems as determined by their comprehensive assessment; -Examples of residents that a paid feeding assistant may assist include residents who are independent in eating and/or those who have some degree of minimal dependence, such as needing cueing or partial assistance, as long as they do not have complicated eating or drinking problems; -Paid feeding assistants are not permitted to assist residents who have complicated eating problems, such as (but not limited to) difficulty swallowing, recurrent lung aspirations, or who receive nutrition through parenteral or enteral means; -Nurses or nurse aides must continue to assist residents who require the assistance of staff with more specialized training to eat or drink; -Paid feeding assistants may assist eligible residents to eat or drink at meal times, snack times, or during activities or social events as needed, whenever the facility can provide the necessary supervision. 1. Review of Feed Aide/Activity Aide BB's employee file showed no documentation he/she completed a State-approved training course for paid feeding assistants. (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Feed Aide CC's employee file showed no documentation he/she completed a State-approved training course for paid feeding assistants. 3. Review of Feed Aide DD's employee file showed no documentation he/she completed a State-approved training course for paid feeding assistants. 4. Review of Resident #11's face sheet showed the resident's diagnoses include: dementia, gastro-esophageal reflux disease (when stomach acid frequently flows back into the tube connecting your mouth and stomach), recurrent pneumonitis (infection of the lungs due to inhalation of food or emesis), dysphagia (difficulty swallowing), and history of abnormal weight loss. Review of the resident's care plan, updated 10/15/19, showed the following: -Nutritional Status: Requires pureed diet with nectar thick liquids; -Assess response to diet and request order for modification as needed; -Allow time to swallow, do not rush; -Offer small bites, remind to swallow if needed; -Feed/position at 90 degrees when eating; -Support head/torso in upright position when eating; -Monitor for signs and symptoms of aspiration and notify physician accordingly; -Adequate servings of offered foods and fluids to maintain adequate nutrition and hydration; -Pureed diet with nectar thick liquids, nutritional supplements as ordered. Review of the resident's Physician's Orders, dated 10/13/21, showed the resident was on a pureed diet with nectar thickened liquids. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 2/4/22, showed staff assessed the resident as: -Severely cognitively impaired; -Dependent on staff for eating; -Held food in mouth/cheeks or residual food in mouth after meals; -Coughed or choked during meals or when swallowing medications; -Mechanically altered diet. 5. Review of Resident #18's care plan, dated 9/6/18, showed the following: (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident requires assistance with Activities of Daily Living (ADL) task performance as follows: one to two assist for eating; - Monitor for signs/symptoms of choking, aspiration, etc. Report immediately of any concerns; - Pureed diet, aspiration precautions (sit upright in chair at 90 degrees, provide 30 minute rest period prior to and after feeding, use straw for liquid, use right side of mouth, check cheek for pocketing); Review of the resident's annual MDS assessment, dated 11/11/21, showed staff assessed the resident as: - Severely cognitively impaired; - No rejection of care; - Required total dependence of one to two staff members with transfers, dressing, eating, toileting, personal hygiene, and bathing; - Coughed or choked during meals or when swallowing medications. Review of resident's physician orders, dated 1/25/22, showed an order for mechanical soft diet, thin liquids, drink with cup. No straw. Hold cup in right hand. 6. Review of Resident #28's care plan, updated 7/29/21, showed the following: -Nutritional Status: Resident is on a regular diet, no added salt, no concentrated sweets; -Resident's disease symptoms will be managed as evidenced by no loose stools, abdominal cramping or bowel distention; -Provide diet per physician's order; -Cater to food preferences; -Encourage resident participation in meal choices. Review of the resident's physician's orders, dated 7/29/21, showed the resident was on a regular diet, no added salt, no concentrated sweets. Review of the resident's quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Diagnoses of heart failure, Alzheimer's disease, anxiety disorder, depression; -Required supervision with eating; (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No chewing or swallowing problems. Review of the resident's nurses notes, dated 1/26/22, showed the following: -Physician contacted, resident is not safe to transfer or eat since adding lorazepam (medication for anxiety) 2 milligram (mg) three times per day; -Order received to decrease lorazepam 1 mg to two times daily. Review of the resident's nurses notes, dated 1/27/2022, showed the following: -Resident not swallowing his/her food; -Pocketing food (holding food in cheeks), nothing was helping. Review of the resident's physician's orders, dated 1/27/22, showed the following: -Speech therapy evaluate and treat for difficulty chewing and swallowing: -Resident's diet changed to mechanical soft, nectar thick liquids, no added salt, no concentrated sweets. Review of the resident's Speech Therapy Evaluation, dated 1/27/22, showed the following: -Resident with a history of dysphagia (difficulty swallowing); -Dependent on nursing care for ADL's; -Resident had been on a regular diet/thin liquids and ate independently with little to no nursing assistance; -Referral to SLP (Speech Language Pathologist) now due to nursing noticing episodes of resident choking on food, coughing, not responsive to food in his/her mouth, letting liquids/ food dribble out of his/her mouth during meals for the last two to three days; -Swallowing difficulties are likely caused by Alzheimer's disease and swallowing complications from it; -SLP was required now to evaluate resident and determine safe diet with decreased coughing/choking or signs and symptoms of aspiration and to educate caregivers; -Precautions: Aspiration risk, no thin liquids, sit 90 degrees during and 20 minutes after eating; -Coughing during evaluation on regular diet/thin liquids consistently occurred. 7. Review of Resident #44's face sheet showed resident had diagnoses that included moderate intellectual disabilities and cerebral palsy (a birth defect that causes abnormal brain development, movement, muscle tone (floppy or rigid limbs) and posture). (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, updated on 3/30/21, showed the following: -He/She required a pureed diet with honey thick liquids; -Aspiration precautions; -Offer small bites, remind to swallow if needed; -Allow time to swallow, do not rush; -When eating, feed resident at 90 degree position; -Monitor for signs and symptoms of aspiration and notify physician accordingly. Review of the resident's physician order sheet, dated 11/15/21, showed the following: -Pureed diet with honey thick liquid; -Aspiration precautions. Review of the resident's annual MDS, dated [DATE], showed staff assessed the resident as: -Severely impaired cognition; -Dependant of one staff member for eating; -He/She had the following signs and symptoms of possible swallowing disorder: loss of liquids/solids from mouth when eating or drinking and held food or residual food in mouth/cheeks in mouth after meals; -Required substantial/maximal assistance to eat with a helper doing more than half the effort. 8. Review of the Resident #48's face sheet showed the resident had diagnoses which included dementia, asthma, gastro-esophageal reflux disease, and dysphagia. Review of the resident's care plan, updated 1/24/21, showed the following: -Nutritional Status: At risk for poor nutritional status related to difficulty swallowing secondary to dysphagia; -Resident will be adequately nourished as evidenced by absence of significant weight loss; -Provide diet per physician's order; -Nectar thicken liquids, pureed no concentrated sweets diet, may have pureed regular dessert if request; -Edentulous (no natural teeth); (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Fed by staff. Review of the resident's quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -New, signs and symptoms of possible swallowing disorder: loss of liquids/solids from mouth when eating or drinking present, holding food in mouth/cheeks or residual food in mouth after meals present, coughing or choking during meals or when swallowing medications present, complaints of difficulty or pain with swallowing present; -Mechanically altered therapeutic diet; -Dependent on staff for eating. Review of the resident's physician's orders, dated 1/11/22, showed orders for a pureed diet, no concentrated sweets, nectar thick liquids, may have regular pureed dessert upon request. 9. Observation on 2/14/22 at 12:20 P.M., showed Feed Aide DD assisted Residents #18, #28 and #48 with lunch. During an interview on 2/14/22 at 12:22 P.M., Feed Aide DD said the following: -He/She was not a CNA; -He/She watched videos and signed a check off sheet to be trained as a feed aide; -Resident #48 was on nectar thickened liquids; -He/She did not know which residents were on aspiration precautions. 10. Observation on 2/15/22 at 11:08 A.M. showed Feed Aide CC assisted Resident #18 with lunch. During an interview on 2/15/22 at 11:08 Feed Aide CC said the following: -He/She was not a CNA; -He/She watched movies to be a feeding assistant; -Resident #18 was served regular liquids and ground meat. 11. During an interview on 2/15/22 at 9:30 A.M., Feed Aide/Activity Aide BB said the following: -He/She was not a CNA; -He/She watched training videos to get trained as a feed aide. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Homes, Tri-County	601 North Galloway Road Vandalia, MO 63382

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/15/22 at 11:15 A.M., showed Feed Aide/Activity Aide BB assisted Residents #44 and #11 with lunch. Observation on 2/16/22 at 11:45 A.M., showed the following; -Resident #11 sat in his/her wheelchair parallel to the dining room table; -Staff served the resident a pureed diet of meat, carrots, cauliflower, chocolate pudding, and two nectar thickened drinks; -Feed Aide BB fed the resident his/her meal; -Feed Aide BB mixed the resident's meat with his/her carrots and cauliflower; -The resident occasionally coughed during the meal. Observation on 2/22/22 at 11:50 A.M., showed the following: -Resident #11 sat in his/her wheelchair at the dining room table; -Staff served the resident a pureed meal with nectar thick liquids; -Feed Aide BB fed the resident; -The resident occasionally coughed and belched during the meal. During an interview on 2/15/22 at 11:15 A.M., Feed Aide/Activity Aide BB said Resident #44 had a pureed diet and Resident #11 had nectar thickened liquids. 12. During an interview on 2/15/22 at 11:43 A.M., the Speech Therapist said Residents #11, #28 and #48 were on aspiration precautions. During an interview on 2/16/22 at 11:48 A.M., the MDS coordinator said the following: -Most of the residents that are fed by staff are in this dining room (east dining room); -There are aspiration risk residents in both the east and west dining rooms; -Paid feeding assistants watch feeding videos and are supervised when they first start for their training; -Paid feeding assistants help feed residents that are on aspiration precautions and mechanically altered diets. During an interview on 2/23/22 at 3:03 P.M., the Director of Nursing (DON) said paid feeding assistants have to attend a state approved training course. (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/23/22 at 5:00 P.M., the administrator said when the previous DON was at the facility, as long as a licensed practical nurse (LPN) supervised the feed aides, the feed aides were okay to feed altered diets. 38016

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to implement their water management program to identify and reduce the risk of Legionella bacteria (cause of Legionnaire's disease - a severe form of pneumonia) growth and spread. The facility failed to ensure facility staff washed their hands after each direct resident contact when indicated by professional standards for one resident (Resident #207) in a sample of 19 residents and one additional resident (Resident #1). The facility also failed to ensure procedures were implemented to address prevention of Tuberculosis (TB) for six employees, in a review of ten sampled employees hired since the previous survey. The facility census was 55. Review of the facility's undated policy,Tuberculosis Testings, showed the following: -The licensed nurse will administer the purified protein derivative (PPD) skin test as directed upon the first day of orientation to all employees and volunteers. The licensed nurse will also be responsible for administration of the second test step and record keeping. This test record will be kept with each employee or volunteer file. This DON designee will also be responsible to assure that ANNUAL testing is completed upon HIRE and properly recorded. -If the initial result is 0-9 mm, the second test should be given at least one week and no more than three weeks after the first test. (The policy did not direct the facility staff to administer the first step of the tuberculin skin test (TST) prior to start date (first date of compensation) and to ensure the first step was read on or before the new employee's start date.) 1. Review of Dietary Staff KK's employee file showed he/she was hired on 10/4/21. Review of Dietary Staff KK's Initial Employment and Annual Tuberculosis Testing showed the following: -First tuberculin skin test (TST) administered on 9/29/21, results read on 10/1/21; -No evidence a second TST was administered within three weeks after the first TST was administered on 9/29/21 to complete the two-step TST, and no evidence of a two-step TST prior to employment. 2. Review of Unit Helper LL's Initial Employment and Annual Tuberculosis Testing showed the following: -Hire date 5/17/21; -First TST administered on 5/7/21, results read on 5/9/21; -No evidence a second TST was administered within three weeks after the first TST was administered on 5/7/21 to complete the two-step TST, and no evidence of a two-step TST prior to employment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of Secretary/Restorative Aide's employee file showed he/she was hired on 7/22/19. Review of Secretary/Restorative Aide's Initial Employment and Annual Tuberculosis Testing showed the following: -He/She received a one-step TST on 1/11/19, 1/7/20, 1/7/21 and 1/5/22; -No evidence a two-step TST completed prior to or within three weeks after employment. 4. Review of Social Services Staff AA's employee file showed he/she was hired on 1/14/22. Review of Social Services Staff AA's Initial Employment and Annual Tuberculosis Testing showed the following: -First TST administered on 1/12/22, results read on 1/14/22; -No evidence a second TST was administered within three weeks after the first TST was administered on 1/14/22 to complete the two-step TST, and no evidence of a two-step TST prior to employment. 5. Review of Nurse Assistant Q's employee file showed the following: -He/She was hired on 4/13/21; -No evidence of anyTST'ss completed. 6. Review of Registered Nurse (RN) C's employee file showed he/she was hired on 3/15/21. Review of RN C's Initial Employment and Annual Tuberculosis Testing showed the following: -First TST administered on 3/9/21, results read on 3/11/21; -No evidence a second TST was administered within three weeks after the first TST was administered on 3/9/21, and no evidence of a two-step TST prior to employment. 7. During an interview on 3/18/22 at 2:00 P.M., the Minimum Data Set (MDS) Coordinator said the facility had not had a director of nursing (DON) for months so licensed staff worked together as a team to administer and read the employee TB tests. She was not responsible for tracking the testing, but administered the TB tests to new hires if the administrator or Office Manager/Human Resources staff asked him/her to administer the test. The new staff were directed to go to a charge nurse 48 hours after the test was administered so the charge nurse could read the results. He/She and other licensed nurses/charge nurses read the results when the new staff approached them for the results. He/She did not track or provide any information to the new staff about receiving the second TB test after the first test was read. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/18/22 at 2:15 P.M., the administrator said the former DON used to be responsible for the employee TB testing. When the former DON left employment at the facility in August 2021, the MDS Coordinator was responsible for the employee TB testing. When a new staff were at the facility completing pre-hire paperwork, she or the Office Manager/HumanResourcess staff sent the new staff to the MDS Coordinator or another licensed nurse (if the MDS Coordinator was not in the building) to administer the TB test. The MDS Coordinator was responsible to ensure the results of the TB tests were read and the second test was given. The Office Manager/Human Resources staff was responsible for overseeing this process. During an interview on 3/18/22 at 3:25 P.M., the Office Manager/Human Resources Staff said she completed a new hire checklist at pre-hire which included the TB tests. She gave the form to the MDS Coordinator or a licensed nurse who was available to complete the TB tests. The nurse administered the TB test and then told the new employee when they were to come back to the facility so a nurse could read the results. He/She was not sure who was responsible for ensuring the new employee received the second TB test. 8. Review of the facility's Handwashing Policy, updated 1/1/22, showed the following: -Proper handwashing technique is used for the prevention of transmission of infectious disease; -All personnel working in the facility are required to wash their hands before and after resident contact or use 60% alcohol-based sanitizer, before and after performing any procedure, after sneezing or blowing nose, after using the toilet, before handling food, and when hands become obviously soiled. 9. Review of Resident #207's face sheet showed the following: -The resident's diagnoses include fracture of lumbosacral spine and pelvis (a broken bone in the lower spine and pelvic region), chronic congestive heart failure (a progressive condition that affects the pumping power of the heart muscle), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), and diabetes mellitus (a group of diseases that result in too much sugar in the blood). Review of the resident's February 2022 physician order sheet showed the following: -Clean open area to coccyx (tailbone) with wound cleanser, apply hydrogel (an insoluble hydrophilic gel used to treat wounds) and cover with a dry dressing daily; -Cleanse areas on malleous (outer ankle) with wound cleanser, apply calmoseptine (a moisture barrier that protects and helps skin irritations) and cover with bordered foam dressing to bilateral outer ankles daily. Observation on 2/15/21 at 1:40 P.M., showed the following: -The resident lay on his/her right side in bed for a dressing change to his/her coccyx; -Licensed Practical Nurse (LPN) D removed the old soiled wound dressing. The dressing had a quarter size amount of light brown drainage; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-LPN D washed his/her hands and applied new gloves; -LPN D cleansed the wound on the resident's coccyx with wound cleanser; -LPN D removed his/her soiled gloves, washed his/her hands, and applied new gloves; -LPN D repositioned the resident with his/her gloved hands; -LPN D applied hydrogel to the wound on the coccyx with a Q-tip; -With the same gloved hand that touched the resident's hip, LPN D touched the center of the clean dressing and applied the dressing directly to the resident's coccyx wound; -The wound on the resident's coccyx was noted to have a small open pink area, with the majority of the wound covered in white tissue; -LPN D gathered his/her supplies/trash and threw them away; -LPN D removed his/her soiled gloves and washed his/her hands. During an interview on 2/16/22 at 3:12 P.M., LPN D said the following: -He/She was not sure why he/she touched the center of the clean dressing with a soiled glove, prior to applying the dressing to the resident's wound; -He/She should not have touched a clean dressing with a soiled glove. 10. Review of Resident #1's quarterly MDS, dated [DATE], showed the following: -Diagnoses include diabetes mellitus (a group of diseases that result in too much sugar in the blood), hemiplegia and hemiparesis following cerebral infarction affecting left side, cerebrovascular accident (damage to the brain from interruption of its blood supply). -Cognitively intact; -Frequently incontinent of bowel and bladder; -Extensive assistance of two staff members for toileting. Observation on 2/16/22 at 7:03 A.M., showed the following: -The resident lay in bed; -He/she was incontinent of stool; -CNA K provided frontal peri-care; -With gloved hands, Activity Director/Certified Nurse Aide (CNA) provided rectal peri-care; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Activity Director/CNA did not remove his/her soiled gloves; -While wearing the same gloves, the Activity Director/CNA applied a clean incontinence brief and pulled up the resident's pants; -Activity Director/CNA and CNA K transferred the resident from his/her bed to his/her wheelchair using the mechanical lift; -Activity Director/CNA removed gloves and washed hands. During an interview on 3/2/22 at 10:39 A.M., the Activity Director/CNA said the following: -Gloves should be changed after each resident contact and hands washed; -He/she does not know why he/she did not remove his/her soiled gloves and apply a different pair after washing his/her hands. 11. During an interview on 2/25/22 at 8:30 A.M., the Director of Nursing said the following: -She would expect all staff to wash their hands when performing resident care; -She would expect all staff to wash their hands as much as needed; -She would expect all staff to wash their hands between a contaminated task and a clean task. 12. Review of the facility policy, Legionella Policy and Water Management, revised January 2021, showed the following: -The facility is committed to the prevention, detection and control of water-borne contaminants; -1. As part of the infection prevention and control program, our facility has a water management program which is overseen by the maintenance department and the water management team; -The water management team: a. Administrator; b. Maintenance; c. Director of Nursing; d. Medical Director; -2. The team is to identify areas in the water system where Legionella can grow and spread in order to reduce the risk of Legionnaire's disease; -3. The CDC water prevention toolkit and ASHRAE recommendations have been used in developing a water management program; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-4. A detailed description and diagram of the water system in the facility will include: a. Water intake-come from the city; b. Cold water delivery-chillers; c. Heating-boilers; d. Hot water delivery-hot water heaters; e. Waste-out to sewer; -5. Identification of areas in the water system that could encourage the growth and spread of Legionella include: a. Water heaters; b. Filters; c. Showerheads; d. Hoses; e. Personal humidifiers; f. Medical machines such as CPAP; -6. Situations that could arise and lead to Legionella: a. Construction; b. Water main breaks; c. Changes in water source; d. Scale or sediment and stagnation; e. Water temperatures; f. Water pressure; g. Inadequate disinfection. -7. Measures used to control the spread of Legionella: a. Diagram of where control measures are applied; b. Monitor control limits; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. Documentation of the program; -8. The Water Management Program will be reviewed at least annually or as needed: a. The control limits are consistently not met; b. A major maintenance project; c. Water service change; d. Any diagnosis of disease associated with the water system. Record review showed no evidence facility staff identified areas in the water system where Legionella can grow and spread in order to reduce the risk of Legionnaire's disease according to their policy. During interview on 2/23/22 at 11:40 A.M., the Maintenance Supervisor said the following: -He has worked in the facility for three years and has been the Maintenance Supervisor for one year; -He does not do anything in regards to monitoring for Legionella. He was never told to do it. During interview on 2/23/22 at 5:00 P.M., the administrator said the Maintenance Supervisor was responsible for the water management program. MO00171180 MO00171181 MO00172908 42592

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 36219 Based on observation, interview, and record review, the facility failed to maintain the wireless call light system to ensure staff carried functioning pagers to alert them to residents' calls for staff assistance. The facility census was 55. Review of the facility policy, Policy and Procedure for Call Light System, updated January 2022, showed the following: -The facility will maintain a call light system in the facility for all residents and staff members to use for assistance and/or emergencies; -All nursing staff will be educated and trained on constant checking of the monitors to ensure call lights are being answered timely and that each resident has their call light within reach of using; -The system will allow each charge nurse or Special Care Unit (SCU) supervisor to carry beepers with them while on duty during their shift; -The beepers will alert the charge nurse immediately when assistance is needed; -Computer monitors are also displayed at each nurse's station as well on the East and [NAME] halls for a visual alert for CNAs to see, in order to know which room has called for assistance; -The first initial green light call which will alert staff when a resident has called for assistance and will go directly to the charge nurse beepers; -If this call is not answered within three minutes, a second call or yellow call will go to the charge nurse or SCU supervisor that this light has not been answered; -At five minutes, a red call signal will alert the charge nurse or SCU supervisor, displaying a resident has had their call light on for at least a total of eight minutes; -These calls will also be displayed on the computer monitor according to color; -Each charge nurse's cart will have a supply of batteries for the beepers; -The call light system will be tested weekly to ensure proper working condition; -If a charge nurse leaves the hall for any reason, the beeper will be passed off to the medication technician on duty or the charge nurse or supervisor in the facility, and that staff member will be in charge of ensuring CNAs are answering call lights in a timely manner; -If a call light is not working properly and cannot be fixed immediately, the resident will be temporarily moved to another room where the call light is functioning properly; -Staff is to notify the Director or Nursing (DON) and administrator of the faulty call light; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The DON and/or administrator have the ability to run a report to monitor the time and effectiveness of the call light system for all units of the facility. 1. Observation and interview on 2/16/22 at 6:15 A.M., showed the following: -A buzzing/vibrating sound at the nurses station; -Certified Medication Technician (CMT) I said the vibrating sound was the call light pager that was on the desk somewhere. The call light pager sounds when the call lights are in overtime; -Observation showed CMT I pushed a medication cart down the hall. Neither CMT I or any other staff responded to the call light pager. 2. Observation on 2/23/22 at 9:38 A.M., showed the call light pager vibrated as it sat on the nurses station desk. Additional observation showed no staff at the desk to acknowledge the call light pager. 3. Observation on 2/23/22 from 5:39 P.M. to 5:46 P.M., at the west nurses' desk showed a pager sat on the nurses desk. No staff were present in the area. 4. Observation on 2/23/22 at 6:48 P.M., at the west nurses' desk showed a pager sat on the nurses desk. The pager vibrated on the desk. No staff were present in the area. During interviews on 2/16/22 at 4:30 P.M. and 2/23/22 at 12:15 P.M., CNA K said the following: -The staff used to have pagers, but they came up missing one day and staff just don't have them anymore; -The wireless call light does not turn on the light over the resident's door; -The only way staff can tell a call light has been turned on is by looking at the monitor; -There was no audible noise when a call light is on; -For the 200 hall, monitors are at the end of the hall between 200 and 300 hall and there is one at the nurses desk; -Staff do not know if call lights are on if they are in a resident room or giving a shower; -If the call light goes to overtime it rolls over to the pager the charge nurse or the administrator had. During an interview on 2/23/22 at 10:00 A.M., Licensed Practical Nurse (LPN) A said the following: -CNA's used to have pagers to carry for the call light system; -The facility can not get pagers anymore; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Now there are just a few pagers that vibrate when a call light goes into overtime; -The charge nurse tried to carry the pager, or someone in administration will help and carry the pager; -A staff member was expected to have to pager to answer the call lights in overtime or make the CNAs aware of the call light. During an interview on 2/22/22 at 1:28 P.M., the DON said all staff used to have pagers that alerted them when a resident's call light was on. She was not sure why they don't all have them anymore. Now the staff have to go to the monitors and check them to see when a call light was on. During interviews on 2/23/22 at 5:00 P.M. and 2/25/22 at 8:30 A.M., the administrator said the following: -Each charge nurse should carry a pager; -The charge nurses should have the pagers near them; -The call light system was not audible; -When a call light is on, it is visible on the monitors and at the nurses desk; -The CNA staff used to carry the pagers; -Some of the pagers were broken and the CNA staff were not using them consistently; -The pagers were very expensive to replace; -She did not know what the requirements were for the facility's call light system in regards to their exception granted by the Department of Health and Senior Services. MO 001742100