STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to protect a resident's right to be treated with dignity and respect when staff entered the resident's room without the resident's or resident's representative's consent and removed personal belongings (Resident #9). The sample size was 20. The census was 90. Review of the facility's Resident Rights and Dignity Protocol, reviewed January 2024, showed:-Protocol: The facility recognizes the resident right to a quality of life that supports privacy, confidentiality, dignity, independent expression, choice and decision making consistent with State law and Federal regulation. Review of the facility's New Resident Information, required for signature within 24 hours of admission, showed:-Room Search Protocol. Revised November 2023; -Purpose: To assure the safety of resident, staff and visitors without violating Resident Rights, the Room Search Policy and Procedure has been established; -Policy: A resident's room may be searched if, after investigation, evidence suggests that the resident has violated facility policy regarding the possession of contraband, prohibited items or stolen property. If recreational marijuana is legalized, you still may not have it in the facility or smoke it; -Procedure: The facility staff should not conduct searches of a resident or their personal belongings unless the resident or resident representative agrees to a voluntary search and understands the reason for the search, if they refuse then legal authorities should be notified to assist as allowed by law. Review of the resident's discharge Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/18/25, showed:-discharged to the hospital on 4/18/25;-Exhibited no behaviors;-Diagnoses included diabetes, anxiety and bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Review of the resident's progress note, showed:-4/21/25 at 3:58 P.M., showed a note by the Administrator. Informed by the Director of Nursing (DON) that resident was observed with a vaporizer in room last week. The DON accompanied this writer to resident's room. Search of resident's room resulted in finding two vape pens, two boxes of wooden matches, one lighter, one vape/electric cigarette battery and six bags of edibles. All items removed from room and locked in administrator's office. Storing any smoking supplies in residents' rooms is a violation of facility policy. Having marijuana on facility property is in violation of facility policy;-4/21/25 at 4:19 P.M., showed a note by the administrator. Will discuss smoking supplies found in room with resident and family/responsible party upon return from the hospital. Review of the resident's census report, showed he/she returned from the hospital on 5/6/25. During an interview on 9/10/25 at 1:04 P.M., the resident said he/she was in the hospital for an extended amount of time. Three days after he/she was admitted to the hospital, the Administrator searched his/her room closet without his/her consent and took six bags of marijuana infused edibles and two vape pens. The resident knew he/she could not smoke marijuana at the facility but did not realize he/she could not eat it. He/She did not have an issue with the facility saying he/she could not have the items. The resident was concerned because they searched his/her room without his/her knowledge or consent. The resident found out (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
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her room was searched by the Administrator and DON from staff at the facility. During an interview on 9/10/25 at 1:20 P.M., the Administrator said she was informed by staff the resident had marijuana in his/her room. She and the DON searched the resident's room and found six bags of marijuana infused edibles and two vaporizer pens. She confiscated the items and called the resident's family member to pick them up. The resident was in the hospital when the room was searched. The Administrator could not recall if she obtained permission from the resident's representative prior to searching the room but did document the occurrence. During an interview on 9/12/25 at approximately 9:30 A.M., the Administrator said she did not obtain permission from the resident or representative prior to searching his/her room. The items were returned to the family, and it was explained that the items were not permitted in the facility. She expected the policies to be followed and resident consent prior to searching a resident's room. 14541571454156

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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 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** Based on observation, interview and record review, the facility failed to provide a safe, comfortable, homelike environment by failing to clean one resident's bathroom after a plumbing issue (Resident #77), failing to clean one resident's wheelchair (Resident #16), failing to clean one resident's room (Resident #37) and failing to keep temperature logs on five residents with personal refrigerators (Resident #11, Resident #48, Resident #17, Resident #4 and Resident #6) The sample was 20. The census is 90. Review of the facility's 100 hall housekeeping checklist, undated, showed;-Sweep/mop soiled closets wipe walls and reduce odors;-Empty trash cans;-Dust top of rooms, light fixtures, nightstands, counter tops, dresser, dispensers, and window sills;-Clean and disinfect sinks, beds. And high touch areas and items;-Sweep rooms;-Mop floor;-Clean and disinfect inside and outside of toilets, top to bottom;-Clean and disinfect shower areas and tubs; -Dust vents;-Sweep floor;-Mop floor including inside of showers. 1.Review of Resident #77's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 6/12/25, showed:-Cognitively intact;-Independent with bed to chair and chair to bed transfers and toilet transfers;-Uses a manual wheelchair;-The resident has an indwelling urinary catheter (a tube inserted into the bladder that drains urine);-Diagnoses included neurogenic bladder (inability to urinate), depression, muscle weakness, and spinal stenosis (narrowing of the spinal canal causing pain). Observation and interview on 9/10/25 at 2:37 P.M., showed the resident was self-propelling in his/her wheelchair to the shower room on 100 hall. The resident said his/her bathroom toilet was backed up bad and there was a large amount of bowel moment on the bathroom floor, and he/she was instructed by nursing staff to empty his/her urinary catheter bag in the shower room. The resident's bathroom had brown water overflowing out of the toilet and large pieces of bowel movement on the floor. Bowel movement oozed on the side of the toilet. Towels and a thin blanket lay on the floor of the bathroom, and was saturated with brown water. At 2:40 P.M., the Assistant Director of Nursing (ADON) entered the resident's bathroom and said he would call housekeeping and maintenance to get the bathroom clean, and get the toilet fixed. Observation and interview on 9/11/25 at 9:45 A.M., showed the resident's bathroom door was open and the toilet had brown water to the top, dried bowel movement on the side of the toilet, large chunks of dried bowel movement on the floor. A pink wash basin was sitting on top of the trash can in the resident's bathroom. A plunger was located next to the toilet. A soiled towel and thin blanket were on the bathroom floor. The resident said no one came to fix his/her toilet or clean his/her bathroom. The resident said the nursing staff instructed the resident to empty his/her urine from his/her catheter bag into the wash basin, dump it in the toilet but do not flush. The resident said he/she was not going to roll his/ her wheelchair over bowel movement to empty his/her catheter. The resident said he/she used the 100-hall shower room to empty his/her catheter during the night. During an interview on 9/11/25 at 9:45 A.M., Certified Nursing Assistant (CNA) B said he/she was not aware the resident's bathroom was soiled. CNA B said he/she thought someone from maintenance locked the bathroom door so the resident and staff did not use it. The bathroom should not have been left soiled overnight. CNA B thought the bathroom was disgusting. The nursing staff can clean most of it, but the housekeeper would have to come in and disinfect the toilet and floors. CNA B would not expect the resident to use the bathroom, and it was not homelike. During an interview on 9/11/25 at 1:20 P.M., the Housekeeping Supervisor said housekeeping staff are expected to clean and disinfect bathrooms daily and as needed. During an interview on 9/12/25 at 8:20 A.M., the Maintenance Director said he was aware the building was having some plumbing issues but was not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aware the resident's toilet had backed up. He expected staff to inform him verbally or fill out a work order to have it fixed. It was not homelike for the resident to have a backed-up toilet and soiled bathroom. During an interview on 9/12/25 at 9:15 A.M., the ADON and the Nurse Manager expected staff to clean the bathroom and have the housekeepers disinfect it. The bathroom should have been cleaned as soon as it happened and not have the resident have a soiled bathroom all night. 2. Review of Resident #16's quarterly MDS, dated [DATE], showed;-Cognitively intact;-Uses manual wheelchair;-Diagnoses included non-Alzheimer's dementia and anxiety. Observation and interview on 9/8/25 at 7:30 A.M., showed the resident sat in his/her wheelchair. The wheels on the wheelchair had food crumbs and dust on them. The area where the wheel connects to the wheelchair had large clumps of gray hair and dust on both sides. The resident said his/her wheelchair was disgusting and he/she would like it cleaned. The resident has never seen the facility staff clean wheelchairs. Observation on 9/9/25 at 11:19 A.M., 9/10/25 at 12:47 P.M., and 9/11/25 at 9:45 A.M., showed the resident sat in his/her wheelchair. The wheel on the resident's wheelchair had food crumbs and dust on them. The area where the wheel connects to the wheelchair had large clumps of gray hair and dust on both sides. During an interview on 9/11/25 at 9:45 A.M., CNA B said it is night shift aides who are responsible for cleaning the resident's wheelchair. There is no wheelchair cleaning schedule. CNA B said the resident's wheelchair needed to be cleaned. During an interview on 9/12/25 at 9:15 A.M., the ADON and Nurse Manager said there was no wheelchair cleaning schedule, and a schedule was just recently put in place. It is the responsibility of the CNAs to clean the residents' wheelchairs. They expected staff to clean wheelchairs if they are visibly soiled. 3. Review of Resident #37's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Diagnoses included non-Alzheimer's dementia, diabetes, hemiplegia (paralysis to one side of the body), stroke and seizures Observation on 9/8/25 at 7:44 A.M., 9/9/25 at 11:34 A.M. and 3:04 P.M., 9/11/25 at 1:20 P.M., showed the resident lay in bed. In the corner of the resident's room behind the resident's bed, lay a crumpled cup and face mask and a large black crumblike substance around the baseboards. The resident's nightstand had a large smear of brown matter. During an interview on 9/12/25 8:20 A.M., Housekeeper D said resident daily room cleaning includes cleaning sinks, floors, furniture, moving furniture out and sweeping behind the furniture. The bathrooms are also cleaned every day. During an interview on 9/11/25 at 1:20 P.M., the Housekeeping Supervisor said resident rooms are cleaned daily and the staff are expected to follow the housekeeping checklist. She expected the housekeeping staff to clean around the baseboards and pick up any trash, move the furniture and mop and sweep behind the furniture. 4. During an interview on 9/12/25 at 10:30 A.M., the Administrator said she expected staff to keep the bathrooms clean, report issues to the appropriate persons when a toilet backs up and she expected the bathroom to be cleaned as soon as it happens. She expected the residents' rooms to be cleaned every day, and floors swept. She expected staff to provide the residents a homelike environment. 5. Review of Resident #11's significant change MDS, dated [DATE], showed:-Cognitively intact;-Upper and lower extremity impairment on one side;-Diagnoses included chronic kidney disease and depression. Observation on 9/9/25 at 11:09 A.M., showed a mini refrigerator in the resident's room with no temperature log on or nearby the refrigerator, and no temperature gauge inside the refrigerator. The refrigerator contained yogurt and various beverages. During an interview, the resident said he/she wasn't sure if staff checked the temperature inside the refrigerator. Observation on 9/11/25 at 8:52 A.M., showed a mini refrigerator in the resident's room with no temperature log on or nearby the refrigerator. 6. Review of Resident #48's admission MDS, dated [DATE], showed:-Moderate cognitive impairment;-Lower extremity impairment on both sides;-Diagnoses included dementia and generalized muscle weakness. Observation on 9/9/25 at 11:04 A.M., (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed a mini refrigerator in the resident's room with no temperature log on or nearby the refrigerator. Observation on 9/10/25 at 7:53 A.M., showed a mini refrigerator in the resident's room with no temperature log on or nearby the refrigerator. The refrigerator contained V8 juices and other beverages. During an interview on 9/10/25 at 9:38 A.M., the resident did not understand questions regarding the temperature of his/her personal refrigerator. 7. Review of Resident #17's MDS, dated [DATE], showed:-Cognitive impairment;-No behaviors;-Utilizes a manual wheelchair;-Diagnoses included diabetes, dementia, anxiety and traumatic brain injury. Observation and interview on 9/8/25 at 9:07 A.M., showed the resident sat in his/her wheelchair in his/her room. A mini refrigerator sat on a stand in the resident's room. No temperature log was on or near the refrigerator. The resident said he/she used the refrigerator regularly and keeps milk in there. Observations on 9/9/25 at 10:59 A.M., 9/10/25 at 7:45 A.M. and 9/11/25 at 8:56 A.M., showed a mini refrigerator in the resident's room. No temperature log was observed on or near the refrigerator. 8. Review of Resident #4's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included high cholesterol, dementia, and psychotic disorder. Observation on 9/9/25 at 4:20 P.M., showed the resident had a personal mini refrigerator in the room. No temperature log sheet observed. Observation and interview on 9/11/25 at 8:53 A.M., showed the resident's refrigerator did not have a temperature log sheet. The resident said he/she had never seen any staff check the refrigerator. The refrigerator contained some milk and juices. The resident's roommate said staff were supposed to check the refrigerator's temperature daily, but nobody was doing it since the time he/she was moved to the room, which was approximately a year ago. 9. Review of Resident #6's annual MDS, dated [DATE], showed:-Moderately impaired cognition;-Diagnoses included diabetes, high cholesterol, high blood pressure, anxiety, depression and schizophrenia (a serious mental health condition that affects how people think, feel and behave). Observation and interview on 9/11/25 at 8:58 A.M., showed the resident had a personal mini refrigerator in the room, by the sink. A blank temperature log sheet was taped on the side of the refrigerator. The resident said he/she did not see any staff checking the refrigerator's temperature. He/She did not know what the piece of paper was for that was attached to the refrigerator. The refrigerator contained milk, chocolate milk and bags of salads. During an interview on 9/11/25 at 8:59 A.M., Housekeeping Aide H said they were not responsible for checking and logging temperature of the residents' personal refrigerators. He/She said the CNAs were responsible for that task. During an interview on 9/11/25 at 9:04 A.M., CNA P said the Certified Medication Technicians (CMT) used to check the temperature of the residents' personal refrigerators. He/She did not remember the last time they were being checked. He/She had not seen anyone check them lately. During an interview on 9/11/25 at 2:23 P.M., Housekeeping Aide D said housekeeping staff does not touch or monitor the temperatures of personal refrigerators in resident rooms. During an interview on 9/11/25 at 2:50 P.M., CNA B said dietary is the only department that checks the refrigerators in their kitchen. 10. During an interview on 9/12/25 at 10:49 A.M., the Administrator said housekeeping is responsible for monitoring temperatures inside resident personal refrigerators. She is unsure how often the refrigerator temperatures are checked. They should be checked routinely, and housekeeping should have some system that should be in place.1454154

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to ensure residents requiring assistance with ADLs (activities of daily living) received the necessary services to maintain adequate personal hygiene in accordance with their needs and preferences (Residents #37, #48, and #71). The sample was 20. The census was 90.Review of the facility's Personal Care Needs policy, reviewed 1/2024, showed:-Protocol: The facility strives to promote a healthy environment and prevent infection by meeting the personal care needs of the residents. The facility also provides the needed support when the resident performs their ADLs. The interdisciplinary plan of care (IPOC) will address the individual needs and preferences of the resident. Personal care and ADL support will be provided according to the resident plan of care. Personal care and support include but is not limited to the following: -Assistance with meals; -Bath/shower; -Grooming/dressing; -Nail care; -Peri-care; -Shave;-Procedure includes: -Develop and implement individualized interventions; -Document on individual resident care plan; -Document in the progress notes if an exception to the established plan of care occurs, i.e., refusals. 1. Review of Resident #37's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 6/12/25, showed:-Moderate cognitive impairment;-Always incontinent of bowel and bladder;-Dependent on staff for toilet hygiene, personal hygiene, bathing and putting on and taking off footwear;-Non-Alzheimer's dementia, diabetes, hemiplegia (paralysis to one side of the body), stroke and seizures. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident experiences bowel and bladder incontinence related to dementia, cognitive impairment, impaired mobility, impaired sensation related to stroke;-Interventions: The resident uses adult incontinent briefs; Monitor for soiling on routine rounds and as needed; Assist to cleanse perineum (genitals and rectal area) and change brief as needed;-Focus: The resident has an ADL and mobility deficit related to cognitive impairment and dementia, shortness of breath, compromised respiratory status, lasting effects of stroke, weakness and limited endurance;-Interventions: Bathing and showering, check nail length and trim and clean on the resident's bathing day; The resident is dependent on staff to complete personal hygiene tasks; The resident is dependent on staff for toileting needs. Observation on 9/8/25 at 7:44 A.M., showed the resident lay in bed. On both hands, the resident's fingernails were approximately one half an inch long with dark matter underneath. The resident's feet were extremely dry with large flakes of skin on the resident's navy-blue mattress. Observation and interview on 9/9/25 at 3:12 P.M., showed Certified Nurse Aide (CNA) E entered the resident's room and explained to the resident that he/she was going to turn and clean the resident. The resident lay in bed, and CNA E checked the resident's brief and said the resident was wet. CNA E positioned the resident on his/her right side and removed the resident's brief. The resident's brief and bed pad were saturated with urine, and the resident also had a large bowel movement. CNA E finished cleaning the resident and said the resident was not on his/her assignment but was helping out another CNA. The resident had extremely dry feet with large flakes of skin on the resident's navy-blue mattress. On both hands, the resident had fingernails that were approximately one-half inch long with dark matter underneath. During an interview on 9/9/25 at 3:35 P.M., CNA F said the assignment switched about 10:30 A.M., and he/she did not know the resident was on his/her assignment. The last time the resident was checked was 10:30 A.M. CNA F said any nursing staff can change residents, but is one of the CNA's primary responsibilities to check incontinent residents every two hours. Observation on 9/10/25 at 10:24 A.M., showed the resident lay in bed. On both hands the resident had long fingernails approximately one half an inch long with dark matter underneath. The resident's feet were extremely (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dry with large flakes of skin on the resident's navy-blue mattress. 2. Review of Resident #48's admission MDS, dated [DATE], showed:-Moderate cognitive impairment;-Rejection of care behavior not exhibited;-Lower extremity impairment on both sides;-Substantial/maximal assistance required for showering/bathing self and lower body dressing;-Partial/moderate assistance required for personal hygiene;-Diagnoses included dementia and generalized muscle weakness. Review of the resident's care plan, in use at the time of survey, showed:-Focus: ADL/mobility deficits - Interventions listed are reflective of resident's usual performance and may fluctuate. The resident has an ADL and/or mobility deficit related to activity intolerance, chronic health conditions, cognitive impairment/dementia, weakness/limited endurance; -Interventions included: Check nail length and trim and clean on bath day and as necessary. The resident requires help from staff with bathing/showering. Resident prefers to have facial hair such as a beard. The resident needs assistance from staff with personal hygiene tasks;-The care plan did not identify the resident as having a history of refusing care. Review of the resident's medical record, showed no documentation in August or September 2025 regarding the resident refusing assistance with hygiene care. Observation and interview on 9/8/25 at 7:02 A.M., showed the resident in bed with his/her feet pressed against the footboard. The resident's toenails were long, thick, and jagged with the big toenail on the right foot protruding approximately 0.5 inches from the top of the resident's toe. The middle toenail on the left foot was purple. During an interview, the resident said he/she gets assistance from staff with showers. He/She was unable to answer other specific questions regarding his/her hygiene and grooming needs and preferences. Observations on 9/9/25 at 12:41 P.M and 4:19 P.M., showed the resident's toenails remained long, thick, and jagged and the middle toenail on the left foot was purple. The resident's beard was scruffy. During an interview on 9/11/25 at 11:15 A.M., the resident said he/she wants his/her beard trimmed but needs staff to help him/her. His/Her toenails have not been trimmed. He/She cannot trim them. During an interview on 9/11/25 at 2:30 P.M., CNA C said the resident requires assistance of one staff with hygiene. He/She can make his/her needs known. Observation and interview on 9/12/25 at 9:06 A.M., showed the Nurse Manager removed the socks from the resident's feet and chunks of flakes fell onto the resident's bed. The bottoms of the resident's feet were dry and flaky. During an interview, the Nurse Manager said the resident's middle toenail was purple. Staff would have seen this when putting on the resident's socks. She would have expected staff to notify the nurse of the discolored toenail. She would have expected staff to put lotion on the resident's feet as part of daily care when getting the resident dressed, and on his/her shower days. CNAs can trim toenails, but Resident #48 will be referred to podiatry. 3. Review of Resident #71's quarterly MDS, dated [DATE], showed:-Short and long-term memory problem;-Severely impaired cognition/rarely made decisions regarding tasks of daily life;-Rejection of care behaviors not exhibited;-Upper and lower extremity impairment on one side;-Dependent for showering/bathing self and personal hygiene;-Substantial/maximal assistance required for upper body dressing;-Setup or clean-up assistance required for eating;-Diagnoses included aphasia (language disorder affecting communication), dementia, and hemiplegia or hemiparesis (weakness on one side of the body). Review of the resident's care plan, in use at the time of survey, showed:-Focus: Restorative - The resident is at risk for decline in eating/self-feeding and requires/benefits from restorative nursing intervention; -Interventions included resident prefers to eat with his/her hands;-Focus: ADL/mobility deficits - ADL self-care performance deficit related to impaired balance, limited mobility and weakness related to comorbidities. He/She will refuse showers at times. Will become aggressive with staff. Refuses nail trimming and shaving or trimming beard; -Interventions included: Be aware due to medical conditions/resident's status, ADL self-care performance and mobility are likely to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fluctuate. The resident requires set-up help when eating. Supervise/assistance as needed. Check nail length and trim and clean on bath day and as necessary to nurse. The resident is usually/always dependent on staff for bathing/showering and to complete personal hygiene tasks. Encourage compliance with hygiene related tasks;-The care plan did not identify interventions for staff to follow if the resident refused care. Observations on 9/10/25 at 8:00 A.M., showed CNA A seated next to the resident in the dining room. The resident used his/her hand to pick up food while eating. His/Her fingernails were long with brown matter underneath, and the front of his/her shirt was soiled with brown streaks of liquid. CNA A poured hand sanitizer on a paper towel and used the towel to wipe the resident's hands. CNA A did not wipe underneath the resident's fingernails. The resident cooperated with the CNA and did not object or refuse assistance. CNA A brought the resident out of the dining room and to the resident's room. At 8:40 A.M., the resident was seated in his/her Broda chair (reclining chair) in his/her room. The front of the resident's shirt remained soiled and the brown matter remained underneath his/her fingernails. During an interview on 9/10/25 at 8:40 A.M., the resident looked at his/her fingernails and said they were not clean. He/She wants clean hands and fingernails. He/She does not like wearing dirty clothes. Observation and interview on 9/10/25 at 12:14 P.M., showed the resident wearing the soiled shirt, and the brown matter remained underneath his/her fingernails. During an interview, the resident said staff have not cleaned him/her up. Observation on 9/11/25 at 7:45 A.M., 8:46 A.M., and 11:13 A.M., showed the resident with long fingernails with brown matter underneath his/her fingernails. During an interview on 9/11/25 at 2:30 P.M., CNA C said the resident requires maximum assistance from staff with his/her ADLs. He/She is not oriented, but can make his/her needs known and can respond appropriately to the questions asked of him/her. He/She can be combative at times, but it's all about how staff approach him/her. Staff need to explain everything they are doing with him/her, step by step, working with him/her on his/her own time and in his/her own way. During an interview on 9/12/25 at 8:58 A.M., the Nurse Manager said the resident often refuses care. He/She may smile and seem agreeable, but then may attempt to hit staff. Staff should gauge the resident's mood when attempting to provide care. The resident has fingernails and he/she does not like people getting underneath them. When the resident is agreeable, staff should seize the opportunity to provide care as tolerated. During an interview on 9/12/25 at 8:44 A.M., the Assistant Director of Nurses (ADON) said the resident requires total assistance from staff with his/her ADLs. The resident has some behaviors of refusing care. Staff should take a calm approach when working with the resident. He/She does better with male caregivers. If the resident refuses care, staff should try again later and with a different approach. 4. During an interview on 9/11/25 at 9:45 A.M. CNA B said all incontinent residents should be checked at minimum every two hours and as needed. The resident's nails can be trimmed on their bathing day, and the resident's feet can be moisturized anytime. 5. During an interview on 9/11/25 at 2:30 P.M., CNA C said nail care should be provided by CNAs during daily care. CNAs can do toenail trimming if a resident is not diabetic or on blood thinners. Staff should check resident's feet when providing daily care. If they observe something new, like a discolored toenail, they should report it to the nurse and encourage the resident to keep their feet elevated. If a resident refuses care, staff should try again later and maybe try to find another staff to offer the assistance. When resident's clothing becomes soiled, staff should clean up the resident and change their clothes. If a resident's hands are dirty after a meal, staff should help the resident wash their hands and get underneath their fingernails. Staff should offer to help shave or trim a resident's beard as part of daily care. 6. During an interview on 9/12/25 at 8:44 A.M., the ADON said nail trims and shaving are done on a resident's shower days. CNAs can provide nail care and toenail care, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unless the resident is diabetic or on a blood thinner, in which case nail care must be done by the nurse. The ADON expected staff to check resident's feet and fingernails when providing daily care. If they observe a resident's toenail is purple or dark in color, they should notify the nurse and the nurse would notify the physician. If a resident uses their hands while eating, staff should help the resident wipe their hands when they are finished eating, and get underneath the resident's fingernails. If a resident's clothing becomes soiled, staff should clean up the resident and change their clothing. During an interview on 9/12/25 at 9:15 A.M., the ADON and the Nurse Manager said they expected staff to check incontinent residents at least every two hours and as needed. Nail care and trimming can be provided by nursing staff during the resident's bath. The resident's feet can also be moisturized at any time but usually with bathing. They would expect staff to know which residents were on their assignments. 7. During an interview on 9/12/25 at 10:30 A.M., the Administrator said she expects staff to check on incontinent residents every two hours to ensure their needs are met. Nursing staff are expected to provide fingernail care and foot care when needed. Staff should apply lotion to a resident's feet if they are noted to be dry and flaking. If staff observe a resident's toenail is discolored, they should report it to the nurse. CNAs can trim a resident's toenails unless they are diabetic. Nurses trim toenails for diabetic residents. If a resident's toenails are too thick and cannot be trimmed by the nurse, the resident should be referred to podiatry. If a resident eats with their hands, staff are expected to wash the resident's hands and get underneath their fingernails, if tolerated. If a resident's clothing becomes soiled, staff are expected to provide care to the resident and change their clothes. Resident #71 has a behavior of refusing care and can become combative with staff. When this occurs, she expected staff to redirect and reapproach later. CNAs can shave and trim a resident's beard. Offering to shave or trim a resident's beard is part of a resident's daily care. 2567916

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate less than 5%. Out of 31 opportunities observed, five errors occurred, resulting in a 16.13 % error rate. (Resident #84 and Resident #86). The census was 90. Review of the facility's Medication Administration policy, dated November 2021, showed:-To administer the following: Right medication; Right dose; Right dosage form; Right route; Right resident; and Right time;-Read the Medication Administration Record (MAR), for the ordered medication dose, dosage form, route, and time;-Verify the pharmacy prescription label on the drug and the manufacturer's identification matches the MAR;-If there is a discrepancy, check the original physician's orders and notify the pharmacy; Do no give the medication until clarified;-Verify that any further medication identifiers match the label and the medication; Identifiers may include drug size, shape and color;-Verify the correct medication, expiration date, dose, dosage form, route, and time again by comparing to the MAR before administering;-Administer oral medications with a full glass of water. Review of the Novolog (an immediate release insulin) FlexPen manufacturer's insert instructions, undated, showed: Key steps in using the FlexPen include priming the pen, dialing the dose, injecting by pressing the button for at least six seconds, removing the needle, and storing the pen without a needle. 1.Review of Resident #84's medical record showed diagnosis that included atrial fibrillation (irregular heartbeat), major depressive disorder, long term use of aspirin, long term use of anticoagulant (blood thinner), heart failure, and neuropathy (pain and numbness to the lower extremities). Review of the resident's physician order sheets (POS), dated, September 2025, showed:-An order dated, 2/5/25, escitalopram oxalate 20 milligrams (mg), give one time a day for depression;-An order dated, 9/3/24, celecoxib (pain medication) capsule 200 mg, give one capsule one time a day for inflammation;-An order dated, 6/25/22, aspirin 81 mg give one tablet, one time a day for atrial fibrillation;-An order dated, 6/25/22, Eliquis (blood thinner) 5 mg, give one tablet, every 12 hours for atrial fibrillation. Observation on 9/10/25 at 8:04 A.M. showed, Certified Medication Technician (CMT) I prepared the resident's medications at the medication cart on the 100 hall. CMT I entered the resident's room and administered the resident's medications. CMT I did not administer the resident's escitalopram oxalate 20 mg, celecoxib 200 mg, aspirin 81 mg, and Eliquis 5 mg.Review of the resident's MAR, dated 9/1 to 9/30/25, showed:-An order dated, 2/5/25, escitalopram oxalate 20 mgs, give one time a day for depression; A.M. med; documented as administered;-An order dated, 9/3/24, celecoxib capsule 200mgs, give one capsule one time a day for inflammation; A.M. med: documented as administered;-An order dated, 6/25/22, aspirin 81 mg give one tablet, one time a day for atrial fibrillation; A.M. med; documented as administered;-An order dated, 6/25/22, Eliquis 5 mgs, give one tablet, every 12 hours for atrial fibrillation; A.M. med; documented as administered. During an interview on 9/10/25 at 10:49 A.M., CMT I said he/she thought he/she gave the resident all of his/her medications. CMT I thought he/she gave the medications to the resident when the surveyor was not observing but wasn't sure. CMT I said he/she double checks the medication orders on the MAR prior to administering medications. During an interview on 9/11/25 at 10:40 Licensed Practical Nurse (LPN) K said when staff are administering medications, physician orders should be followed and medications should be given at the time the MAR shows in its entirety. If a medication was not given for any reason, it should be charted as not given. Medications should be checked twice against the MAR prior to giving the medicine to ensure accuracy. During an interview on 9/12/25 at 9:15 A.M., the Assistant Director of Nursing (ADON) and the Nurse Manager said all medications are expected to be given per the physician orders in its entirety. Staff are expected to utilize the five rights when administering medications to ensure accuracy. During an interview on 9/12/25 at 10:30 A.M., the Administrator said she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expects staff to follow physician orders and accurately give residents their medications in their entirety. 2. Review of Resident #86's medical record showed diagnoses that included cognitive communication deficit and diabetes.Review of the resident's physician order sheets (POS), dated, September 2025, showed:-An order dated, 5/22/25, Novolog FlexPen subcutaneous (fatty layer of the skin) solution pen injector 100 units per milliliter (ml), inject 14 units subcutaneously with meals;-An order dated, 5/22/25, Novolog FlexPen subcutaneous solution pen injector 100 units per ml, inject per sliding scale (a measurement of blood sugar), if blood sugar is: 151-200 inject 2 units; 201-250 inject 4 units; 251-300 inject 6 units; 301-350 inject 8 units; 351-400 inject 10 units.Observation on 9/9/25 at 11:34 A.M., showed Licensed Practical Nurse (LPN) J took the resident's blood sugar and the resident's blood sugar showed 173. LPN dialed the resident's Novolog FlexPen to 16 units, entered the resident's room and administered the Novolog insulin to the back of the resident's left arm. LPN J did not prime the Novolog FlexPen prior to administering the insulin. During an interview on 9/11/25 at 8:56 A.M., Registered Nurse (RN) A said the insulin pens are to be primed with two units of insulin before administering the insulin to the resident every time. Priming the pen removes any air bubbles and ensures the insulin dose more accurate. During an interview on 9/11/25 at 10:40 A.M., LPN K said insulin FlexPens should only be primed when the pen is being used for the first time. LPN K was not aware if the insulin FlexPens should be primed with each use. During an interview on 9/12/25 at 9:15 A.M., the Assistant Director of Nursing (ADON) and the Nurse Manager said the insulin FlexPens are expected to be primed by the nursing staff administering the medication with 2 units of insulin each time the FlexPen is being used. It ensures a more accurate dose by removing any air bubbles. During an interview on 9/12/25 at 10:30 A.M., the Administrator said she would expect staff to prime insulin FlexPens prior to each use. 1454154