STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265225	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Living Center	415 Sidney Street, Saint James, MO 65559

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, facility staff failed to complete a baseline care plan within 48 hours of admission for three residents (Resident #7, #16, and #30) out 13 sampled residents. The facility census was 43.1. Review of the facility's policy titled Care Plan, Temporary, undated, showed a temporary care plan will be implemented to meet the new residents' immediate needs. To assure that the residents immediate care needs are met and maintained, a temporary care plan will be implemented for the resident within twenty-four hours of admission. The temporary care plan will be used until the comprehensive assessment has been completed and an interdisciplinary care plan has been developed according to the Resident Assessment Instrument (RAI), manual used to complete resident assessments, process. 2. Review of Resident #7's medical record showed staff documented the resident was admitted to the facility on [DATE]. Review of the record showed a baseline care plan completed on 12/20/24. 3. Review of Resident #16's medical record showed staff documented the resident was admitted to the facility on [DATE]. Review of the record showed a baseline care plan completed on 07/21/25. 4. Review of Resident #30's medical record showed staff documented the resident was admitted to the facility on [DATE]. Review of the record showed a baseline care plan completed on 7/08/25. 5. During an interview on 09/25/25 at 10:10 A.M., License Practical Nurse (LPN) E said there is an admission checklist at the nurse's station, and it shows the admitting charge nurse is to complete the baseline care plan within two hours of a resident being admitted . He/She said the baseline care plan is completed upon admission, so staff know the resident's normal day to day routines and how to care for the resident. He/She said if the baseline care plan is not completed then staff will not know how to care for the resident. During an interview on 09/25/25 at 12:31 P.M., the Care Plan Coordinator said he/she is very new to this role and facility, but he/she believes the admitting charge nurse is responsible for completing the baseline care plans. He/She said the baseline care plan should be completed 24-48 hours after admission. He/She said the importance of having a baseline care plan is so staff to know how to care for the resident. During an interview on 09/25/25 at 1:00 P.M., the Director of Nursing (DON) said baseline care plans should be completed upon admission by the admitting charge nurse. He/She said the baseline care plan should be completed as soon as possible but within 24 hours. He/She said the importance of baseline care plans is for staff to know how to care for the newly admitted resident. During an interview on 09/25/25 at 1:50 P.M., the administrator said baseline care plans should be completed upon admission. He/She said previously it was the Care Plan Coordinator who completed them. He/She said baseline care plans should be completed within 24 hours. He/She said the importance of completing a baseline care plan is, so staff know how to care for the resident.

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to review and revise the care plan after falls for five residents (Resident #4, #5, #16, #20, and #42) out of 13 sampled residents. The facility census was 43.1. Review of the facility policy titled Care Plan Comprehensive, undated, showed an individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be based on a thorough assessment that includes but is not limited to the Minimum Data Set (MDS), a federally mandated assessment tool. The interdisciplinary care plan team is responsible for the periodic review and updating of care plans, when a significant change in the resident's condition has occurred, at least quarterly, and when changes occur that impact the resident's care (i.e., change in diet, discontinuation of therapy, changes in care areas that do not require a significant change assessment). 2. Review of Resident #4's Annual MDS assessment, dated 06/13/25, showed staff assessed the resident as: -Severely cognitively impaired; -Used a wheelchair; -Required partial to moderate assist with all mobility; -Had not fallen since admission or prior assessment; -Diagnoses of arthritis, high blood pressure, heart disease, anxiety and depression. Review of the resident's medical record showed staff documented: -On 05/15/25 unwitnessed fall with bruising to right side face; -On 09/7/25 unwitnessed fall without injury. Review of the resident's care plan, dated 06/23/25, showed the care area for falls updated 06/28/24. The care plan did not contain documentation of the falls on 05/15/25 or 09/07/25 or updated interventions. 3. Review of Resident #5's Quarterly MDS assessment, dated 08/22/25, showed staff assessed the resident as: -Severely cognitively impaired; -Used a wheelchair; -Had upper extremity impairment on one side; -Dependent on staff for all mobility; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Had no falls since admission or prior assessment; -Diagnoses of hip fracture, other fracture, high blood pressure, and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of the resident's medical record showed staff documented: -On 07/19/25 unwitnessed fall with left femur fracture; -On 09/22/25 unwitnessed fall with no injury. Review of the resident's care plan, dated 08/28/25, showed the care plan did not contain documentation of the falls on 07/19/25 or 09/22/25 or updated interventions. 4. Review of Resident #16's admission MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Used a wheelchair; -Required supervision or touch assist with all mobility; -Diagnoses of non-traumatic brain dysfunction, cancer, and high blood pressure. Review of the resident's medical record showed staff documented: -On 08/03/25 unwitnessed fall without injury; -On 08/19/25 unwitnessed fall without injury; -On 09/03/25 unwitnessed fall without injury. Review of the resident's care plan, dated 07/25/25, showed the care area for falls updated on 07/25/25. The care plan did not contain documentation of the 08/03/25, 08/19/25 or 09/03/25 falls or updated interventions. 5. Review of Resident #20's Quarterly MDS assessment, dated 06/10/25, showed staff assessed the resident as: -Severely cognitively impaired; -Did not use mobility devices; -Required supervision or touch assist with walking; -Had fallen since admission or prior assessment; -Had two falls without injury; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses of heart failure, high blood pressure, anxiety, dementia, and bipolar disorder (associated with episodes of mood swings ranging from depressive lows to manic highs). Review of the resident's medical record showed documented: -On 05/14/25 witnessed fall, no injury; -On 08/12/25 unwitnessed fall with reopening of right elbow scab; -On 09/6/25 unwitnessed fall no apparent injury, sent to emergency room for evaluation, bruise to upper back; -On 09/11/25 witnessed fall, bruise on back of head. Review of the resident's care plan, dated 06/16/25, showed staff did not document the falls or updated interventions for the falls. 6. Review of Resident #42's admission MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Used a walker and wheelchair; -Required partial to moderate assist with all mobility; -Had not fallen prior to admission; -Diagnoses of high blood pressure, diabetes, and Alzheimer's Disease. Review of the resident's medical record showed staff documented: -On 09/17/25 unwitnessed fall, no injury; -On 09/19/25 unwitnessed fall, bruising to left eye. Review of the resident's care plan, dated 08/19/25, showed staff did not document the falls or updated interventions for the falls. 7. During an interview on 09/25/25 at 9:32 A.M., Certified Medication Technician (CMT) A said care plans should have all fall interventions listed for the resident. During an interview on 09/25/25 at 9:36 A.M., Certified Nurse Aide (CNA) C said all fall interventions should be listed on the residents' care plans. During an interview on 09/25/25 at 10:16 A.M., Licensed Practical Nurse (LPN) E said all fall interventions should be on the care LPN E said he/she did not know if the nurses could update or edit care plans, usually the MDS Coordinator or Director of Nursing (DON) does it, or even the Social Services Director (SSD), but he/she has never edited a care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/25/2025 at 12:31 P.M., the MDS Coordinator said he/she just started working at the facility on 09/03/25, and this is his/her first full week in his/her office. The MDS Coordinator said he/she has not been trained on care plans yet. He/she said care plans should be updated after every fall and with new interventions. The MDS Coordinator said everyone uses the care plan from CNAs to dietary staff, so they know how to care for the residents. During an interview on 09/25/25 at 1:00 P.M., the DON said care plans should be updated after every fall and should include new interventions. He/she did not know they were not updated; he/she has only been in this position for about one month. The DON said the MDS Coordinator is responsible for updating the care plan, but the nurses should be able to update the care plans as well, and he/she will have to train them. During an interview on 09/25/25 at 1:30 P.M., the administrator said care plans should be updated after every fall and with new interventions and the MDS Coordinator is responsible for updating them. The administrator said he/she would think that the nurses would be able to update them as well but is not sure what access they have in the system, and he/she did not know they were not being done.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, facility staff failed to document the neurological assessments (an assessment completed to determine if the nervous system is impaired) for six residents (#4, #5, #8, #16, #20, and #42) out of 13 sampled residents. Facility staff failed to complete the event documentation for four residents (Resident #4, #8, #20 and #42) out of 13 sampled after falls. The facility census was 43. 1. Review of the facility policy titled Event Investigation, undated, showed the purpose is to investigate the cause of all injuries which have not been witnessed, and to identify any injuries after a resident sustains an event. Complete an event report form as soon as possible whenever there is an unusual, unexpected and/or unintended event that is not consistent with the routine operation of the facility, the routine care of the resident and/or adversely effects or has the potential to adversely affect a resident or visitor. Examples of when a form should be completed include fracture/dislocation of unknown origin, bruise/skin tear of unknown origin, fall or person found on the floor. The charge nurse is responsible for completion of the Report of Event form and forwarding to the Director of Nursing (DON) as soon as possible. Review of the facilities observation report titled Neurological Checks 72-hour monitoring eight hour shifts, undated, showed neurological checks are required for 72 hours after an unwitnessed fall or head injury. The frequency for neurological checks is for the first hour every 15 minutes times four; for the second hour every 30 minutes times two; for the next two hours every one-hour times two; and for the next 72 hours every shift. 2. Review of Resident #4's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 06/13/25, showed staff assessed the resident as: -Severely cognitively impaired; -Used a wheelchair; -Required partial to moderate assist with all mobility; -Had not fallen since admission or prior assessment. Review of the resident's progress notes showed staff documented: -On 05/15/25: Unwitnessed fall with bruising to right side of face. The medical record did not contain documentation of neurological checks completed;-On 09/07/25: Unwitnessed fall without injury. The medical record did not contain nine of 17 neurological checks. Review of the resident's medical record showed staff did not document a fall event report for 05/15/25 or 09/07/25. 3. Review of Resident #5's Quarterly MDS assessment, dated 08/22/25, showed staff assessed the resident as: -Severely cognitively impaired; -Used a wheelchair; -Had upper extremity impairment on one side; -Dependent on staff for all mobility; -Had no falls since admission or prior assessment. Review of the resident's progress notes showed staff documented: -On 08/18/25: Unwitnessed fall with skin tear. The medical record did not contain 11 of 17 neurological checks;-On 09/22/25: Fall with no injury. The medical record did not contain eight of 17 neurological checks. 4. Review of Resident #8's Quarterly MDS assessment, dated 08/22/25, showed staff assessed the resident as: -Moderate Cognitive impairment; -Used a wheelchair; -Required substantial/maximal assist from staff for all mobility; -Had not fallen since admission or prior assessment;-Diagnoses of non-traumatic brain dysfunction. Review of the resident's progress notes showed staff documented: -On 07/13/25: Unwitnessed fall. The medical record did not contain seven of 17 neurological checks;-On 09/20/25: Unwitnessed fall. The medical record did not contain completed neurological checks. Review of the resident's medical record showed staff did not document a fall event report for the 07/13/25 and 09/20/25 falls. 5. Review of Resident #16's admission MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Used a wheelchair; -Required supervision or touch assist with all mobility; -Diagnoses of non-traumatic brain dysfunction, cancer, and high blood pressure. Review of the resident's progress notes showed staff documented: -On 08/03/25: Unwitnessed fall. The medical record did not contain 16 of 17 neurological checks;-On 08/19/25: Unwitnessed fall. The (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical record did not contain completed neurological checks;-On 09/03/25: Unwitnessed fall. The medical record did not contain completed neurological checks. 6. Review of Resident #20's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Did not use mobility devices; -Required supervision or touch assist with walking;-Had fallen since admission or prior assessment; -Had two falls without injury. Review of the resident's progress notes showed: -On 07/24/25: Unwitnessed fall with small skin tear to left elbow. The medical record did not contain documentation of neurological checks completed;-On 08/12/25: Unwitnessed fall with reopening of right elbow scab. The medical record did not contain documentation of neurological checks completed; -On 09/06/25: Unwitnessed fall with no apparent injury, sent to the emergency room (ER) for evaluation with a bruise to upper back on. The medical record did not contain five of 17 neurological checks;-On 09/11/25: Witnessed fall with small hematoma (bruise) on back of head. The medical record did not contain three of 17 neurological checks, and the completed 14 neurological checks consisted of only vital signs (blood pressure, heart rate, temperature, respiratory rate and oxygen saturation). Review of the resident's medical record showed staff did not document a fall event report for the falls. 7. Review of Resident #42's admission MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Used a walker and wheelchair; -Required partial to moderate assist with all mobility; -Had not fallen prior to admission. Review of the resident's progress notes showed staff documented: -On 09/17/25: Unwitnessed fall with no injury. The medical record did not contain documentation of neurological checks completed;-On 09/19/25: Unwitnessed fall with bruising to the left eye. The medical record did not contain five of 17 neurological checks, and the completed 12 neurological checks consisted only of vital signs. Review of the resident's medical record showed staff did not document fall event report for the 09/19/25 fall. 8. During an interview on 09/25/25 at 10:16 A.M., Licensed Practical Nurse (LPN) E said if a resident has a fall and hits his/her head he/she will begin neurological checks, or if it was unwitnessed. LPN E said if the resident requires neurological checks, they should be completed every 15 minutes for the first hour, then every 30 minutes for two hours, then every hour for the remainder of the shift, then every shift for three days. LPN E said neurological checks are documented under the event or observation in the computer, and staff are supposed to fill out the event report, and typically the charge nurse at the time is supposed to open the event. LPN E said he/she did not know why the event reports were not being done consistently and was not sure why the neurological checks were not being done consistently. LPN E said he/she is not sure if the documentation is being followed through on, the facility has not had a consistent DON. LPN E said staff use a daily report form to document which residents had falls or need to have neurological checks completed. LPN E said he/she completes neurological checks to ensure there is no obvious head injury or something that could start hours after such as a head injury. LPN E said the DON is responsible for overseeing staff to ensure all documentation is completed, but without a consistent DON staff have gotten loose in their charting. During an interview on 09/25/25 at 1:00 P.M., the DON said neurological checks should be completed if a resident bumps their head or has an unwitnessed fall. He/she said neurological checks should be completed every 15 minutes times four, every four hours after that for 24 hours, then every shift for 72 hours. He/she said the neurological checks he/she has seen were done on paper, and he/she does not know why staff do not consistently complete them. The DON said he/she did not know what the frequency was for the checks in the computer, and he/she has only worked at the facility for about a month and is working on getting everything organized. He/She said the nurses are responsible for completing the neurological checks and event reports. The DON said it would be ideal for the staff to complete event reports as soon as the falls (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	happens, and then start the neurological checks, and complete all assessments that need to be done, and this is what he/she expects them to do, because the assessments can detect brain bleeds or a concussion or any type of issue. During an interview on 09/25/25 at 1:30 P.M., the administrator said neurological checks should be completed for unwitnessed falls or witnessed falls with head involvement, and he/she was not sure of the frequency, but knows at least each shift should be doing something and it is for 72 hours. The administrator said it should be documented in the computer under observations, nurses should also do a follow up progress note in the computer, and an event report should be completed for unwitnessed falls and the charge nurse is responsible. He/she said it is important to complete neurological checks to make sure there are not any neurological deficits or a brain bleed, and if there are staff can get the resident sent out in a timely manner to prevent more injury or harm.

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, facility staff failed to ensure safety in the shower room with an unsecured shower drain cover for one resident (Resident #9) out of 13 sampled residents. The facility census was 43. 1. Review of the facility's Preventative Maintenance List, undated, showed it contained a monthly review and checklist of the physical environment for each area of the facility, and did not contain the shower rooms as an area the maintenance staff checked for condition. Review of the policies provided by the facility showed the policies did not contain a policy for reporting maintenance concerns and repairs needed. 2. Review of Resident #9's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Intact cognition; -Used a wheelchair; -Required moderate assist from staff members with bathing; -Had one non-injury fall. Review of the resident's medical record showed the record did not contain even documentation of the resident's shower chair wheel going in the drain. During an interview on 09/24/25 at 9:27 A.M., the resident said staff put him/her in a white plastic shower chair, propelled him/her forward, and the front wheel of the shower chair went in the open drain, which had been missing three screws on the drain cover. The resident said the drain cover flipped up and sent him/her forward in the chair, and he/she had to grab the bar on the shower wall to keep from falling out of the shower chair. The resident said staff pulled the shower chair backwards and told him/her to let go of the bar and he/she told the staff he/she couldn't, he/she would fall out of the shower chair and on to the floor. The resident said he/she is now afraid to go take a shower until it gets fixed. Observation on 09/24/2025 at 10:54 A.M., showed the shower room occupied by an unknown resident and staff. The metal shower drain cover has three missing screws used to secure the cover to the metal drain, and is flipped up on side, out of the drain. The plastic shower chair has its front left wheel down in the open drain. The shower chair tilted forward. Observation on 09/25/25 at 11:59 A.M., showed the shower room occupied by an unknown resident and staff. The metal shower drain cover has three missing screws used to secure the cover to the metal drain, and is flipped up on side, out of the drain. During an interview on 09/25/25 at 12:00 P.M., CNA M said he/she provides the residents shower, and he/she had noticed the drain cover does not have screws in it, and it never has. The CNA said he/she had a resident on a shower bed, and the wheel from the shower bed went down in the drain and broke off. The CNA said he/she hasn't told anyone the drain cover is not screwed down, because he/she didn't know it was supposed to be screwed down. The CNA said staff should put issues with environment, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or equipment on a maintenance slip in the maintenance book. During an interview on 09/25/25 at 12:07 P.M., Licensed Practical Nurse (LPN) E said he/she wasn't aware the drain in the shower is broken, and typically a maintenance request should be filled out. The LPN said the shower drain cover popping up out of the drain could be a trip hazard, and a resident could get cut on it. The LPN said anyone can fill out a maintenance request form, it's on the Maintenance Supervisor's door. The LPN said nobody has reported a resident being propelled in a plastic shower chair, and it going in the drain. The LPN said staff should have informed him/her if a chair fell in the drain. The LPN said it would be a safety concern. During an interview on 09/25/25 at 12:32 P.M., CNA F said he/she has not reported the broken drain cover to the current Maintenance Supervisor. The CNA said he/she has pushed the shower chair with the resident in it, and the wheel fell into the drain. The CNA said he/she has pushed the resident into the drain, he/she can see how dangerous it is, but he/she can only tell maintenance so many times. The CNA said he/she should have told the current Maintenance Supervisor, it is the only Maintenance Supervisor, he/she hasn't told. During an interview on 09/25/25 at 12:39 P.M., the Maintenance Supervisor said he/she was not aware the shower drain is supposed to be screwed down. The Maintenance Supervisor said he/she hasn't ever had anyone report to him/her, any issues with the shower drain. The Maintenance Director said he/she would expect staff to report it, staff should have filled out a maintenance request on door. During an interview on 09/25/25 at 1:01 P.M., the DON said staff has reported issues with the shower drain to him/her. The DON said if the staff propelled a resident in the shower chair and it went into the drain, the staff should have reported it to the charge nurse, and an event form should have been filled out. The DON said the event forms are in the system, so he/she has access to go in and review the event forms. The DON said the staff should also notify maintenance and the administrator to get the drain cover fixed, because the next time a resident may not be able to catch themselves on an assist bar and fall in shower. During an interview on 09/25/25 at 1:25 P.M., the administrator said staff has not reported a broken shower drain to him/her. The administrator said staff has not reported a shower chair falling into the shower drain, with a resident in it. The administrator said there would be a risk for injury, by the resident being thrown out of the shower chair. The administrator said he/she would expect staff to stop using that shower until the drain is fixed, and to notify maintenance. The administrator said he/she would expect an event report completed. The administrator said the shower aides and Maintenance are responsible to make sure shower rooms are maintained. The administrator said he/she is responsible to make sure the building is maintained. The administrator said he/she is not aware the shower room is not on the monthly preventative maintenance list; it should be on the monthly maintenance list.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265225	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Living Center	415 Sidney Street, Saint James, MO 65559

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, facility staff failed to change one resident's (Resident #9's) of three sampled residents supra-pubic indwelling urinary catheter (flexible tube inserted through the abdomen directly into the bladder to drain urine) per physician's order and failed to provide catheter care. The facility census was 44.1. Review of the facility's policy titled Catheter Care, undated, showed catheter care is to be provided, to prevent infection and reduce irritation. 2. Review of Resident #9's face sheet showed staff documented a diagnosis of Neuromuscular dysfunction of bladder (Nerves that control bladder function are damaged, leading to problems with storing and releasing urine). Review of the resident's care plan, dated 07/03/25, showed staff documented the resident has an indwelling urinary catheter and catheter care should be provided every shift. Review of the resident's physician's order sheet (POS), dated September 2025, showed: -Order for catheter care every shift and to change catheter monthly on the 18th.-Cleanse area around suprapubic catheter, pat dry, place split gauze around catheter, secure with tape once a day. Review of the resident's Treatment Administration Record (TAR), dated September 2025, did not contain documentation staff provided catheter care on the evening shift for 09/03/25, 09/12/25, 09/15/25, 09/18/25, 09/19/25, and 09/23/25. Review showed staff did not document they changed the resident's catheter as ordered on 09/18/25. Observation on 09/22/2025 at 3:45 P.M., showed the resident in bed with his/her supra-pubic catheter tube secured to his/her leg and the catheter site with dried, reddish and black drainage around it. During an interview on 09/22/2025 at 3:45 P.M., the resident said it is probably time for staff to change his/her catheter. Observation on 09/24/25 at 8:58 A.M., showed the resident in bed with his/her catheter tubing secured to his/her leg. The catheter site had dried black and reddish drainage around it and on the catheter tubing. During an interview on 09/24/25 8:58 A.M., the resident said the staff does not always provide catheter care. He/She said the night shift and evening shift did not complete it, or place gauze at the catheter insertion site. The resident said he/she tries not to bother the staff, is appreciative of the care and never turns it down. Observation on 09/24/25 at 4:16 P.M. showed the Director of Nursing (DON) entered the resident's room and observed the resident's catheter site had dried black and reddish brown drainage around the tubing and did not have a split sponge in place. At this time, the DON explained to the resident they should have a split sponge at the catheter site, and he/she did not know why the resident did not. Observation showed the DON attempted to wipe the dried drainage from the tube. The DON explained to the resident staff are supposed to clean the catheter site. The resident explained to the DON staff are supposed to, but they don't and had not received catheter care and has not had the gauze around the tubing today, or yesterday. During an interview on 09/25/25 at 11:15 A.M., the DON said Registered Nurse (RN) L said he/she forgot to do the resident's catheter care the night before. The DON said by the looks of the resident's catheter tubing, it had not been changed on the 18th and if the TAR had not been signed by a nurse, he/she would say the catheter did not get changed. During an interview on 09/25/25 at 11:40 A.M., Licensed Practical Nurse (LPN) E said he/she has noticed some mornings the resident does not have a split bandage around the catheter site. The LPN said the resident is supposed to have his/her catheter changed once a month. The LPN said if a nurse comes on shift and a treatment has not been signed on the TAR, it should fall on the next shift nurse to get those treatments completed. The LPN said treatments not signed for is an error and should be brought to the DON. The LPN said he/she does not recall telling the DON when he/she came in the morning of the 19th that the resident's catheter had not been documented as changed. During an interview on 09/25/25 at 1:01 P.M., the DON said he/she is (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible to ensure the nurses complete treatments. The DON said he/she just got trained in the system and has not had the chance to look at the TARS. The DON said he/she had not been made aware of missing signatures on the resident's TAR. During an interview on 09/25/25 at 1:25 P.M., the administrator said when treatments are due, they pop up on the TARs the nurse is working on. The administrator said no one has told him/her about missing signatures on the resident's TAR, or the resident missing treatments. The administrator said he/she would expect the nurse who comes on shift after the missing treatments, to report the missing treatments to the DON and perform the treatments that needed to be performed. During an interview on 09/25/25 at 1:54 P.M., RN L said he/she ran out of time on his/her shift and that is why the resident's treatments were not done on the 23rd. The RN said he/she did not change the resident's catheter on the 18th, because it did not pop up for him/her to do it.