STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265881	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Dardenne Prairie	7275 State Highway N Dardenne Prairie, MO 63368

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed physician orders for two residents (Resident #4 and #5) of ten sampled residents. Staff failed to follow physician orders for dressing changes to intravenous (IV) sites and wounds and failed to follow physician orders to secure an indwelling catheter. The facility census was 29.The facility provided no policy for following physician orders upon request.Review of the facility policy Wound Treatment Management with a revision date of 4/2025 showed the following:-To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders;-The facility will follow specific physician orders for providing wound care.Review of the facility policy Skin Assessment with a revision date of 4/2025 showed the following:-It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management;-A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and at least weekly thereafter. 1. Review of Resident #4's face sheet showed the following:-admitted to the facility on [DATE];-Diagnoses including osteomyelitis (infection of the bone) of vertebra, sacral and sacrococcygeal region (lower back and tailbone region of the spine), multiple sclerosis (an autoimmune disease that damages nerves). Review of the resident's care plan for infection dated 10/28/25 showed the resident had osteomyelitis of the sacrum. Staff should provide antibiotics and wound care as prescribed.Review of the resident's care plan for altercation to skin integrity dated 10/28/25 directed staff to weekly skin checks per facility schedule. Review of the resident's care plan for Stage 4 Pressure Ulcer (PU a full-thickness tissue loss where skin, fat, and muscle have been destroyed, exposing underlying bone, tendon, or muscle) dated 10/28/25 directed staff to complete treatments to the resident's pressure ulcer as prescribed.Review of the resident's Physician Orders (POS) dated October 2025 showed the following:-Complete weekly skin checks on Wednesday with an order date of 10/30/25;-PICC (Peripherally Inserted Central Catheter - (a long, thin tube inserted into a vein in the arm and threaded to a large vein near the heart. It is used for long-term intravenous (IV) treatments). Dressing change weekly and as needed with an order dated of 10/28/25;-Urinary catheter (a tube inserted in the bladder to drain urine) anchor and change every Sunday;-Urinary catheter care every shift;-Cleanse under both breasts with soap and water BID (two times a day) and apply antifungal powder;-Admit wound care standing orders: coccyx (tailbone), cleanse with wound cleanser, pat dry, apply cover dressing and notify wound care provider for further directions with a start date of 10/28/25. Review of the resident's Medication Administration Record/Treatment Administration Record (MAR/TAR) dated October 2025 on 11/5/25 showed the following:-Coccyx wound: sterile saline, skin prep, pack with Opticell AG (a type of silver antibacterial gelling fiber wound dressing), apply four by four dressing every 72 hours with a start date of 10/28/25;-There was no documentation staff completed this dressing change on (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/28/25;- Admit wound care standing orders: coccyx, cleanse with wound cleanser, pat dry, apply cover dressing and notify wound care provider for further directions BID (day and night) with a start date of 10/28/25; the day shift on 10/29/25 was blank with no documentation staff completed the ordered dressing change and blank on the night shift on 10/28/25, 10/29/25 and 10/30/25;-Cleanse under breasts with soap and water BID and apply antifungal powder documented was blank on 10/30/25 at 7:00 P.M. with no documentation staff completed the treatment; -Urinary catheter care was not included on the MAR/TAR for staff to document completion;-Urinary catheter anchor change every Sunday was not on the MAR/TAR for staff to document completion. Review of the resident's MAR/TAR dated November 2025 on 11/5/25 showed the following:-PICC line dressing change documented as completed on 11/3/25;-Cleanse under breast with soap and water BID and antifungal powder BID;- There was nothing documented on 11/1/25 at 7:00 A.M. or 7:00 P.M. showing staff completed the ordered treatment and no documentation on 11/2/25 at 7:00 P.M. that staff completed the treatment; -No documentation staff completed urinary catheter care;- Urinary catheter anchor change every Sunday was not part of the MAR/TAR for staff to document completion. Observation and interview on 11/5/25 at 10:20 A.M. showed the following:-Resident #4 lay in the bed with a dressing to the left upper arm where the PICC line was inserted. The dressing on the PICC line was dated 10/22/25;-An indwelling catheter bag hung on the side of the bed with yellow urine;-Resident #4 said that staff has not changed or cleaned the PICC line site since he/she admitted to the facility and staff had not performed any catheter care. His/her treatment to the wound on his/her coccyx has not been done in several days. Observation on 11/5/25 at 3:00 P.M. with the Assistant Director of Nursing (ADON and Registered Nurse (RN) A showed the following:-The ADON and RN A rolled the resident onto his/her side to change the dressing to the wound on the coccyx. The dressing on the resident's coccyx was dated 11/3/25 and when removed was soiled with fecal matter;-There was no anchor on the resident's leg to hold the indwelling catheter in place;-The dressing to the PICC line on the upper left arm was dated 10/22/25. During an interview on 11/5/25 RN A said the following:-Nurses complete the daily dressing changes. The resident's dressing should have been changed twice daily until the contracted wound nurse assessed the resident on 11/4/25 and gave new orders;-Certified Nurse Aides (CNAs) should have ensured that an anchor was in place for the catheter;-The dressing to the PICC line should have been changed. 2. Review of Resident #5's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of urinary tract infection, urinary retention and chronic kidney disease. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 8/27/25 showed the following:-Alert and oriented and able to make needs known;-Able to understand others and able to make self understood;-Requires assistance with Activates of Daily Living (ADL's);- Indwelling urinary catheter. Review of the resident's care plan for indwelling catheter dated 8/26/25 showed the following:The resident requires an indwelling catheter due to wounds and urinary retention;-Catheter care every shift and as needed, change catheter as needed, monitor for signs and symptoms of a UTI. Review of the resident's care plan for at risk for skin alterations dated 8/14/25 directed staff to complete weekly skin checks. Review of the resident's POS dated November 2025 showed the following:-Complete weekly skin assessment on Fridays;-Urinary catheter care every shift and as needed;-Urinary catheter anchor, change every Sunday. Observation on 11/5/25 at 10:28 A.M. showed Resident #5 sat in a wheelchair with an indwelling urinary catheter. The catheter tubing hung down and touched the floor; there was sediment in the tubing. Observation on 11/5/25 at 2:35 P.M. with the ADON and RN A showed the following:-The resident sat in a wheelchair with an indwelling urinary catheter. The catheter tubing hung down and touched the floor; there was sediment in the tubing;-The ADON offered the resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter care, the resident said he/she had not had catheter care in several days;-The ADON and RN helped the resident come to a standing position and the ADON performed catheter care. There was no anchor securing the tubing to the resident's leg and the tubing pulled as the resident stood. The resident said he/she felt the catheter tube pulling down;-RN A said that the catheter tubing should not be on the floor, and he/she was going to call the physician about the sediment in the tubing. During an interview on 11/5/25 at 4:30 P.M. the Director of Nursing said the following:-She would expect staff to follow physician orders;-Resident #4's dressing should have been changed as ordered by the physician and Resident #5's indwelling catheter should have an anchor. 265881

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to secure indwelling catheter drainage tubing and bags for two residents (Resident 4, and #5), in a review of ten residents with indwelling catheters. These failures increased the residents' risk for urinary tract infections. The facility census was 29. Review of the facility policy for Catheter Care with a revision date of 4/2025 showed the following:-It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use;-Catheter care will be performed every shift and as needed by nursing personnel;-Privacy bags will be available and catheter drainage bags will be covered at all times while in use;-Catheter drainage bags will be positioned below bladder level, clear from floor, and will not be level with the resident while the resident is in bed;-Ensure the drainage bag is located below the level of the bladder to discourage backflow of urine. 1. Review of Resident #4's face sheet showed the following:-admitted to the facility on [DATE] with diagnoses of osteomyelitis (infection of the bone);- Multiple sclerosis (an autoimmune disease of the nervous system). Review of the admission assessment dated [DATE] showed the resident was alert and oriented, able to make needs known. Able to make self-understood and able to understand others. Review of the resident's care plan for Indwelling Catheter dated 10/28/25 showed the following:-The resident required an indwelling catheter at this time secondary to neurogenic bladder (a condition where nerve damage prevents the brain and bladder from communicating properly, leading to a loss of bladder control);-Interventions: catheter care every shift and as needed, ensure drainage bag has a dignity cover, keep the drain bag below the level of the bladder. Review of the resident's Physician Orders (POS) dated October 2025 showed the following:-Urinary catheter (a tube inserted in the bladder to drain urine) anchor change every Sunday;-Urinary catheter care every shift. Observation and interview on 11/5/25 at 10:20 A.M. showed the following:-The resident had an indwelling catheter with yellow urine, there was no drainage bag cover over the drainage bag;-The resident said he/she was supposed to have catheter care every shift, but this was not done. It had been several days since his/her catheter has been cleaned. Observation on 11/5/25 at 3:00 P.M. with the Assisted Director of Nursing (ADON) and Registered Nurse (RN) A showed the following:-The resident lay in bed;- The ADON provided wound care;-The resident's urinary catheter did not have an anchor on the resident's leg to secure the catheter tubing;-The urinary catheter drained yellow urine and the urinary drainage bag that was positioned on the side of the bed that was closest to the door opening to the hallway was not covered with a dignity bag. 2. Review of Resident #5's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of urinary tract infection, urinary retention and chronic kidney disease. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 8/27/25, showed the following:-Alert and oriented and able to make needs known;-Able to understand others and able to make self understood;-Requires assistance with Activates of Daily Living (ADL's);- Indwelling urinary catheter. Review of the resident's care plan for Indwelling Catheter dated 8/26/25 showed the following:-The resident required an indwelling catheter due to wounds and urinary retention;-Catheter care every shift and as needed, change catheter as needed, monitor for signs and symptoms of a UTI. Review of the resident's POS dated November 2025 showed the following:-Urinary catheter care every shift and as needed;-Urinary catheter anchor, change every Sunday. Observation on 11/5/25 at 10:28 A.M. showed Resident #5 sat in a wheelchair with an indwelling urinary catheter. The catheter tubing hung down and touched the floor; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was sediment in the tubing. The catheter bag did not have a dignity cover, the drainage bag was visible from the door. Observation on 11/5/25 at 2:35 P.M. with the ADON and RN A showed the following:-The resident sat in a wheelchair with an indwelling urinary catheter. The catheter tubing hung down and touched the floor; there was sediment in the tubing;-The ADON offered the resident catheter care, the resident said he/she had not had catheter care in several days;-The ADON and RN helped the resident come to a standing position and the ADON performed catheter care. There was no anchor securing the tubing to the resident's leg and the tubing pulled as the resident stood. The resident said he/she felt the catheter tube pulling down;-RN A said that the catheter tubing should not be on the floor, and he/she was going to call the physician about the sediment in the tubing. During an interview on 11/5/25 at 9:30 A.M. the Director of Nursing said the following:-Catheter care should be done every shift;-The indwelling catheter tubing should be anchored to the resident's leg to prevent the tubing from pulling and should be changed weekly and dated when changed;-Indwelling catheter tubing should not be on the floor and the catheter bag should be covered;-She would expect staff to provide catheter care every shift, place a catheter tubing anchor in place and date when applied. Catheter tubing should not be on the floor. 2655993

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow current infection control standards for four residents (Resident #1, #3, #7 and #10), in a review of ten sampled residents when staff failed to perform proper hand hygiene and change gloves to prevent infection during personal care for Resident #1, #3, #7 and #10, and failed to properly handle soiled linens during personal care for Resident #10. The facility census was 29.Review of the facility policy for Hand Hygiene with a revision date of 4/2025 showed the following:-All staff will perform proper hand hygiene procedures to prevent the spread of infection to tother personnel, residents and visitors. This applies to all staff working in all locations within the facility;-Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice;-Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Hands hygiene is done when hands are visibly dirty, visibly soiled with blood or other body fluids, between resident contacts, after handling contaminated objects, before performing invasive procedures, before applying and after removing personal protective equipment (PPE), including gloves, before and after handling clean or soiled dressings, linens, before performing resident care procedures, before and after providing care to residents in isolation, after handling items potentially contaminated with blood, body fluids, secretions, or excretions, when, during resident care, moving from a contaminated body site to a clean body site, when in doubt;-The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (putting on) gloves, and immediately after removing gloves. Review of the facility policy for Handling Soiled Linen with a revision date of 4/2025 showed the following:-It is the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. This policy pertains to soiled linen;-All used linen should be handled using standard precautions (i.e. gloves) and treated as potentially contaminated;-Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces and persons;-Used or soiled linen shall be collected at the bedside (or point of use, such as dining room) and placed in a [NAME] bag or designated linen receptacle;-Wash hands after contact with soiled linen. 1. Review of Resident #1's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of spinal stenosis (the narrowing of the spinal canal that puts pressure on the nerves and spinal cord like pain, numbness), urinary tract infection, diabetes, and end stage renal disease with dialysis (the final stage of kidney failure where the kidneys permanently stop working, requiring dialysis). Review of the resident's Minimum Data Set (MDS) a federally mandated assessment instrument completed by staff, dated 8/29/25 showed the following:-Alert and oriented and able to make decisions;-Able to make self-understood and able to understand others;-Dependent upon staff for personal hygiene;-Indwelling catheter. Review of the resident's care plan for indwelling catheter dated 8/29/25 directed staff to complete catheter care each shift. Observation and interview on 10/31/25 at 9:55 A.M. showed the following:-Resident #1 lay in bed with an indwelling catheter, the tubing of the catheter was whitish colored with thick sediment in the tubing;-The resident said he/she went to dialysis three times a week, his/her last appointment was yesterday. The physician at the dialysis clinic said the catheter needed to be changed;-He/She had been incontinent of feces and needed to be changed. The resident turned on the call light. Observation on 10/31/25 at 10:33 A.M. showed the following:-Certified Nurse Aide (CNA) D answered the resident's call light; the resident told CNA D he/she needed to be changed;-CNA D put on a gown and took a pair of gloves out of a box. Without washing his/her hands CNA D (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	applied the gloves, went into the resident's bathroom, put several washcloths in warm water and placed the wet washcloths on the sheet on the resident's bed;-CNA D then rolled the resident over and removed the resident's brief. With a wet washcloth he/she removed dried feces from the anal area then placed the soiled washcloth on the sheet. Without performing hand hygiene and changing gloves, CNA D opened the top drawer of the nightstand cabinet and retrieved a tube of protective, placed some of the ointment on his/her soiled gloves, and applied the ointment to the residents' buttocks. Without changing gloves and performing hand hygiene, CNA D then took a clean brief from the resident's nightstand, put the clean brief on the resident and without changing the sheet, covered the resident with blankets; -CNA D went into the resident's bathroom, placed the soiled washcloth and the soiled brief in a trash bag, removed his/her gown and gloves, and without washing his/her hands exited the resident's room. 2. Review of Resident #3's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of compression fracture of the vertebrae (a break in a bone in the spine), and diabetes. Review of the resident's comprehensive MDS dated [DATE] showed the following:-Alert and oriented and able to make decisions;-Able to make self understood and understand others;-Dependent upon staff for toileting and toilet hygiene;-Incontinent of bladder and bowel. Observation and interview on 10/31/25 at 10:45 A.M. showed the following:-The resident sat in a wheelchair beside the bed and said he/she had been incontinent and needed some help; he/she had been waiting for over an hour for help;-At 10:50 A.M. CNA D and CNA E entered the resident's room and without washing their hands applied gloves;-CNA D transferred the resident from the wheelchair to the bed and removed the resident's pants and brief that were soiled brown with urine stains and had a slight odor; -CNA E placed a package of wipes on the bed;-With the same gloved hands, CNA E took a wipe from the package and removed feces from the resident's anal area and placed the wipe on the resident's bed sheet, then got another wipe from the package and began to wipe of a thick layer of protective ointment from the resident's buttocks, using the same wipe several times to remove the protective ointment;-CNA E, without changing his/her gloves and performing hand hygiene, opened the nightstand drawer and retrieved a tube of cream, put the cream on his/her soiled gloves and applied it to the resident's buttocks;-With out changing gloves and washing hands, CNA E took a clean brief and placed it on the resident, then pulled the sheet up over the resident;-CNA E then took the soiled wipes and placed them in a trash can in the bathroom, removed his/her gloves and without washing hands exited the room. During an interview on 11/5/25 at 4:30 P.M. CNA E said the following:-He/She did not change gloves or wash his/her hands after providing incontinent care to Resident #3;-He/she should have removed his/her gloves and washed hands after providing care;-Soiled linen should not be thrown on the floor. 3. Review of Resident #7's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of kidney failure, and atrial fibrillation (irregular heartbeat). Review of the resident's admission nurses note dated 10/31/25, showed the resident was alert and oriented, able to make decisions and able to understand others and able to make self understood. Review of the resident's care plan for incontinence dated 11/3/25 showed the following:-The resident is at risk for incontinence due to decreased mobility;-Provide assistance for toileting, provide incontinence care after each incontinent episode. Observation on 11/5/25 at 11:15 A.M. showed the following:-The resident sat on the toilet in the resident's bathroom;-Without washing his/her hands or performing hand hygiene, CNA D put on a pair of gloves then transferred the resident from the toilet to a standing position at the rail in the bathroom. There was urine and feces in the toilet. CNA D took a wipe from a package and wiped the resident's anal area, the wipe had fecal matter on the wipe. CNA D folded the wipe over then wiped the resident's anal area several more times with the soiled wipe; -CNA D threw the soiled wipe in the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trash can, and with the same soiled gloves, removed a clean brief from a package of briefs and placed the brief on the resident; --Wearing the same soiled gloves CNA D then pulled the resident's pants up and assisted the resident to sit down in the wheelchair, then pushed the resident in the wheelchair to the side of the bed, picked up the resident's call light, grabbed the resident's clothing, attached the call light to the resident's clothing, moved the resident's water pitcher, cell phone and television remote on the over the bed table all with soiled gloves; -CAN D then pick up the plastic trash can liner out of the trash can, removed his/her gloves and put them in the plastic bag and tied the bag;-Without washing his/her hands or performing hand hygiene CNA D walked out of the resident's room, tossed the bag with the soiled wipes and gloves onto the floor in the hall, and walked to the nurses station and began looking at paperwork. 4. Review of Resident #10's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of urinary retention (the inability to completely empty the bladder), and dementia. Review of the resident's admission nurses note dated 11/4/25 showed the following:-Alert and oriented, difficulty making decisions;-Had an indwelling catheter;- Incontinent of bowel. Review of the resident's care plan for indwelling catheter dated 11/4/25 showed the following:-The resident has an indwelling catheter due to urinary retention;-Catheter care every shift and as needed. Observation on 11/5/25 at 4:00 P.M. showed the following:-CNA D was in the resident's and said the resident need to have catheter care and had been incontinent of feces;-CNA D wore a pair of gloves;-CNA D wet a washcloth in the resident's bathroom sink then returned to the resident's bedside;-CAN D rolled the resident over to his/her side and with the wet washcloth removed fecal matter from the resident buttocks, then threw the soiled washcloth on the floor. Feces remained on the resident's buttocks;-Wearing the same soiled gloves, CNA D opened the drawers of the resident's nightstand to look for more washcloths or wipes and could not find any;-Without removing his/her soiled gloves and washing his/her hands or performing hand hygiene, CNA D left the and returned with a package of wipes. He/She did not wash his/her hands or change gloves before removing a clean wipe and cleaning the remaining feces from the resident's buttocks;-With the same soiled gloves, he/she touched the resident's exposed skin on the resident's back and rolled the resident over to his/her back;-With the same soiled gloves, CNA D removed another wipe from the package and wiped around the resident's meatus (the external opening of the urethra, through which urine exits the body), and with the same soiled wipe, wiped the catheter tubing inside of the meatus. Using the same soiled wipe CAN D then wiped down the catheter tubing, placed the wipe in a plastic bag and put the plastic bag on the floor;-Without changing gloves or washing hands he/she then picked up the plastic bag and the soiled washcloth, moved the over the bed table, using the remote to the bed, lowered the bed, touched the doorknob to open the door and left the room. During an interview on 11/5/25 at 11:30 A.M. CNA D said the following:-Gloves should be changed every few residents unless there was fecal matter on the gloves;-Hands are washed when gloves are changed. During an interview on 11/5/25 at 5:30 P.M. the Director of Nursing said the following:-Staff should wash their hands or perform hand hygiene before providing care and after providing care, and between clean and dirty tasks;-Soiled linen should not be thrown on the floor, staff should bag the soiled linen and take it to the laundry. 2655993