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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265112 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/14/2024 |
| NAME OF PROVIDER OR SUPPLIER Florissant Valley Health & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Graham Road Florissant, MO 63031 | |

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) |
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| <p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>41061</p> <p>See deficiencies cited at NRN712</p> <p>Based on observation, interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service by not designating a person to serve as the Director of Food and Nutrition Services after the Dietary Manager (DM) was terminated on 7/30/24. This deficient practice had the potential to affect all residents in the facility. The census was 76.</p> |

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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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41061</p> <p>See deficiencies cited at NRN712</p> <p>Based on observation, interview and record review, the facility failed to keep the kitchen equipment clean and floors free of debris, grease, and grime by not following their monthly, weekly, and daily cleaning lists. Additionally, the facility failed to store food in a safe and sanitary manner to prevent potential cross-contamination and failed to label and date food items. This had the potential to affect all residents who consumed food from the facility kitchen. The census was 76.</p> |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>41061</p> <p>See deficiencies cited at NRN712</p> <p>Based on observation and interview, the facility failed to maintain an effective pest control program to control the presence of flies and gnats in the kitchen. The census was 76.</p> |