STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265351	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lansdowne Village	4624 Lansdowne Avenue Saint Louis, MO 63116

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. (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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who required assistance with personal care received the care timely for three residents who were left wet/soiled for extended periods (Residents #10, #59 and #6). Moreover, the facility failed to ensure staff cleansed all areas of the skin for these residents during incontinence care. The sample size was 24. The census was 121.Review of the facility's Incontinent Care policy, dated 7/21/22, showed:-The facility will provide incontinence care as directed in the plan of care;-Perform hand hygiene and apply gloves;-Remove soiled brief/under-pad;-Cleanse perineal area from front to back;-Cleanse the rectal area;-Use a clean surface area of the cloth for each wipe;-Remove gloves and perform handy hygiene and apply clean gloves;-If necessary, apply protective ointment;-Remove gloves and perform hand hygiene;-Reposition resident in a safe/comfortable position. 1. Review of Resident #10's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 9/8/25, showed:-Resident rarely/never understood;-Dependent on toilet hygiene;-Always incontinent of bowel and bladder;-Diagnoses included pneumonia, stroke and hemiplegia or hemiparesis (paralysis or weakness on one side of the body). Review of the resident's care plan, in use at the time of the investigation, showed:-Focus: Activities of daily living (ADL) self-care performance deficit;-Goal: Maintain current level of function with ADLs;-Interventions include: Personal hygiene care: Dependent on staff. During an interview on 9/25/25 at 9:53 A.M., the resident's spouse said he/she is at the facility at 8:00 A.M. every day to help his/her spouse because staff do not check on him/her for hours. The resident is always left wet. Staff just do not help. He/She talked to the Administrator, but nothing changes. He/She does not believe staff are providing the care the resident needs, either while he/she is at the facility or after he/she leaves. He/She is at the facility a lot. During an observation and interview on 9/26/25 at 10:11 A.M., the resident's spouse said the resident needed to be changed. Observation showed the resident lay in bed with his/her head elevated. At 10:20 A.M., Certified Nursing Assistant (CNA) N entered the room to provide care. He/She washed his/her hands and applied two pairs of gloves and proper personal protective equipment (PPE). The resident's spouse assisted CNA N to unsecure the resident's brief and help to position the resident in the bed. CNA N pushed the resident's brief down between the resident's legs and assisted the resident to turn to his/her left side, to face away from him/her. The resident had soft bowel movement throughout the brief and on his/her skin. Barrier cream was visible on the resident's skin. CNA N cleansed the stool from the resident's buttocks and then removed one pair of gloves, leaving the other on. He/She applied barrier cream to his/her left gloved hand and applied the cream to the resident's buttocks area. CNA N then applied a clean brief. CNA N failed to cleanse the resident's genitals or inner legs, that were potentially soiled. During observation and interview on 9/29/25 at 8:06 A.M., the resident's wife said the resident was wet. He/She unsecured the resident's brief and showed a saturated brief with urine soaked through the brief and saturated through two towels that lay under the resident. Loose stool was visible near the back of the brief. The resident's skin appeared reddened. The resident's spouse said he/she waved down staff when he/she arrived and saw how wet the resident was, but he/she thought they just thought he/she was waving and not requesting help. Observation on 9/29/25 at 8:13 A.M., showed CNA N entered the room to provide care. The resident had two towels under him/her which were visibly wet with urine. CNA N said he/she needed to get the wound nurse for a skin assessment. At 8:20 A.M., CNA N returned, followed shortly by the wound nurse. CNA N placed gloves on and unsecured the resident's brief. The brief appeared heavy and saturated with urine. Chunks of cotton from the brief stuck to the resident's genitals and buttocks. Liquid stool was between the resident's legs and on his/her buttocks. CNA N began to wipe off the stool to allow the wound nurse to visualize the buttocks. The buttocks were bright red and appeared excoriated. CNA N said this is the first time he/she provided care to the resident on his/her shift, but he/she only arrived about an hour ago. The resident is not typically this wet when he/she comes in. The night shift should not have allowed the resident to be this wet and should have changed the resident before he/she was wet enough to soak through the brief. The wound nurse said the resident needed to continue to receive the barrier cream during care to treat the excoriation. 2. Review of the Resident #59's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment; -Dependent on staff for toilet hygiene;-Frequently incontinent of urine and bowel;-Diagnoses included Parkinson's disease (a movement disorder that worsens over time), heart failure and history of hip fracture. Review of the resident's care plan

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure menus and recipes were followed to ensure they maintain nutritional value. Staff served the wrong meal for breakfast for one of three breakfast meal observations. Staff failed to follow the recipe for two of three puree diets to ensure proper nutritional value and texture. In addition, staff failed to follow meal tickets to ensure preferences were reasonably accommodated for one resident (Resident #24). This had the potential to affect all residents at the facility. The census was 121.1. Review of the facility's menu for the date of 9/30/25, showed cereal of choice, breakfast sandwiches, bacon, and hashbrowns. Observation of the breakfast hall tray meal service on 9/30/25 from 8:30 A.M. thorough 10:00 A.M., showed no breakfast sandwiches observed to be provided. Residents got a variety of items, such as eggs, bacon, and oatmeal. During an interview on 9/30/25 at 1:22 P. M., Resident #4 said today for breakfast he/she got two fried eggs, oatmeal, and bacon. He/She did not get a sandwich for breakfast. Residents have discussed this during resident council meetings, yet nothing has changed. During an interview on 9/30/25 at 10:25 A.M., Resident #24 said for breakfast today he/she got two boiled eggs, one piece of bacon, and nothing else. During an interview on 9/30/25 at 1:49 P.M., Activity Aide M said during the resident council meetings, residents report that what is served for meals is not what is in the menu, which is a frequent concern. During an interview on 9/30/25 at 11:30 A.M., with the Dietary Manager (DM) and Administrator, the DM said today for breakfast, residents were served hashbrowns, bacon, eggs, and oatmeal. Residents should have been served breakfast sandwiches. Dietary staff did not make breakfast sandwiches because most people cannot use their hands, or they want something different. If they made breakfast sandwiches, it would be bacon on bread with cheese and an egg. During an interview on 9/30/25 at 11:52 A.M., the Dietician said staff should follow the menus. 2. During an interview on 9/25/25 at 8:30 A.M., [NAME] K said there are currently 10 residents on a puree diet. 3. Review of the facility's Puree Egg recipe, showed measure the desired number of servings into the food processor. Blend until smooth. Add milk if product needs thinning. Observation on 9/26/25 at 5:15 A.M., showed [NAME] J placed cooked scrambled eggs and a few hardboiled eggs into a blender. He/She then added hot water and blended the eggs. He/She added more hot water and blended. Observation showed the puree recipe book lay closed on the counter next to [NAME] J and was not used. [NAME] J said he/she was not sure how many eggs were used for the scrambled eggs because it was made the day prior. He/She poured the puree out in a steam table pan. It appeared thick and slightly chunky. A sample of the pureed eggs showed it tasted bland and watered down and had a gritty/[NAME] texture. [NAME] J covered the pan with plastic wrap and placed it on the steam table. During an interview on 9/30/25 at 11:30 A.M., with the DM and Administrator, the DM said recipes should be followed. 4. Review of the facility's Cereal Oatmeal Quick recipe, showed:-Water: 2 1/2 gallon;-Instant Oatmeal: 3 pounds (48 oz);-Stir Oats into briskly boiling water. [NAME] for 10 to 12 minutes;-Remove from heat and cover. Let stand for 5 minutes. If oatmeal thickens, add boiling water to obtain a thick pouring consistency; -Pureed: Measure desired number of servings into a food processor. Blend until smooth. Use the fork drip test and the spoon tilt to test to confirm texture. Observation on 9/26/25 at 6:41 A.M., showed [NAME] J opened two quick rolled oats tubs. The tubs appeared to be 42 ounces. He/She poured one full tub and part of the other tub into what appeared to be a 40-quart pot that sat on the stove with steaming hot water. He/She stirred the oats. At 6:51 A.M., [NAME] J added a small, unmeasured amount of melted butter into the pot. He/She stirred the oatmeal and carried the pot to the back food prep station. There, he/she poured the oatmeal into two different steamtable pans. The oatmeal appeared watery. A sample taste of the oatmeal showed it was thin and watery and the oats not fully cooked. There was no flavor. A greasy feel could be felt on the lips from the added butter, but no butter flavor tasted. [NAME] J said he/she would have preferred to cook it longer, but he/she was pressed for time. He/She covered both with plastic wrap and placed the pans onto the steam table. [NAME] J did not puree any of the oatmeal. At 7:18 A. M., [NAME] J stirred the oatmeal. It continued to appear thin and watery. At 7:28 A.M., [NAME] J began meal service. He/She served up one hall cart at a time. Other dietary staff read out the meal tickets as he/she served the trays. He/She placed the oatmeal on trays for regular diets and puree diets. During an interview on 9/30/25 at 11:30 A.M., with the DM and Administrator, the DM said for residents on a puree diet, the oatmeal should be pureed. Recipes should be followed. 5. Review of Resident #24's meal ticket, dated 10/1/25, showed regular diet;-Breakfast notes: Two fresh fruit;-Lunch note: Two fresh fruit;-Dinner note: Two

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review, the facility failed to maintain an effective pest control program in the facility kitchen. Staff failed to ensure food debris was cleaned up daily resulting in roaches being present in the kitchen. The census was 121.Review of the facility's Pest Control policy, dated 8/2/21, showed:-The facility maintains an effective pest control program to remain free of pests and rodents. Pest control strategies are developed emphasizing kitchens, cafeterias, laundries, central supply areas, loading docks, construction, activities, and other regions prone to pest infestations;-All food stored in the dietary area is kept in a designated area in securely covered containers and stored off of the floor and away from the walls. Review of 5 months of pest control visit documents, showed:-Technician visit on 5/9/25: Target issue- ants. No further notes of the areas treated, recommendations, or findings;-Technician visit on 6/26/25: Target issues- spiders and mice. No further notes of the areas treated, recommendations, or findings;-Technician visit on 7/17/25: Target issues- spiders, ants, and mice. Technician comments: Treated for roaches in kitchen and break room baited exterior rodent station for mice activity;-Technician visit on 8/18/25: Target issue- spiders and mice. Technician comments: Treated all areas as needed, replaced bait in rodent stations as needed;-Technician visit on 9/9/25: Target issue- ants and spiders. Technician comments: Treated 3 office, kitchen, nurses stations, dining room, and 3 bathrooms;-Technician visit on 9/26/25: Target issue- ants and spiders. Technician comments: Treated kitchen for roaches. Observation of breakfast meal prep in the kitchen on 9/26/25 at 5:04 A.M., showed [NAME] J arrived through the back entrance and unlocked the kitchen door to allow the surveyor entrance. [NAME] J said he/she is the only dietary staff at this time and will begin breakfast meal prep. Observation of the kitchen, showed trays already set up with utensils, resident diet tickets, and napkins. As [NAME] J placed breakfast meat in the oven, a roach crawled across the back food prep area along the floor. Observation in the back food prep area showed a bin of parsley flakes with no lid and several other seasoning containers with the lids opened sat on the prep station. A second roach crawled out from under the 3-vat sink. Observation under the sink showed trash and food debris on the floor. Observation behind the oven showed trash and food debris, to include an opened individual serving sized jelly container. A 2-tier rolling cart sat near the dish washing sink with a tater tot on the bottom tier. Dirty dishes sat in the dish machine area. Food debris sat in the 3-vat sink. As [NAME] J prepped for breakfast, at 5:47 A.M., a small baby roach crawled across the shelf above the 3-vat sink where clean serving dishes sat. [NAME] J walked over and placed the mixer in the middle rinse sink of the 3-vat sink and ran hot water over it. As [NAME] J stood at the stove, a roach crawled from under the back side of the steam table, closest to the oven and stove, up onto the second shelf of the steam table/prep station and crawled into a white storage bin. Serving utensils were kept in the white storage bin. After a few minutes, the roach crawled back out of the storage bin and around the edge of the bin and then crawled down onto the shelf. Observation of the front side of the steam table, near the ice maker, showed a dead roach lay on the bottom shelf. A second dead roach was also seen a few inches away. There was a buildup of food debris under the various serving stations and dish station. Dirt and debris build-up in the grout between the floor tiles. At 7:05 A.M., a roach crawled out of a drain on the floor near the 3-vat sink. It scurried towards the back food prep area and went under the back food prep station. Observation of the drain showed food debris caked around the edges in the crevices. At 7:07 A.M., [NAME] J reached into the white bin that the roach had crawled into, located on the shelf of the steam table and grabbed a servings scoop from the bin. He/She paced it in the scrambled eggs. [NAME] J said he/she needed a serving spoon for purees and then pulled out the white bin that had previously had the roach in it, yelled out oh gross, and pushed the container back under the shelf. He/She then shivered and said gross. Observation at 7:19 A.M., showed a roach crawled out of the bin that [NAME] J had just looked in and it crawled into the neighboring bin, that also contained serving spoons. The cook began cooking pancakes. At 7:28 A.M., a baby roach crawled down the wall near the 3-vat sink. At 7:38 A.M. , a roach crawled along the back wall behind the oven, on the floor. It hid behind an electric cord. At 7:48 A.M. , [NAME] J grabbed a spatula form the bin that the roach had most recently been seen crawling into and used it to flip pancakes. At 7:55 A.M., a very large, winged roach crawled out from under the stove and crawled to under the steam table. Observation under the stove showed trash, napkins, plastic wrap, along with food debris and a buildup of dirt. Observation of the kitchen on 9/29/25 at 7:16 A.M., showed debris on the kitchen floor. A dead roach in the wash bin of the 3-vat sink. A roach smashed on the ground in front of the steam table. At 7:23 A.M., [NAME] K said he/she had seen some roaches but not too bad. The facility is